





## **ACUPUNCTURE POLICIES & PROCEDURES**

### **❖ RE-SCHEDULING / CANCELLING / MISSING APPOINTMENTS**

Acupuncture is a *cumulative medicine*- a specific frequency and consistency of treatment is required to ensure the greatest possible treatment results. If you need to change the time of your appointment, plan to come at another time on the same day or, if the same day is not possible, be sure to make up the missed appointment within 7 days. We request the courtesy of at least 24-hour notice for re-scheduling or cancelling appointments and the treatment of late arrivals will be up to the acupuncturist's discretion.

### **❖ NOTIFY THE OFFICE IF YOU BECOME SICK**

Infections and illnesses such as common colds, flu's, ear/sinus infections and allergies are often easily treated with acupuncture and herbal prescriptions if addressed within the first 24 hours of onset. This can reduce or eliminate the need for antibiotics, expensive medications and medical visits, and can greatly reduce the duration of illness! In some cases, the illness itself may also become complicated or exacerbated by any current herbal formula you may be taking. It is essential to let your acupuncturist know of any such illnesses, especially if you are taking prescribed herbal formulas.

### **❖ FEE SCHEDULE & PAYMENT POLICY**

There are a growing number of insurance companies that provide coverage for acupuncture treatment, coverage, however, varies greatly between different plans. As a courtesy, we will gladly call to check your insurance coverage and benefits as well as process insurance claims for you, should your particular plan cover acupuncture treatment. Please be aware that we are an out-of-network provider and most insurance plans do not cover 100% of treatment fees. Therefore, we do ask that you pay your deductible amount and co-pay at the time of treatment. We cannot guarantee reimbursement by your insurance company and you are ultimately responsible for any portion of your balance that is not covered, should your insurance company deny any portion of your claim. For patients not filing insurance, payment is due in-full at the time of service. We accept cash, checks, Mastercard and Visa.

❖ <b>New Patient Visit with Treatment</b>	<b>\$90</b>
❖ <b>Follow-Up Treatments</b>	<b>\$60</b>
❖ <b>Acupuncture or Herbal Consult</b>	<b>\$45</b>

### **❖ PRIVACY POLICY**

We are dedicated to providing service with respect to human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. As per the Health Insurance Portability and Accountability Act (HIPAA), and applicable state and federal regulations, your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. A complete, 4 page outline of our Detailed Notice of Privacy Practices is available at any time, by request, for your records.

*I have read and understand the above information and policies. I take full responsibility for alerting the acupuncturist of any conditions that arise which may affect my on-going treatment and I voluntarily agree to the terms and conditions stated above. I understand and accept that payment is expected at the time of service and I am responsible for full-payment of services rendered which are not covered by insurance benefits. I also understand and accept that I am expected to notify the office with a minimum of 24 hours prior to any cancellations or changes to my appointment time. I understand that the use and communication of my health information is only for the purpose of providing my treatment, obtaining payment and conducting health care operations and that my personal information will not be used for other purposes unless my permission has been asked for and given.*

Patient or Guardian's Name (Print)

Patient or Guardian's (Signature)

Date



“A journey of a thousand miles begins with a single step.” ~ Lao Tzu

*All information gathered below is for professional use only and will be held strictly confidential.*

**GENERAL PATIENT INFORMATION**

1<sup>st</sup> time being treated with Acupuncture?  Yes  No  
 Have you ever used Chinese Herbal Therapy?  Yes  No  
 Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ Sex:  Male  Female  
 Height: \_\_\_\_\_' \_\_\_\_\_ Weight: \_\_\_\_\_ lbs  
 Name of Parent or Guardian and their relation to patient (if applicable):  
 \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Apt/Suite #:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home Ph#:** \_\_\_\_\_ **Work Ph#:** \_\_\_\_\_ **Cell Ph#:** \_\_\_\_\_  
**Email Address: (Required for herbal Rx)** \_\_\_\_\_  
 Married  Partner  Single  Separated  Divorced  Widowed  Child  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Referred By? \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Other Contact #: \_\_\_\_\_  
 Name and Ph# of Primary Physician: \_\_\_\_\_

**THE FOLLOWING IS NEEDED FOR THE PURPOSE OF ORDERING ONLINE HERBAL PRESCRIPTIONS ON YOUR BEHALF:**

What address would you like your herbs shipped to?  Same as above  
 Other: \_\_\_\_\_

Is the billing address for the credit card you would use to pick up your online prescription different from above?  No  Yes: \_\_\_\_\_

What email address would you like the prescription pick-up notification sent to?

**INSURANCE ASSIGNMENT OF BENEFITS (If applicable)**

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted and further agrees to authorize Melanie L Miller, L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (patient) hereby authorize my Insurance Company to pay and hereby assign directly to Melanie L Miller, L.Ac. all owed benefits. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Additionally, in Chinese medicine, the body is considered an integrated whole. Although seemingly unrelated, symptoms and conditions that manifest in one area of the body may be indicative of and closely linked to symptoms and conditions occurring in another part of the body. In other words, any presenting sign or symptom could confirm or exclude a diagnosis and drastically change your treatment plan. So that I may gather a comprehensive picture of your body's condition, please complete this questionnaire as thoroughly as possible.*

What is the primary reason for your visit today and to what extent does it impair or limit your daily activities? \_\_\_\_\_

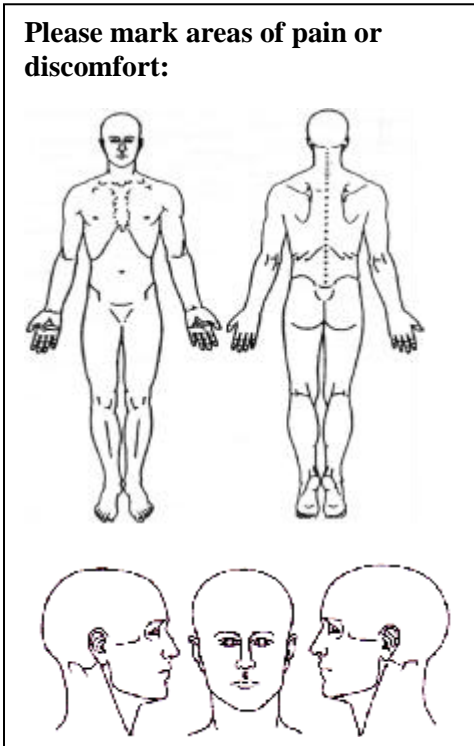
Other Healthcare Providers seen for this condition: \_\_\_\_\_

Treatments provided and the results of those treatments? \_\_\_\_\_

**MEDICAL HISTORY**

**Very important: Do you have any of the following?**

- Cardiac Pacemaker    Seizure Disorder    Hypoglycemia / Diabetes    Bleeding Disorder    High needle anxiety
- Low pain threshold    Taking Coumadin/Warfarin/other blood-thinners    Believe you are or may be pregnant



On a scale of 1-10, how would you rate the average intensity of pain or discomfort? \_\_\_\_\_  
 (1= Slight pain, 10= Extremely intense pain)

- Is the pain or discomfort:
- Sharp    Dull Ache    Throbbing    Cramping    Shooting    Burning
  - Moving    Fixed    Numbness    Tingling
  - Other: \_\_\_\_\_

Are the symptoms worse at any particular time of day? \_\_\_\_\_

How often do you experience symptoms? \_\_\_\_\_

- What makes it **better**?  Pressure/Massage    Cold    Heat    Stillness/Rest  
 Movement/Exercise    Other \_\_\_\_\_

- What makes it **worse**?  Pressure/Massage    Cold    Heat    Stillness/Rest  
 Movement/Exercise    Cold Weather    Damp Weather  
 Other \_\_\_\_\_

**History of hospitalizations or surgeries?**    No    Yes   If so, please describe, including approximate dates:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Medical History:**

- Allergies  Asthma/Bronchitis  Tuberculosis  Alcoholism  Drug Abuse  Obesity  Depression/Anxiety
- Mental/Emotional Disorders  Alzheimers/Dementia  Bleeding Disorders  Cancer/Tumors
- High Blood Pressure  Heart Disease  Kidney Disease  Thyroid Disorder  Seizures  Diabetes  Stroke
- Anemia  Nervous or Musculoskeletal Disorders

**What was your health like as a child?** \_\_\_\_\_

**History of any Infectious Diseases or Sexually Transmitted Diseases?**  No  Currently  In the past  
If so, please describe, including approximate dates of infection: \_\_\_\_\_

**Frequent use of Antibiotics?**  Yes  No

**Do you have any known allergies or sensitivities?**  No  Yes \_\_\_\_\_

**Please list ALL of your current medications (prescription and over-the-counter):**

Name of medication	Prescribed for	Effective?	Noteable side effects?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	

**List any other herbs, vitamins or nutritional supplements that you are currently taking:**  
\_\_\_\_\_  
\_\_\_\_\_

**LIFESTYLE**

**Do you have a regular exercise program?**  Yes  No If so, please describe: \_\_\_\_\_

**Vegan/Vegetarian?**  Yes  No **Known sensitivities to Dairy/Gluten/Wheat?**  No  Yes \_\_\_\_\_

**Please describe your average daily diet:**

Morning: \_\_\_\_\_ Snacks: \_\_\_\_\_  
Afternoon: \_\_\_\_\_ Evening: \_\_\_\_\_

**How much water do you drink per day?** \_\_\_\_\_ glasses \_\_\_\_\_ bottles

**Are you a smoker?**  Yes  No  In the past If so, for how long? \_\_\_\_\_ yrs Packs/day? \_\_\_\_\_

**Do you consume:** Alcohol  Yes  No Coffee  Yes  No Soda  Yes  No Tea  Yes  No  
**Recreational Drug Use?** Again, all information gathered below is for professional use only and will be held strictly confidential.  No  Currently  In the past (Length of time since last usage: \_\_\_\_\_)  Drug(s) \_\_\_\_\_

## HEALTH INVENTORY

### ❖ Perceived Temperature:

- Fevers  Chills  Tendency to feel hot  Tendency to feel cold  Afternoon fever  Night sweats  Cold hands  
 Cold feet  Strong Thirst  Lack of thirst  Hot sensation in the hands/ feet/ chest  
 Other \_\_\_\_\_

### ❖ Energy Level & Immunity:

- Chronic fatigue  Occasional fatigue  Afternoon drowsiness  General body weakness  Sudden Energy Drops  
 Fatigue after exercise  Fatigue after eating  Easily catch colds/Flu's  Frequent Allergies  Slow wound healing  
 Chronic infections  Bruises/bleeds easily  Other \_\_\_\_\_

How would you rate your overall energy level on a scale of 1-10? \_\_\_\_\_ (1= Extreme Fatigue, 10= High Energy)

### ❖ Sleep Patterns:

- Chronic Insomnia (How long? \_\_\_\_\_)  Occasional Insomnia  Wakes unrested  Frequent waking  
 Difficulty staying asleep  Difficulty falling asleep  Wakes to use bathroom (# times per night? \_\_\_\_\_)  
 Restless Leg Syndrome  Unpleasant dreams /Nightmares  Bedwetting  Frequent or vivid dreams  
 Average # hours sleep/night? \_\_\_\_\_ hrs.  Other: \_\_\_\_\_

### ❖ Skin & Hair

- Itching  Dry Skin/Hair  Oily Skin/Hair  Dry, Cracked Nails  Clammy Hands/Feet  Dandruff  Skin Ulcers  
 Eczema  Psoriasis  Hair Loss  Hives  Rashes  Acne  Excessive sweating  Lack of sweating  
 Recent/Changing Moles  Other: \_\_\_\_\_

### ❖ Head, Eyes, Ears, Nose, Throat

- Dizziness  Vertigo  Glasses/Contact Lenses  Blurry vision  Cataracts  Glaucoma  Eye strain/pain  
 Spots or "Floaters" in front of eyes  Poor night vision  Ear ringing ("Tinnitus")  Hearing loss  TMJ pain  
 Hearing Aid  Ear aches/infections  Sinus Pressure  Sinus Congestion  Sinus Drainage  Sinus Infections  
 Nose bleeds  Headaches  Migraines  Facial pain  Teeth grinding  Lip or tongue sores  Dry mouth/Throat  
 Recurrent sore throat  Toothache  Gum disease/Bleeding gums  Other \_\_\_\_\_

### ❖ Cardiovascular System

- High Blood Pressure  Low Blood Pressure  Pacemaker  Blood Clots  Palpitations  Rapid Heartbeat  
 Irregular Heartbeat  Heart Murmur  Mitral Valve Prolapse  Poor circulation  Swelling of Hands/Feet  
 History of Heart Attack  Heart Surgery  Chest Pain/tightness  Phlebitis(venous inflammation)  Fainting  
 Lightheadedness  Easy bleeding/bruising  Anemia  Varicose Veins  Other \_\_\_\_\_

### ❖ Respiratory System

- Cough  Dry cough  Coughing Up Blood  Asthma  Wheezing  Bronchitis  Pneumonia  
 Difficulty inhaling  Difficulty exhaling  Shortness of breath  Chest tightness/heaviness  Painful Breathing  
 Easily Winded  Other \_\_\_\_\_

Phlegm/Mucous:  Thick  Thin  Sm amt.  Lg amt.  Green  Yellow  Brown  Blood tinged

### ❖ Gastro-Intestinal System

- Poor appetite  Over-active appetite  Changes in Appetite  Cravings  Nausea  Vomiting  Constipation  
 Diarrhea  Incomplete BMs  Abdominal pain  Stomachache  Gas/Bloating  Belching  Indigestion  
 Bad breath  Hiccups  Acid Regurgitation  Stomach Ulcers  Intestinal Ulcers  IBS/IBD  Hemorrhoids  
 Leaky-Gut Syndrome  Gluten/Wheat Intolerance  Chronic laxative use  Rectal pain/burning  Blood in stools  
 Weight Loss \_\_\_\_\_ lbs  Weight Gain \_\_\_\_\_ lbs  Other \_\_\_\_\_

### ❖ Urinary System

- Painful urination  Frequent urination  Urgency to urinate  Unable to hold urine  Dribbling urination  
 Incomplete urination  Decreased urine flow  Blood in urine  Cloudy urine  Kidney stones  Bedwetting  
 Frequent night urination (# times per night? \_\_\_\_\_)  Urinary Tract Infections  Other \_\_\_\_\_

❖ **Neurological System**

- Seizures  Tremors  Poor Balance  Concussion  Numbness/tingling  Muscle twitching  Paralysis
 Lack of coordination  Loss of Balance  Multiple Sclerosis  Other \_\_\_\_\_

❖ **Musculo-Skeletal System**

- Muscle weakness  Muscle cramping/spasms  Muscle soreness  Muscle tightness  Scoliosis  Leg pain
 Joint pain/disorder  Neck/Shoulder pain  Upper back pain  Mid-back pain  Lower back pain
 Pain around/under ribs  Sprains/Strains  Carpal-Tunnel Syndrome  Rheumatoid Arthritis  Osteo-Arthritis
 Osteoporosis  Fibromyalgia  Paralysis  Tendonitis  Medial Epicondylitis "Golfer's Elbow"
 Lateral Epicondylitis "Tennis Elbow"  Puffiness or Swelling  Limited range of motion
 Other \_\_\_\_\_

❖ **Psychological/Emotional**

- How would you rate your overall stress level on a scale of 0-10? \_\_\_\_\_ (0= No stress, 10= Extremely high stress)
 Depression  Anxiety  Panic Attacks  Nervousness  Fear  Anger/short temper  Easy to be frustrated
 Sadness  Worry a lot  Excitability  Irritability  Sensitive  Cry easily  Poor memory
 Poor concentration  Difficulty making decisions  ADD/ADHD  Obsessive Compulsive Disorder  Autism
 Alzheimer's/Dementia  Bi-Polar Disorder  Other \_\_\_\_\_

**Other:**

- Hypothyroid  Hyperthyroid  Diabetes Type I  Diabetes Type II  Hepatitis A / B / C
 Pre-mature graying hair  Pre-mature balding  Tooth-loss  Weak Bones / Frequent or multiple fractures
 Cancer/Tumors: \_\_\_\_\_  Chemo/Radiation?  Yes  No  Remission?  Yes  No

MEN ONLY:
 Premature ejaculation  Increased Libido  Low sperm count  Painful intercourse  Prostate problems: \_\_\_\_\_
 Infertility  Nocturnal emissions  Decreased Libido  Pain in groin/genitalia  Irregular sperm morphology
 Feeling of coldness or numbness of genitalia  Impotence/Erectile Dysfunction  Vasectomy: When? \_\_\_\_\_  Poor sperm mobility  Testicular pain/redness/swelling

WOMEN ONLY: # Pregnancies: \_\_\_\_\_ # Births: \_\_\_\_\_ # Miscarriages: \_\_\_\_\_ # Abortions: \_\_\_\_\_
Average duration of Period: \_\_\_\_\_ days (Avg. 4-7) Average length of Cycle: \_\_\_\_\_ days (Avg. 24-32)
Average Menstrual Flow:  Heavy  Moderate  Light  Spotting
Cramps:  None  Severe  Moderate  Mild
 Before Period  During Period  After Period
Clots:  None  Large  Medium  Small
PMS?  No  Yes, Main emotion(s)? \_\_\_\_\_
Breast Tenderness?  Yes  No
Lower Back Pain?  Yes  No
Post-Period Weakness or fatigue?  Yes  No
Birth control?  Yes  No  In the past
If so, what kind? \_\_\_\_\_
How long have you been on Birth Control? \_\_\_\_\_ yrs
Other contraceptive methods? \_\_\_\_\_
Menopausal?  Yes  No
If so, starting at what age? \_\_\_\_\_
Night sweats?  Yes  No
Hot flashes?  Yes  No
If so, what time of day?:
 Morning  Afternoon  Evening  All day
How intense?  Mild  Moderate  Severe
 Irregular periods  Ever have an abnormal PAP smear?  Breast lumps/cysts
 Bleeding between cycles  Uterine fibroids  Ovarian cysts
 Endometriosis  Hysterectomy: Date \_\_\_\_\_  Yeast/Vaginal Infections
 Vaginal discharge  Vaginal dryness  Increased Libido
 Decreased Libido  Pain in groin/genitalia

I have provided all requested information on this form to the very best of my knowledge.

Patient or Guardian's (Signature) Patient or Guardian's Name (Print) Date