New Patient Registration Form

Today's Date: ____/___/______

Patient's Name: _________________________ _________________________ ____________
LAST First Middle Initial

Date of Birth: ____/____/_______ Age: _______ Gender: ☐ F ☐ M Marital Status: _______________

Occupation: ______________________________ Employer: ______________________________________

Address: ____

Email: ____ Phone number: _____________________

Emergency Contact / Relationship: _________________________ Phone number: _____________________

Person Responsible for Service Fee: ________________________ Relationship to Patient: _______________

I was referred by: _______________________________________

Identification Verification

Patient's name and DOB matches a government issued photo ID: ☐ Driver's License ☐ Other: _______________

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New Patient Intake Form

Welcome! This intake form is extremely detailed. The more I know about what's going on for you, the better we can develop a treatment plan. Please provide as much information as you can, even if it seems unrelated to your reason for coming in.

1. Main Concerns

What's the reason for today's session (**Chief Complaint**): ____

How long have you had this condition? ____________ Any known causes? ________________________

2. GENERAL Health

Weight: __________lbs Height ______________

STRESS: Stress level: low /moderate/high ________ Top stressors? _____________________________

SLEEP: Bed time: ___________ Difficulty falling sleep? ____ Waking up feeling refreshed? __________
Wake up at night? ____ If yes, how frequent? _____ If yes, any hot sensation, night sweat?____

ENERGY: Do you feel fatigue / low energy? _______ If yes, when (AM, PM, all day)?_______________

GI (Gastrointestinal):
Bowel Movement: Frequency _____ Stool (soft/loose/dry)? _________ Diarrhea? ____ Constipation? ________
Appetite (poor, good, heavy)? ____________________ Hunger? _______ Bloated after eating? ____
Thirst: easily? ____________ Like drinking cold water? ______ Like drinking warm water? _____

URINATION: Urinate at night? ____ Unusual patterns? _____________ UTI history? __________

Ensure you check **ALL** that apply:
Wear a pacemaker? ________ Implanted prosthetic heart valve? _______ Anemia? _____________
Diabetes? ________________ History of bleeding disorder / current anticoagulation therapy? ___________
Feel warm easily? __ Feel cold easily? ______________ Cold feet/hands? ____________________
Sweat: easily?______ Spontaneous sweat during day? __ Sweat at night when wake up? _________

List all past **surgeries**: ____
List other **MAJOR medical conditions** you have been diagnosed with: ______________________________
List **MAJOR medical conditions** your **direct family members** have: ______________________________
Prescription medications you're currently taking: ____
Vitamins / Supplements you're currently taking: ____
List all **allergies**: ____
Foods / Drinks that you have **sensitivity** to: ____
Are you a **vegetarian**? __________________
Coffee/Caffeine frequency per day: ________ **Alcohol** frequency per week: ________________________
Do you **smoke**? ________________________ Do you use **recreational drugs**? ____________________
Do you **exercises**? _________ What and how frequent? ___________________________________

3. FEMALE Health History (if you are a MALE, skip the section)

Menopause? If yes, started when? _____ Any symptoms (hot flashes, night sweat, insomnia)? _________
If no, answer the FOLLOWING questions:

Are you **currently pregnant**? ______ If yes, how many weeks? _____________ Due date? _____________

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Have you **pregnant** before? ________ If yes, how many live births, when? ________________________
Any **miscarriage** before? __________ If yes, how many, at what weeks, any known cause / chromosome abnormality? ____
Any **abortion** before? _____________ If yes, how many, at what weeks? __________________________

ARE YOU PLANNING TO CONCEIVE? ________ If yes, how long have you tried? _______________
Have you done **IUI**? ___________ If yes, when, what's the results? ___________________________
Have you done **IVF**? __________ If yes, what's the detailed results (# cycles, when, antral follicle count, # eggs retrieved, # embryos, # chromosome normal embryos/blasts, any failed transfer/implantation)? __
____

Blood hormone level in the past 12 months? AMH _________(DATE)
FSH _________(DATE, cycle day?) Estradiol (E2) _________(DATE, cycle day?)
Any diagnosis for: PCOS, Endometriosis, Fibroids, Blocked fallopian tube, Autoimmune condition

Menstruation: Age menses began _____ How many days between cycles_______ days or (irregular)
LMP: Date menses last began _____________ Length of cycle ____ days
Flow: __Heavy __Moderate __Light
Color: __Pale red __Dull red __Red __Bright red __Brown Clots? ________
Ovulation: tracking your **OPK, BBT**? __________ Cervical mucus change in **mid cycle**? ___________
PMS? ___ How long? _____ Symptoms (irritability, tender breasts, food cravings, fatigue)? __________
Around your **periods, any pains**, *pain level on the scale of 0 to 10 (0 is "no pain", 10 is "worst pain")*
Cramps / abdomen pain? ___ If yes, when (before, during, after)? Pain level? ____
Low back pain? __________ If yes, when (before, during, after)? Pain level? ____
Headaches / migraines? ____ If yes, when (before, during, after)? Pain level? ____

Candidiasis? _______ Vaginal discharge: __Dry __Clear __Sticky __White __Yellow __Red __Smell

4. MALE Health History (if you are a FEMALE seeking FERTILITY treatment, please complete this section for your partner)

Do you have recent sperm test in the past 12 months? If yes, was Semen Liquefaction normal? _______________
What's the Sperm Count? Motility? Morphology/normal forms? ____

Do you have low back pain? _______ If yes, complete the Pain Assessment section.

Check those that apply:
__Frequent urination __Unable to hold urine __Night time urination __Cloudy urine
__Excessive libido / sex drive __Decreased libido __Premature ejaculation __Impotence
__Sweat at palm / feet __Sweat at scrotum / genital area __Heavy sensation at legs
__Sexual Transmitted Disease __Surgery or injury history to genital area

5. PAIN Assessment (If you have no pain, skip this section)

Are you currently experiencing pain? ________ When did the pain onset (first started)? ________________
Where is location of the pain? _____________ Does the pain radiate? ______________________________
Please describe the pain (sharp / burning / dull / aching / shooting / traveling / tingling / numb)? ________________
Does the pain affect your daily activities (movement, range of motion, sleep, stress level, etc)? ________________
Condition related to auto accident? _________ *Related to employment?*________ *Employer:* ___________
How would you rate the severity of pain level, *on the scale of 0 to 10 (0 is "no pain", 10 is "worst pain")* _______
Is the pain getting worse? ________________
What makes it feel better? ________________ What makes it feel worse? _________________________

Appointment, Cancellation & Payment Policy

In order to familiarize you with the financial policy of **Harmony Acupuncture Chinese Medicine, Inc.**, we would like to explain how your visits and medical bills will be handled at this office.

Appointments

New Patients Only - A $120 **deposit** is required to hold your initial appointment. The deposit will be applied as a **credit** towards your visit. If you cancel more than 24 hours before your appointment, please email us at info@HarmonyAcCM.com to request a full refund.

We highly recommend scheduling your appointments in advance to get the appointment times you desire, to save valuable time in our office, and to give us a chance to prepare for your visit for a better treatment experience.

Cancellation

- Our office has a **24 hour cancellation policy**. If you **miss** your appointment, **cancel** or **change** your appointment with less than 24 hour notice, you will be charged the **full amount for the session**.
- This policy is in place out of respect for our practitioner and patients. It allows us enough time to schedule another patient trying to get in for care.

Payment Arrangements

- Payments are **due at the time of services**, *unless other arrangement being made between our office and patient prior to the treatment.* Our office accepts Zelle, Credit Cards and many other electronic payment methods.

Insurance

We are out-of-network provider with all insurances. Our office will collect the full amount of your sessions by time of service. If you insurance plan has the out-of-network coverage, you will work with your insurance company directly for reimbursement of covered condition.

Release of Information

I am also authorizing this office upon request from my insurance carrier the release of any medical or other information necessary to process the claim. I also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care

If I suspend or terminate care at any time, my portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to me, and I ultimately will be personally responsible for payment regardless of insurance coverage.

I have read and agree to the above.

Print Name: ________________________________ **Relationship to Patient:** ____________

LAST, First

Signature: ________________________________ **Date:** ______________________

Consent Form

Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a **history of bleeding disorder** or **current anticoagulation therapy**, **implanted pacemaker** or **prosthetic heart valve**, **use of medications**, and/or **pregnancy**. It is important that you notify your practitioner if any of these apply to you. **Please read each item to acknowledge that you have read the entire statement.**

I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

Pregnancy: I will immediately notify the treating provider should I become pregnant or if I am in the process of trying to become pregnant, so that my practitioner can avoid using acupuncture points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial during the pregnancy.

I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine. I understand that in some cases, symptoms may release or intensify temporarily during the course of treatment before relief is sustained.

I understand that I may stop treatment at any time.

I understand that while this document describes major risk of treatment, other side effects and risks may occur.

Acupuncture: I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that caused a collapsed lung) and infection.

Moxibustion: I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of maxibustion.

Cupping/Gua Sha: I understand that cupping is the application of round vacuum cups over a large muscular area such as the back, Gua Sha is the application of a smooth object such as a porcelain spoon over muscular area. I understand that I may be given Cupping and/or Gua Sha to enhance blood circulation to the designated area. These methods may produce a **deep redness, discoloration, minor skin bruising, and on rare occasions, a minor blister** which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury. Some patients experience temporary indentation of their skin after Gua Sha treatment, and in some instances minor bleeding can occur. If any bleeding occurs, there is an associated risk of infection.

Infrared and TDP (Teding Diancibo Pu) lamp therapy: I understand that these therapies consist of warming the skin with a heat source mounted to an adjustable arm and positioned above the body. If the heat source comes into close proximity with or contacts the skin, there is the risk of a burn.

Herbs and/or Nutritional Supplements: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's own

restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but, if I do decide to take these substances, I must follow the direction for administration and dosage.

I understand that recommended herbs are traditionally considered safe in the practice of TMC, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, changes in bowel movement, rash, hives, and tingling of the tongue, and the possible aggravation of symptoms existing prior to herbal treatment. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner and suspend taking them if any unanticipated or unpleasant effects associated with herb or supplement treatment.

Acupressure/Tui Na Massage: I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that side effects that may result from this treatment include, but are not limited to: bruising, muscle soreness, and the possible aggravation of symptoms existing prior to treatment.

I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with Traditional Chinese Medicine and Acupuncture Treatment. I understand that I am free to withdraw my consent to treatment at any time.

Patient Name: ____________________________________
LAST, First

Signature: ____ **Date:** ____________________________

If singed by person authorized to consent on behalf of the patient, please indicate name and relationship to patient.

Authorized Person: _________________________________ **Relationship:** ______________________
LAST, First

Notice of Privacy Practices (HIPPA)

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Harmony Acupuncture Chinese Medicine, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"It is our policy to provide a substitute health care provider, authorized by **Harmony Acupuncture Chinese Medicine, Inc.,** *to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting disease or infection exposure; reporting child abuse or neglect; reporting elder or dependent adult abuse; reporting domestic violence; and reporting to the Food and Drug Administration problems with products and reactions to medications.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation & Research
Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Marketing & Other Communication
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your schedule appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."

Your Health Information Rights
- You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **Harmony Acupuncture Chinese Medicine, Inc.**
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints
Complaints about your privacy rights, or how **Harmony Acupuncture Chinese Medicine, Inc.** has handled your health information should be directed to **Jinming Kwok** by calling office at **(408) 386-1128.** If **Jinming Kwok** is not available, you may make an appointment for a personal conference in person or by telephone within 10 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT: **www.hcfa.gov/medicaid/hipaa**

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of **Harmony Acupuncture Chinese Medicine, Inc.**, detailing how my information may be used and disclosed as permitted under federal and state law.

Patient Name: ____________________________ Signed: ______________________________ Date: _____________
LAST, First

If not signed by patient, please indicate relationship to patient (e.g., mother) and name of the person who signed.

Name: __________________________________ Relationship: ________________________