

Amy (Zoe) Darling ~ Health Questionnaire

Your Name _____

PRIMARY CONCERN

What brings you here today? _____

When did this begin? _____

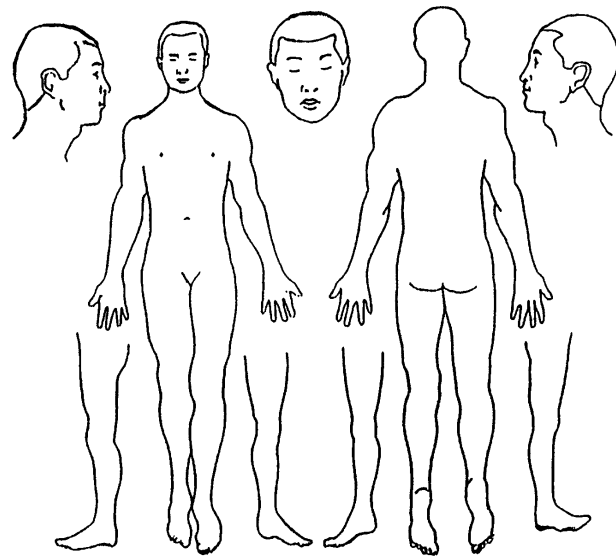
How does this impact your daily life? _____

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 How did you learn about my clinic?
with Chinese Herbal Medicine? Yes No _____

Show areas of concern
(pain, weakness, numbness, 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

How do you move your body on a regular basis? _____

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

Alcohol _____

Caffeine _____

Tobacco _____

Marijuana _____

CURRENT MEDICATIONS (Please include vitamins and supplements, separate page or listed on back okay)

item	for what condition	prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____

Blood Thinning Medication? Yes No

MEDICAL HISTORY

	SELF	FAMILY MEMBER		SELF	FAMILY MEMBER
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker (self only pertinent)	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach & Intestinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery (type & date)? _____					
Other _____					

GENERAL

<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Sudden Energy Drop? Time? _____	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Bleed or Bruise Easily	<input type="checkbox"/> Night Sweats	Other? _____
	<input type="checkbox"/> Change in Appetite	

MUSCULOSKELETAL

Please write the location and nature of concerns below

GASTROINTESTINAL

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

If so, what kind & when? _____

<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Black Stools
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Belching	<input type="checkbox"/> Blood in Stools
<input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gas	<input type="checkbox"/> Abdominal Pain or Cramping	

GYNECOLOGY & PREGNANCY

If you've transitioned, please check here for us to discuss in detail _____

Age at First Menses _____

First Date of Last Menses _____

Period Between Menses _____

How many days long? _____

Unusual Character (Circle: Heavy, Light, Frequent)

Painful Periods

Pain during sex

Clots

Irregular periods

Do you use birth control?
Yes No

Last Pap smear date _____

of Pregnancies _____

of Births _____

Miscarriages _____

Abortions _____

PSYCHOLOGICAL

<input type="checkbox"/> Depression	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Addiction Issues
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Attempted or considered suicide
<input type="checkbox"/> Easily Susceptible to Stress	<input type="checkbox"/> Anger/Bad Temper	Other? _____

GENITO-URINARY

<input type="checkbox"/> Pain When Urinating	<input type="checkbox"/> Kidney Stones	Particular color to your urine?
<input type="checkbox"/> Urgency to Urinate	Do you wake at night to urinate?	Other? _____
<input type="checkbox"/> Halting Urination	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/> Blood in Urine	How often? _____x	

SKIN & HAIR

<input type="checkbox"/> Rashes	<input type="checkbox"/> Change in hair or skin texture	<input type="checkbox"/> Pimples
<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema	Other? _____
<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Psoriasis	

SLEEP

Place an X that describes your sleep most accurately on the spectrum below

Like a peaceful baby _____ Thrashing, awake all night long

HEAD, EYES, EARS, NOSE & THROAT

- | | | |
|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Ear aches |
| <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Grinding Teeth or Jaw Pain | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Headaches? |
| | | Other? _____ |

CARDIOVASCULAR

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pain | Other? _____ |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Fainting | |

RESPIRATORY

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with Deep Breathing |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty Breathing Lying Down | Other? _____ |

NEUROLOGICAL

- | | | |
|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Memory Concerns | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Parasthesia (abnormal sensation) | <input type="checkbox"/> Concussion | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Lack of Coordination | | Other? _____ |

Anything you haven't found a space to mention? Please feel welcome to include here:

CONSENT FOR TREATMENT

Acupuncture is one of a *many-fingered hand* of East Asian Medicine. Amy's toolbag includes:

- Acupuncture
- Electric stimulation
- Chinese herbal prescriptions
- Tuina and Sotai massage
- Cupping
- Gua Sha
- Heat Lamp, moxa and other warming techniques.
- Mindfulness and Awareness practices.
- Qi Gong and other movement exercise.
- Dietary counsel and recommendations.

Amy will always review and explain new modalities before administering. I understand I am always free to ask questions or decline a particular element of treatment. By signing below, I release Amy 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 as a part of this healing relationship, I am responsible and encouraged to ask questions about my treatment at any time.

Signature of patient (or guardian)

Date

Amy (Zoe) Darling
509 Olive Way, Suite 1358, Seattle, WA 98101
Patient Registration

FIRST Name: _____ MI: _____ LAST: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ SSN: _____ PRIMARY ph: (____) _____

Employer: _____ Alternate phone (____) _____

Date of Birth: ____/____/____ Age: _____ Height: _____ Weight _____

Place of Birth _____ Gender _____

Employment: Employed F/T Student P/T Student Retired Other

Relationship 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 (Zoe) Darling, LAC.

Signature: _____ Date: _____

INSURANCE VERIFICATION FORM

PLEASE CALL YOUR INSURANCE AND COMPLETE THIS FORM. This will help you understand what your insurance covers, and what is your financial responsibility.

Patient name: _____

Date of call: _____ Time: _____ Name of person you talked to _____

CIRCLE or FILL IN AS APPROPRIATE

1. Is Acupuncture covered on this plan? YES or NO
2. Is Amy Darling a preferred provider with my plan? If not, are there out of network benefits?
3. Is pre-authorization required? YES or NO
4. Is referral required? YES or NO If so, who can make a referral?
5. Am I limited to specific diagnosis codes? YES or NO

Please note, some Insurance companies limit diagnosis codes for which they allow a patient to access their acupuncture benefit. Some allow only specific kinds of pain and deny other claims. 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/limitations.

6. Is there a deductible? YES or NO What is the deductible? \$ _____

How much have I met this year? \$ _____

7. Is there a maximum yearly benefit for Acupuncture? YES or NO

Per _____ Calendar Year OR _____ Fiscal year Renewal Date? _____

_____ of visits

_____ of visits used year to date

8. What percentage is covered? _____% or if it is a \$ amount per year, how much \$ _____

9. Is there a co-payment or percentage that I am responsible for? YES or NO
If yes, what is it? \$ _____

10. When my acupuncturist bills for an "Office Visit", time spent in interview, is my copay different? YES or NO

11. Are benefits for other forms of care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture? YES or NO

12. If my acupuncturist bills for manual modalities (massage or cupping) during acupuncture treatment, will these take away from my benefits for massage or physical therapy?
YES or NO

13. If my acupuncturist bills using mental health codes (ex. anxiety, insomnia, depression, will these be drawn from my acupuncture benefit or my mental health benefit? YES or NO
If drawn from mental health, what are my benefit limits?

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 entities 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.

<p>PLEASE DO NOT COMMUNICATE WITH ME BY EMAIL</p> <p>_____</p> <p>Signature</p>

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

Date