Amy C. Darling ~ Health Questionnaire

Patient Name _____

PRIMARY CONCERN

What primary concern brings you here today? _____

When did this problem begin? _____

To what extent does this interfere with your daily life? _____

What treatments/interventions have you tried? _____

_____

Have you been given a western diagnosis for this problem? If so, what is it? _____

Have you been treated with Acupuncture before? Yes ☐ No ☐

Chinese Herbal Medicine? Yes ☐ No ☐

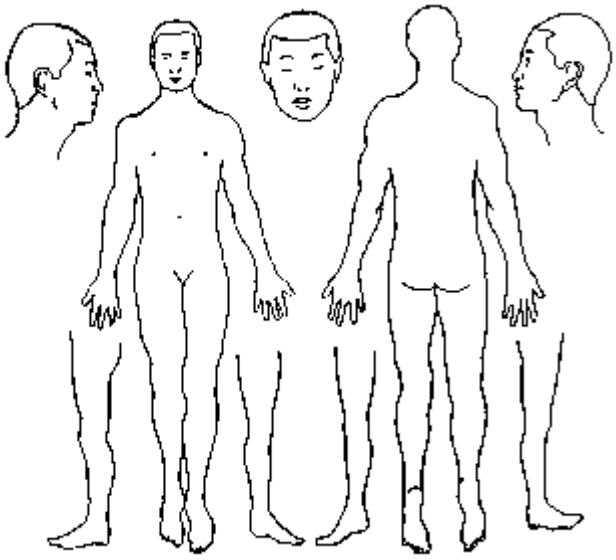
How did you learn about my clinic? _____

On the images to the right, indicate areas of concern (pain, weakness, numbness, rash etc). Describe details below

_____

_____

_____



What are major sources of stress in your life? _____

Allergies (drugs, chemicals, foods)? _____

Do you consider yourself an active person? Yes ☐ No ☐

If/ when you exercise, what form does that take? _____

Indicate use per week. If you have quit any of the following, how long ago?

Alcohol _____ Caffeine _____

Tobacco _____ Marijuana _____

CURRENT MEDICATIONS (include all vitamins, supplements, herbs and pharmaceutical medications)

item	dosage	for what condition	prescribed by

Blood Thinning Medication? Yes ☐ No ☐

MEDICAL HISTORY (please indicate date & information as appropriate)

	SELF	FAMILY MEMBER		SELF	FAMILY MEMBER
Anemia	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Thyroid Disease	☐	☐
Allergies	☐	☐	Depression/Mental Illness	☐	☐
Cancer	☐	☐	Seizures	☐	☐
Bleeding Disorders	☐	☐	Pacemaker (self only pertinent)	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐
Eating Disorder	☐	☐	Stomach & Intestinal Disorders	☐	☐
Hepatitis	☐	☐	Drug or Alcohol Abuse	☐	☐
High Blood Pressure	☐	☐			

Birth History - Was your own or that of your children a prolonged labor? ☐ requiring forceps? ☐ caesarian? ☐

Surgery (type & date)?_____

Other _____

GENERAL

[] Poor Appetite
[] Fevers
[] Chills
[] Sweat Easily
[] Localized Weakness
[] Bleed or Bruise Easily
[] Peculiar Tastes or Smells
[] Strong Thirst (cold or hot drinks)
[] Sudden Energy Drop? Time? ____
[] Fatigue
[] Poor Sleeping
[] Night Sweats
[] Cravings for? _____
[] Change in Appetite
[] Weight Gain
[] Weight Loss
Other? _____

MUSCULOSKELETAL

[] Neck Pain
[] Shoulder Pain
[] Hand/Wrist Pain
[] Back Pain
[] Hip Pain
[] Knee Pain
[] Foot/Ankle Pains
[] Muscle Weakness
[] Muscle Pains
Other? _____

GASTROINTESTINAL Have you ever been or are you currently on a restricted diet? Yes ☐ No ☐

If so, what kind & when?

[] Nausea
[] Vomiting
[] Constipation
[] Gas
[] Black Stools
[] Blood in Stools
[] Bad Breath
[] Rectal Pain
[] Chronic Laxative Use
[] Hemorrhoids
[] Diarrhea
[] Belching
[] Indigestion
[] Abdominal Pain or Cramping

GYNECOLOGY & PREGNANCY

# of Pregnancies _____
# of Births _____
Miscarriages _____
Abortions _____
Premature Births _____
Age at First Menses _____
First Date of Last Menses _____
Period Between Menses _____
Duration _____
[] Unusual Character (Heavy or Light, Frequency)
[] Painful Periods
[] Clots
[] Vaginal Discharge
[] Vaginal Sores
[]Irregular periods
[] Breast Lumps
[] Changes in Body/Psyche Prior to Menstruation
Last Pap smear date _____
Do you use birth control? Yes ☐ No ☐
What type and for how long?
Other? _____

PSYCHOLOGICAL

[] Depression
[] Anxiety
[] Bipolar
[] Anger/Bad Temper
[] Addiction Issues
[] Easily Susceptible to Stress
[] Panic Attacks
[] Attempted or considered suicide
Other? _____

GENITO-URINARY

[] Pain When Urinating
[] Frequent Urination
[] Urgency to Urinate
[] Unable to Hold Urine
[] Decrease in Flow
[] Halting Urination
[] Blood in Urine
[] Kidney Stones
[] Sores on Genitals
[] Impotency
Do you wake at night to urinate? Yes ☐ No ☐
How often? _____x
Particular color to your urine?
Other?_____

SKIN & HAIR

[] Rashes
[] Itching
[] Dandruff
[] Loss of Hair
[] Change in hair or skin texture
[] Eczema
[] Psoriasis
[] Pimples
Other? _____

HEAD, EYES, EARS, NOSE & THROAT

[] Dizziness
[] Glasses
[] Poor Vision
[] Spots in Front of Eyes
[] Eye Pain
[] Blurry Vision
[] Ringing in Ears
[] Sinus Problems
[] Nose Bleeds
[] Grinding Teeth or Jaw Pain
[] Facial Pain
[] Teeth Problems
[] Concussions
[] Migraines
[] Earaches
[] Sores on Lips or Tongue
[]Headaches?
Other? _____

CARDIOVASCULAR

[] High Blood Pressure
[] Low Blood Pressure
[] Dizziness
[] Cold Hands or Feet
[] Swelling of Hands
[] Blood Clots
[] Phlebitis
[] Chest Pain
[] Fainting
[] Swelling of Feet
[] Difficulty in Breathing
Other? _____

RESPIRATORY

[] Cough
[] Coughing Blood
[] Bronchitis
[] Pneumonia
[] Difficulty Breathing Lying Down
[] Pain with Deep Breathing
[] Production of Phlegm
[] Phlegm Color? _____
Other_____

NEUROLOGICAL

[] Seizures
[] Parasthesia (abnormal sensation)
[] Areas of Numbness
[] Lack of Coordination
[] Poor Memory
[] Concussion
[] Stroke
[]Tremors
[] Loss of Balance
[] Dizziness
Other? _____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Amy C. Darling, LAc to provide the following care:

Acupuncture ~insertion of sterilized, single use needles through the skin into underlying tissues at specific points.
Electrical stimulation ~stimulation of acupuncture points with a mild electrical current.
Herbal prescriptions ~ may be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally or externally. I recognize that herbal medicine may be a necessary component of my treatment and will comply with instructions. Herbal formulas may include shell, mineral, and animal products.
I will make it known if I do not want animal-based products prescribed.
Tui-Na ~ a form of Chinese bodywork which may include massage or stretching.
Moxibustion (moxa) ~ indirect or direct burning of mugwort leaf (artemesia) on specific areas of the body.
Cupping ~ cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Some bruising may result.
Gua Sha ~ rubbing or scraping of an area of the body with a blunt, round instrument. Some bruising may result.
Plum Blossom ~ light tapping of an area of the body with a small sterile hammer which has seven points.
I recognize the **potential side effects** to include discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of skin; nausea; loose bowel movements; abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in other unforeseen consequences.

I hereby release Amy C. Darling from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and discontinue treatment at any time. I recognize it is my responsibility to communicate if I am experiencing discomfort in any way during treatment. Additionally, I recognize that I am both free and in fact encouraged to ask questions about my treatment at any time.

_____ _____
Signature of patient or guardian Date

Amy C. Darling
509 Olive Way, Suite 1358, Seattle, WA 98101
Patient Registration

FIRST Name: MI: LAST:

Street Address:

City: State: Zip:

Email: SSN: Home ph: ( )

Employer: Alternate phone ( )

Date of Birth: / / Age: Height: Weight

Gender: ( )M ( )F Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Partnered ( )Divorced ( )Widowed ( )Dependent ( )Other

Referred by: Primary Care Provider:

In case of emergency contact: Relationship: Phone: ( )

Primary Insurance:

If you will be paying out of pocket, simply sign below.

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscribers Name: Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Dependent ( )Other

I.D. # as shown on card: ( )Group #:

Employer of Insured:

Secondary Insurance:

Is this visit injury related? ( ) Y ( ) N Auto accident ( ) Y ( ) N * Please note at this time L & I DOES NOT pay for acupuncture

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscribers Name: Date of Birth: / /

Relationship to you : ( )Self ( )Spouse ( )Dependent ( )Other

I.D. Claim # as shown on card: Policy #

Employer if applicable: Effective / Date of Injury: / /

Please read the following statement carefully before signing:

I, the undersigned, understand and agree that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I will be billed and held responsible for all charges. I understand that if I cancel an appointment with less than 24 hour notice will be charged a $50 fee. I authorize Amy C. Darling, LAc to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize payment to be directly made to Amy C. Darling, LAc.

Signature: _____ Date: _____

INSURANCE VERIFICATION FORM

PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM BY ASKING THE FOLLOWING QUESTIONS:

Patient name: _____

Date of call:_____ Time: _____ Spoke to: _____

Insurance Company: _____

1. Is Acupuncture covered on this plan? ⎡ Yes /⎡ No
2. Is referral required? ⎡ Yes /⎡ No If so, who can make a referral?
3. Is pre-authorization required? ⎡ Yes /⎡ No
4. Am I limited to specific diagnosis codes? ⎡ Yes /⎡ No

   Some Insurance plans only reimburse for specific kinds of pain. If you are seeking treatment for things others than physical pain, we will need to discuss how to access your benefit while honoring the Insurance company's restrictions.

5. Is there a deductible? ⎡ Yes /⎡ No If yes, what is the deductible? $_____

   How much has been met? $_____

6. Is there a maximum yearly benefit for Acupuncture? ⎡ Yes /⎡ No

   #_____ of visits per year?
   #_____ of visits used year to date

7. What % is covered? _____%
8. Is there a co-payment or % I am responsible for?⎡ Yes /⎡ No. IF YES, amount? $_____
9. When my acupuncturist bills an Office Visit (time spent in interview) is my copay different?⎡ Yes /⎡ No IF YES, $_____?
10. Are benefits for other forms of care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture?⎡ Yes /⎡ No
11. If my acupuncturist bills for manual modalities (massage or cupping) provided during acupuncture treatment, will these take away from my benefits for massage or physical therapy? ⎡ Yes /⎡ No

Please note, benefits stated by a representative cannot be guaranteed.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situations, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONSENT

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities such as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosures relating to worker's compensation programs.
- We may share your protected health information with a third party "business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between a business associate and us involves the use or disclosure of your protected health information, we will have a

written contract that contains terms that will protect the privacy of your protected health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc.). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices form this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about my privacy practices:

Privacy Officer
Amy C. Darling
509 Olive Way Suite 1358
Seattle, WA 98101
(206) 920-9929

For more information on HIPAA or to file a complaint:

The US Dept. of Health &
Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
877-696-6775

This notice has been issued and considered effective as of the date signed. This copy shall be retained by the department for a minimum of six (6) years.

Please note, in the interest of convenience for my patients, I make myself available to communicate by email. I cannot assure the privacy of this communication medium. If you prefer **NOT** to communicate by email, in the interest of assured privacy of your personal information, you must sign in the box to the right.

PLEASE DO NOT COMMUNICATE WITH ME BY EMAIL

_____
Signature

_____ _____
Signature of Patient or Legal Representative Date
I have thoroughly reviewed these privacy policies.