

Chinese Acupuncture and Herbology Clinic

Patient Insurance & General Information

GENERAL PATIENT INFORMATION

Last Name _____	First Name _____
Marital Status: _____	DOB: _____
Home Phone _____	Cell Phone _____
Work Phone _____	Email _____
Address _____	
(street)	(city) (state) (zip)
Name of Emergency Contact Person _____	
Phone Number for Emergency Contact Person _____	
Your Primary Care Physician _____	

Who can we thank for referring you? _____

PATIENT INSURANCE INFORMATION

Insured's ID Number _____	Insured's Policy Number _____
Insurance Plan Name or Program Name _____	
Patient Relationship to Insured (circle one)	Self Spouse Child
If Relationship to Insured is other than "Self" What is Insured's Name? _____	

Present Health Concerns

Please list most important health
Concerns in order of significance

Prior diagnosis of this problem?
If so, what?

1. _____

2. _____

3. _____

4. _____

5. _____

FOR OFFICE USE ONLY

ICD-9 CODE(S): _____

DATE OF FIRST TREATMENT: _____



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369 Montford Ave., Asheville, NC 28801 828-258-9016
206 Chadwick Ave., Hendersonville, NC 28792 828-698-3335
442 Walnut St., Waynesville, NC 28786 828-452-9699

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Ht/Wt: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Check here to receive our email newsletter

Phone #: _____ Cell: _____

Occupation: _____ Marital status: _____

Emergency Contact Name: _____ Phone: _____

Who may we thank for referring you? _____

Recent Health Care Providers: Name, Date, Service Provided: _____

MAIN CONCERN: _____

How does this problem affect your daily activities? _____

When did you first notice symptoms? _____

If you have been diagnosed, what is diagnosis? _____

What kinds of treatment or therapies have you tried? _____

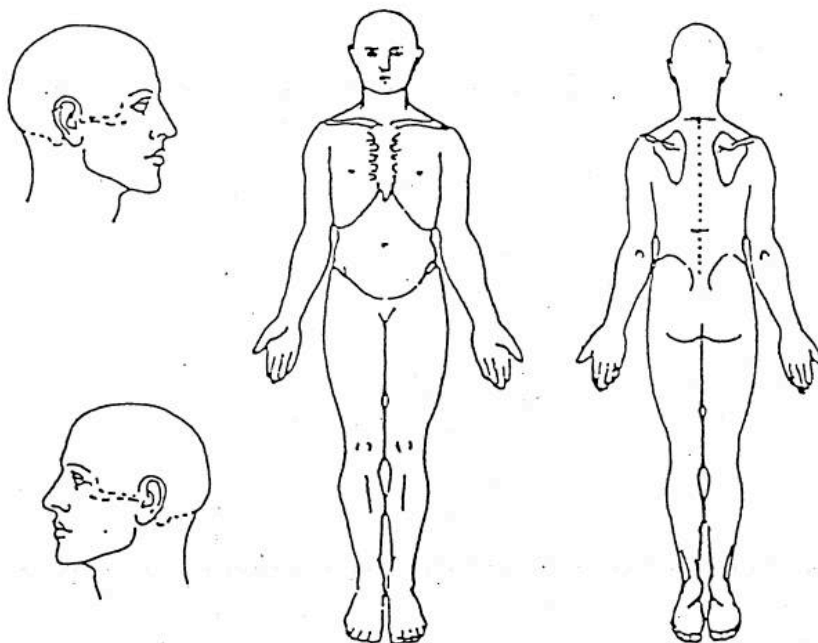
Hospitalizations/Surgeries/Accidents: _____

Allergies: _____

Family Health History

<i>Family Member</i>	<i>Age</i>	<i>Important Diseases/Illnesses</i>	<i>Deceased Y/N</i>

Please mark painful or distressed areas on the charts below



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

LIFESTYLE

Exercise

Sedentary (No exercise)

Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)

Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)

Diet

Are you dieting? Yes No

If yes, are you on a physician prescribed medical diet? Yes No

of meals you eat in an average day? _____

Describe daily diet: _____

Caffeine/ Alcohol/ Drugs

Indicate # of cups/cans per day Coffee _____ Tea _____ Cola _____

Tobacco _____ packs per day Type? _____ # of years _____

Tobacco

Do you drink alcohol? Yes No

If so, how many drinks per week? _____

Do you use recreational drugs? Type _____ Yes No

MENTAL HEALTH

Is stress a major problem for you? Yes No

Do you feel depressed? Yes No

Do you panic when stressed? Yes No

Do you have problems with eating or your appetite? Yes No

Do you cry frequently? Yes No

Have you ever attempted suicide? Yes No

Have you ever seriously thought about hurting yourself? Yes No

Do you have trouble sleeping? Yes No

Have you ever been to a counselor? Yes No

PERSONAL HISTORY

General	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Night Sweats
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever
	<input type="checkbox"/> Disturbed Sleep	<input type="checkbox"/> Sweating easily	<input type="checkbox"/> Chills
	<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Bleeding/bruising	<input type="checkbox"/> Sudden energy drop
	<input type="checkbox"/> Cravings	<input type="checkbox"/> Tremors	<input type="checkbox"/> Poor Balance
	<input type="checkbox"/> Strong Thirst		
Skin and Hair	<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Recent moles
	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Pimples	<input type="checkbox"/> Changes in hair texture
	<input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Hair loss
	<input type="checkbox"/> Itching		
Head, Eyes, Ears, Nose, Throat	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Recurrent sore throats
	<input type="checkbox"/> Concussions	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Nose bleeds
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Grinding teeth
	<input type="checkbox"/> Glasses	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores on lips or tongue
	<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Facial pain
	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Teeth problems
	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Eye strain	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Jaw clicks
	<input type="checkbox"/> Photophobia	<input type="checkbox"/> TMJ	<input type="checkbox"/> Gum/teeth problems
Cardiovascular	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High B.P.	<input type="checkbox"/> Swelling of feet
	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Blood clots
	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Difficulty in breathing
	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Phlebitis
	<input type="checkbox"/> Tightening in chest	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Stroke
Respiratory	<input type="checkbox"/> Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Frequent colds or flu
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Excessive phlegm
Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Rectal pain
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Black stools	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Abdominal pain/cramps
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Chronic laxative use
	<input type="checkbox"/> Gas/ Bloating	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Chron's
	<input type="checkbox"/> Parasites	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Colitis
Genitourinary	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sores on genitals
	<input type="checkbox"/> Low to no sex drive	<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Impotence/frigidity
	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	
Musculoskeletal	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hand/wrist pain
	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Shoulder pain
	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Foot/ankle pains	<input type="checkbox"/> Hip pain
	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Varicose veins	

Neuropsychological	<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Bad temper
	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> Frequent mood swings
Other Illness	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Eating disorder
	<input type="checkbox"/> AIDS	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Underweight	<input type="checkbox"/> Overweight

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____

Period occurs every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? _____

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? _____

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the last year? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

MEN ONLY

Do you usually get up to urinate during the night? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Please list drugs, herbs and supplements you currently take:



Chinese Acupuncture and Herbology Clinic

Asheville Hendersonville Waynesville

Patient's Consent for the Purposes of Treatment, Payment And HealthCare Operations (Please sign and return)

I _____ give consent to the *Chinese Acupuncture and Herbology Clinic* to use and disclose my Individual Identifiable Health Information or Protected Health Information for these specific purposes:

1. to provide treatment to me,
2. to process payment for this service, and
3. for general administrative operations.

Protected Health Information is any information that includes:

1. Demographic information
2. My past or present health condition
3. My past or present financial information and agreement of future payments for healthcare services
4. Healthcare operations include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I _____ refuse to give consent to this HIPPA form.

Date: _____

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment or payment of healthcare services by the Chinese Acupuncture Clinic, but the clinic is not required to agree to these restrictions. However, if the *Chinese Acupuncture and Herbology Clinic* agrees to a restriction that I request, the restriction is binding.

I understand I have the right to read and discuss the *Notice of Privacy Policies and Procedures* form of this acupuncture practice before I sign this consent regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has already acted in accordance to this consent.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

ashevilleacupuncture.com

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Acknowledgement of Receipt Of Notice of Privacy Policies

The following acknowledges that the Chinese Acupuncture and Herbology Clinic has provided you with a *Statement of Privacy Policies*.

I, _____, have read, reviewed, understood and agree to the *Statement of Privacy Policies* for healthcare services at the *Chinese Acupuncture and Herbology Clinic*.

Signed: _____

Date: _____

Acknowledgement of Receipt Of Office Policies

The following acknowledges that the Chinese Acupuncture and Herbology Clinic has provided you with a *Statement of Office Policies*.

I, _____, have read, reviewed, understood and agree to the *Statement of Office Policies* for healthcare services at the Chinese Acupuncture and Herbology Clinic.

I agree to provide at least 24 hours notice of cancellation and otherwise understand I will incur a charge of \$40 for the missed appointment.

Signed: _____

Date: _____

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Chinese Acupuncture and Herbology

Clinic

Asheville

Hendersonville

Waynesville

Notice Of Privacy Policies

The Chinese Acupuncture and Herbology Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. Outlined here are policies we follow and rights to which you are entitled, according to North Carolina law.

We gather personal and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

This information is used for treatment, payment and healthcare operations. Please be aware that during the course of our relationship we will likely use and disclose protected health information (PHI) about you for these treatment, payment, and healthcare operations. PHI is identifying information about your past and present physical or mental health condition.

You may specifically authorize us to use PHI for any purpose or to disclose the health information we have about you by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose.

Marketing

The Chinese Acupuncture Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

Disclosure

The Chinese Acupuncture Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

The Chinese Acupuncture and Herbology Clinic maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter the office.

If you have questions, complaints or want more information, please contact David Treviño or Joshua Herr at our clinic in Asheville. If you wish to make a formal complaint, send it to:

U.S. Department of Health and Human Services
DHHS (Office of Civil Rights)
200 Independence Avenue SW
Room 509F HHH Building
Washington DC 20201

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Office Policies

Welcome to our clinic! For your convenience, we will explain our office policies so that we can serve you more efficiently. Please read the following carefully and keep for your files.

1. Please refrain from wearing perfume oils, as some of our patients are sensitive to these.
2. Please provide your practitioner with a list of any and all medications and/or supplements you are currently taking.
3. Acupuncture is a very safe medical procedure and well known for its efficacy and lack of side effects. Occasionally, bruising may occur. Do not be alarmed, but if you have questions or concerns, we encourage you to call the office.
4. We recommend relaxation and/or sleep after treatment.
5. Please pay in full at the time of service. We do not file insurance, but will furnish you with the appropriate forms that you can file with your insurance company if you wish. Please be aware that at present, Medicare does not cover acupuncture in the state of North Carolina.
6. There is a \$40 charge for cancellation of your appointment with less than 24 hours notice. At the Chinese Acupuncture Clinic, we schedule a specific amount of time for each patient to be with their practitioner. We do this because we are committed to providing the very best service. An advance cancellation notice allows an opportunity to extend services to the many people on our waiting list.
7. Please be on time for your appointments. If you find that you cannot be on time please notify our office. If you are late for your appointment, the doctor may not be able to see you.
8. All herbs are paid for at the time of receipt. We can also leave herbs in the after-hours box outside the clinic or mail them to you with payment in advance.
9. There is a \$20 charge for returned checks.
10. We accept cash, personal check and Visa/MasterCard.
11. Please advise us of any change in your address or phone number(s).
12. As a courtesy to others, please turn your cell phone off while at the clinic, unless there is an emergency.
13. Please do not leave your children unattended.

Thank you.



Chinese Acupuncture and Herbology Clinic

Asheville Hendersonville Waynesville

Schedule of Fees

Payment is due at the time of treatment by cash, personal check or Visa/MasterCard. Please check with your insurance provider about coverage for acupuncture. We are happy to provide you with an additional copy of your receipt if you wish to file with your insurance company. We can file an insurance claim for a couple specific health insurance plans. Our front desk staff can identify if your plan is included. If you are in need of a referral to an allopathic physician, we can recommend a physician to you.

Below you will find a list of fees that apply to most office visits. We serve a diverse population of patients that need varying lengths of time with our providers. In order to best serve you, extended evaluation times may be needed for complex diagnosis or care conditions. A complete list of fees for services can be provided to you upon request.

Adults (16 years and over)

Initial: Consultation & treatment - \$130 Consultation only - \$80
Extended Initial: Consultation and treatment - \$195 - \$260
Thereafter: Consultation & treatment - \$80 Consultation only - \$50

Adolescents (13 to 15 years)

Initial: Consultation & treatment \$80
Thereafter: Consultation &/or treatment \$50

Children (infant to 12 years)

Initial: Consultation & treatment \$80
Thereafter: Consultation &/or treatment \$40

Emergency And After Hours Fee Schedule

Home Or Hospital Visit - \$200

Consultation & Treatment for New Patients:

Adult - \$200 Adolescent - \$140
Child - \$100

For Established Patients:

Adult - \$150 Adolescent & Child - \$60

Telephone Consultation - \$15

Massage Fees

30 Minutes - \$35
60 Minutes - \$50
80 Minutes - \$80

Massage At Your Home

60 Minutes - \$75
90 Minutes - \$105

*10 treatments (to be used within twelve months)
may be purchased in advance for \$720.*

Cancellation Policy - We charge \$40 for appointments cancelled with less than 24 hours notice. Thank you for your understanding.

Thank you for choosing us to be your healthcare provider.

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Welcome.

Thank you for choosing the Chinese Acupuncture and Herbology Clinic for your health care needs. While acupuncture treatment and its benefits continues to become more integrated into the mainstream healthcare system, insurance companies in North Carolina are not yet required to cover its cost. Our clinic does not file claims with personal health insurance plans, but we can provide you with copies of your invoices, which should contain all the information your insurance company needs. We may be able to file for personal injury claims and worker compensation. To help you speak with your insurance company in a way that might lead to coverage, we've provided the following checklist of questions that should be asked.

Checklist

- ◆ *Does my plan cover acupuncture?*
- ◆ *Does my insurance cover these treatment codes:*
 - 97810 – proc: acupuncture*
 - 97811 – acupuncture additional*
- ◆ *What is the annual acupuncture benefit (dollar amount or number of treatments)?*
- ◆ *Does my plan require that an MD perform the acupuncture?*
- ◆ *Does my plan cover acupuncture for the treatment of (refer to your condition)?*
- ◆ *Does my plan require a referral from a Primary Care Physician (PCP)?*
- ◆ *Does my plan require pre-authorization before treatment?*
- ◆ *Does my plan require re-authorization after a specific number of treatments?*
- ◆ *What is the phone number, fax number or address that I should send reports, authorization requests and claims to?*
- ◆ *Is there an applicable deductible amount that has yet to be met? What is that amount?*

Name of representative spoken to: _____

We also wish to support our patients whose insurance providers have not awarded coverage and do not recognize acupuncture as part of a benefits plan. As it is a political issue, we recommend that you write your insurance company and the State Insurance Commissioner to ask why North Carolina insurance companies are not required to cover such beneficial health services. This may encourage new discussions on acupuncture coverage. You might also wish to write your state representative and request support for insurance coverage of acupuncture services by Licensed Acupuncturists.

It is our sincere wish that you gain as much coverage as possible. If you have any questions or concerns, please contact us at 828-258-9016 or by e-mail at info@chineseacupuncture-wnc.com.

The staff of the Chinese Acupuncture and Herbology Clinic

*Jim Long, Commissioner of Insurance
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
NC: 800-546-5664
Outside NC: 919-807-6750*

*House representatives vary by
county. Yours can be found at
[http://www.ncga.state.nc.us/
House/House.html](http://www.ncga.state.nc.us/House/House.html).*