Office Use Only
Assigned Patient ID: _____________

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: _______________

Do you have a primary care physician (PCP)? (Yes) (No); If yes, who is your PCP? ___________________________

I was referred by: _______________________________________

Insurance Information

Primary Insurance Co.: ___________________________________ (Cigna, Aetna etc.) Insurance Type: ____________________ (PPO, HMO etc.)

ID #: ______________________ Group #:_________________ Employer: _________________________

Insured Person's Name: __________________________________ Insured Person's DOB: ____/____/________

Patient Relationship to Insured Person: (Spouse) (Child) Other: ____________________________

Authorization

- I assign the payment of my insurance benefits directly to Harmony Acupuncture Chinese Medicine, Inc.
- I understand that I am fully responsible for treatment costs not covered by insurance.

Signature: ____ Date: ______________________

If not signed by patient,
Name of authorized person / Relationship: ____

Identification Verification

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

Jinming D. Kwok, L.Ac.
Harmony Acupuncture Chinese Medicine, Inc.
2040 Forest Ave, Suite 8, San Jose, CA 95128
(408) 386-1128
info@HarmonyAcCM.com

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

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 or **cancel** your appointment with less than 24 hour notice, you will be charged the **full cost of the service**. If you **change** your appointment with less than 24 hour notice, you will be charged **$35**.
- This policy is in place out of respect for our practitioner and our patients. This 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 Credit Cards or Cash.
- ***Patients with insurance****:* We require that you pay 100% of your charges on each visit until your insurance payment has been verified. Copays are collected at each visit. Any unpaid balances will be considered past due 30 days following insurance reimbursement. You also agree that when you have not paid in full to the provider, any check sent to you will be brought in to the provider to pay the remaining balance.

Insurance Coverage

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits

I am authorizing payment of medical benefits to be made directly to this office. If my insurance carrier sends payment to me for services incurred in this office, I agree to send or bring those payments to this office upon receipt. I understand that I am financially responsible for charges not paid according to this assignment.

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:** ______________________________

Jinming D. Kwok, L.Ac.
Harmony Acupuncture Chinese Medicine, Inc. (408) 386-1128
2040 Forest Ave, Suite 8, San Jose, CA 95128 info@HarmonyAcCM.com

Patient's Name: ___________________________________ Age: _________ Date: ___/___/_________

Weight: _____________lbs Height _______________ HR: _________ BP: _________________

Present Illness

Reason for today's visit (Chief Complaint): ____

What caused this condition? ____

Condition related to auto accident? (Yes) (No) *Related to employment? (Yes) (No) Employer:* _________________

How long have you had this condition? _______________________ Is it getting worse? (Yes) (No)

What makes it feel better? ____

What makes it feel worse? ____

Are you currently under the care of another physician for this condition? (Yes) (No)

If yes, who? ______________________________________ *How long under his/her care?* ________________

Medical History

Have you had acupuncture before? (Yes) (No); If yes, when was your last treatment, what for? __________________

Prescription medications you're currently taking:

Name: __________________________ *Dosage/Times: (per day)* ___________________ *Purpose:* ____________________

__________________________ ___________________ ____________________

__________________________ ___________________ ____________________

Vitamins/ Supplements / Herbal Prescription you're currently taking: ____

____

Please list all past surgeries: ____

Please list all allergies: *Environmental:*____

*Foods:*____

Foods / Drinks that you have sensitivity to: ______________________________________

Are you a vegetarian? (Yes) (No) Coffee/Caffeine frequency per day: __________________

Cigarette frequency per week: _________________ Alcohol type / frequency per week: __________________

Marijuana frequency per week: ________________ Other recreational drugs / frequency: __________________

Do you exercise? (Yes) (No) Type:______________________________ Frequency per week: __________

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Please check/circle any of the following conditions you have or have had in the past (**P** for past, **C** for current)*:*

Stress: *(Heavy)* *(Moderate)* *(Light)* *(None)*

Insomnia: __*Difficult to fall in sleep* __*Dream disturbed sleep* __*Wake up at night* __*Wake up early* *Other:* _______

__**Fatigue**	__**Body heaviness**	__**Low energy**: *(Morning)* *(All Day)* *Other:* ______________		
__Accident Trauma	__Arteriosclerosis	__Epilepsy	__Measles	__Scarlet Fever
__AIDS/HIV	__Cancer	__Goiter	__Mult. Sclerosis	__Thyroid Disease
__Alcoholism	__Chicken Pox	__Gout	__Mumps	__Tuberculosis
__Allergies	__Diabetes	__Hepatitis	__Pleurisy	__Typhoid Fever
__Appendicitis	__Drug Addiction	__Herpes	__Polio	__Venereal Disease/STD

Other General Symptoms/Conditions

__Poor appetite	__Shortness of breath	__Sweat easily	__Headache (HA): __*Migraine* __*Tension*
__Heavy appetite	__Poor circulation	__Night sweats	*Other HA:* ________________
__Recent weight loss	__Cold hands/ feet	__Hot flashes	__Vertigo/ Dizziness
__Recent weight gain	__Chills __Fever	__Anemia	__Low WBC count

Neuropsychological

__Depression	__Anxiety	__Bipolar	__Schizophrenia	__Abuse survivor
__Easily stressed	__Numbness	__Seizures	__fainting	__Considered/ attempted suicide
__Poor memory	__Irritability	__Tics/twitch	*Other:* ____	

__Seeing a psychiatrist/therapist? Name of the physician: ____

Metabolic Health

__Diabetes mellitus (Type 1) (Type 2)	*Family history:* __*Mother* __*Father* __*Siblings* *Other:* _______________
__Hypertension *(high blood pressure)*	__*Mother* __*Father* __*Siblings* *Other:* _______________
__Hyperlipidemia *(high cholesterol)*	__*Mother* __*Father* __*Siblings* *Other:* _______________

Gastrointestinal

__Acid regurgitation	__Nausea	__Laxative use	__Intestinal pain/cramps	__Black stools
__Hiccups	__Vomiting	__Constipation	__Rectal pain	__Blood in stools
__Gas	__Bad breath	__Hemorrhoids	__Itchy/burning anus	__Mucus in stools
__Bloating	__Ulcers	__Diarrhea	__Anal fissure	__IBS

Bowel Movements (frequency/day):______________________________

Musculoskeletal

Muscle pain __Fibromyalgia __Body ache __Neck pain __Upper back pain __Lower back pain __Sciatic

__Abdomen pain Other: ____

__Muscle weakness __Muscle cramps/Spasms __Limited ROM (range of motion) at: _________________

Joint pain __Shoulder pain __Knee pain __TMJ Other:____

Skin and hair

__Acne	__Eczema	__Itching skin	__Rashes/Hives	__Dry skin
__Dandruff	__Psoriasis	__Fungal infections	__Hair loss	

Head, Eyes, Ears, Nose, and Throat

__**Eye** strain/pain	__Red eyes	__**Nose** bleeds	__Excess saliva	__Gum problems
__Poor vision	__**Ear** aches	__Sinus problems	__Excess phlegm	__Enlarged thyroid
__Night blindness	__Ear itchiness	__Dry mouth	__Sores on tongue	__Swollen glands
__Cataracts	__Poor hearing	__Lumps in throat	__Grinding teeth	__Headaches
__Glaucoma	__Ringing in ears	__Sore throat	__Teeth problems	__Vertigo/Dizziness

Respiratory

__Asthma/ Wheezing	__Shortness of breath	__Cough- wet / dry	__Sputum: (thick) (watery)
__Pneumonia	__Tightness in Chest	__Coughing blood	__Difficulty breathing, when? __________

Cardiovascular- Hematologic

__Heart palpitations	__Chest pain	__Stroke	__Bleeding disorder
__Tachycardia (fast HR)	__High blood pressure	__Pacemaker	__Blood clots
__Irregular heart beat	__Low blood pressure	__Prosthetic heart valve	__Anticoagulation therapy

Genito-Urinary

			For male patients only
__Frequent urination	__Unable to hold urine	__Venereal disease/Sexual Transmitted D.	__*Nocturnal emissions*
__Painful urination	__Bed wetting	__Kidney stones	__*Premature ejaculation*
__Night time urination	__Excessive libido	__Blood in urine	__*Impotence*
__Urgent urination	__Decreased libido	__Cloudy urine	__*Enlarged prostate*

Any other symptoms & conditions you would like to discuss & work on:

For female patients only - Gynecological history

Are you currently pregnant? (Yes) (No) If yes, how many weeks? ________

Are you planning to conceive? (Yes) (No) If yes, how long have you tried? ________ Are you doing IVF/IUI? _____
Have you pregnant before? (Yes) (No) If yes, how many live births? ____
Have you had miscarriage before? (Yes) (No) If yes, how many? ________

Menopause? Yes (At what age? _____) If yes, do you have: (hot flashes) (night sweat) (insomnia) other: _______

No (If no, answer menstruation questions below)

Menstruation: Age menses began _____ years old Date menses last began ______________

Length of cycle ____ days How many days between cycles_______ days or (irregular)

Flow: __Heavy __Moderate __Light __Spotting between cycles

Color: __Pale red __Dull red __Red __Bright red __Brown Clots? (Yes) (No)

Do you have abdomen pain? (Yes) (No) If yes, when? (Before) (During) (After)

__ PMS signs: (mood swings) (tender breasts) (food cravings) (fatigue) Other: _________________

Vaginal discharge: __Dry __Clear __Sticky __White __Yellow __Red __Smell

Any of these symptoms/conditions? __Breast lumps __Breast distention/pain __Endometriosis __PCOS

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: ________________________