Patient Confidential Information

Name: _____
First Middle Last

Address: _____
Street

_____
City State Zip

Primary Phone : _____ Alternate Phone: _____
SELECT ONE: MOBILE HOME WORK MOBILE HOME WORK

Please provide an E-mail address at which you would like to receive appointment reminders:

E-mail: _____

Age: _____ Date of Birth: ____/____/____ Sex: M F Marital Status: S M D W

Place of Birth: _____ Occupation: _____ Employer: _____

If you would like us to bill your insurance company for services rendered, please furnish your insurance information at the front desk prior to treatment. We do not guarantee insurance benefits. Regardless of insurance coverage, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of the patient.

Whom may we thank for referring you to our office?: _____
(i.e. Patient name, Yelp, Google, other practitioner, walk-by, etc.)

In case of emergency, call: _____
Name Relation

Primary Phone: _____ Alternate Phone: _____

CANCELLATION POLICY

Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours notice for cancellations is required. Not providing 24 hours notice, not showing, or being more than 20 minutes late for an appointment results in a charge of the standard fee to your account. If your appointment slot is filled after you cancel, this fee is waived. Compliance with this policy enables better service to you and other patients. Thank you for your understanding.

_____ _____
Patient Signature Date

Medical History Questionnaire

Please complete the following as completely and accurately as possible.

Name: _____ Date: _____

Present Illness/Injury:

Please list your major symptoms that concern you in order of importance

	Symptom	When did this condition begin?	What treatment have you received already?
1.			
2.			
3.			
4.			
5.			

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had? When?

What allergies, if any, do you have?

What medications have you taken within the last 3 months (include dosages)?

What supplements are you taking (include dosages)?

Have any of your blood relatives had any of the following?

- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Thyroid Disorder
- ☐ Allergies

Name: _____

When was your last physical exam? Were any abnormalities found? Please explain.

Please give a brief description of what you eat and drink on a typical day, including approximate times of consumption.

Morning Afternoon Evening

What types of exercise do you do during the week? How often and for what duration?

On average, how many hours do you sleep each night? Any difficulty falling or staying asleep?

How many hours per week do you work? What type of work do you do (desk, standing, labor, etc.)?

How many cigarettes do you smoke each day?
How much coffee, tea, cola or other caffeinated beverages do you drink per week?
How much alcohol do you drink per week?
Please list any use of drugs for non-medical purposes:

Check the symptoms that pertain to you:

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensations in the hands, feet, chest
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweat easily
- ☐ Dizziness
- ☐ See floating black spots
- ☐ Palpitations
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain radiating to shoulder
- ☐ Insomnia
- ☐ Cough
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose or skin
- ☐ Allergies
- ☐ Chills alternating with fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Low appetite or Large appetite
- ☐ Loose stools or Constipation
- ☐ Abdominal bloating and/or gas after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruise easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness, sluggishness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Mouth sores/canker sores
- ☐ Bleeding, swollen, painful gums
- ☐ Heartburn and/ or Belching
- ☐ Stomach pain

Check the symptoms that pertain to you:

- ☐ Vomiting
- ☐ Diarrhea alternating with constipation
- ☐ Tight feeling in the chest
- ☐ Bitter taste in the mouth
- ☐ Blood shot/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscles spasms, twitching, cramping
- ☐ Seizures/convulsions
- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than once per night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears

Urine is:

- ☐ Pale yellow
- ☐ Clear
- ☐ Dark yellow
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Has odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent

Libido (sex drive) is:

- ☐ Low
- ☐ Moderate
- ☐ High

Indicate if you currently have or have had any of the following:

- ☐ Cold sores
- ☐ Genital herpes
- ☐ Epstein Barr virus (EBV)
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ Epilepsy or convulsions
- ☐ Kidney disease
- ☐ Urinary bladder problems or infections
- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Respiratory problems
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Warts
- ☐ Peptic ulcer
- ☐ Pancreatitis
- ☐ Anemia or other blood disorder
- ☐ Bleeding disorder
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hernia
- ☐ Thyroid disorder
- ☐ Hemorrhoids
- ☐ Sexually transmitted diseases
- ☐ Disorder of the genitals
- ☐ Gynecological disorder
- ☐ Congenital abnormalities
- ☐ Skin diseases
- ☐ Cardiac pacemaker
- ☐ Surgical implants
- ☐ Change in bowel or bladder habits
- ☐ Sores that will not heal
- ☐ Unusual bleeding or discharge
- ☐ Indigestion
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome/disease
- ☐ Gallstones
- ☐ Lupus Erythematosus
- ☐ Difficulty swallowing
- ☐ Obvious change in a wart or mole
- ☐ Chronic Cough
- ☐ Hoarseness
- ☐ History of smoking
- ☐ History of smokeless tobacco use
- ☐ History of drinking alcohol
- ☐ History of recreational drug use
- ☐ HIV/ AIDS

Name: _____

Women: Menstrual History

Age of your first period: _____

Length of flow (days): _____

Length of entire menstrual cycle, from day 1 of one period to day 1 of next period: _____

Date of your last period: _____

Any abnormal vaginal discharge? Yes No

Do you believe you are pregnant or that it may be possible? Yes No

Number of previous pregnancies: _____ Number of live births: _____

Date of last gynecological checkup: _____

Are you taking birth control pills/patch? Yes No

Have you taken birth control pills in the past? Yes No If yes, dates of use: _____

Do you have a history of any of the following?

- ☐ Menstrual cramps
- ☐ Menstrual blood clots
- ☐ Excessive bleeding
- ☐ PMS
- ☐ Breast swelling/tenderness
- ☐ Water gain
- ☐ Abnormal Pap smear
- ☐ Irregular cycle
- ☐ History of hormone therapy
- ☐ Breast cysts
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Pregnancy
- ☐ Infertility
- ☐ Difficulty getting/staying pregnant
- ☐ Emotional changes with period
- ☐ Hot flashes
- ☐ Vaginal yeast infections

Men: Urology History

Do you have a history of any of the following?

- ☐ Premature ejaculation
- ☐ Erectile Dysfunction
- ☐ Prostate problems
- ☐ Infertility

Notice of Patient Privacy

Effective Date: February 11, 2009

Health Insurance Portability and Accountability Act (HIPAA)

L.A. Wellness is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact L.A. Wellness at (310) 335-0073. You may also send a written complaint to the US Department of Health and Human Services.

_____

Printed Name

_____ _____

Patient Signature Date

PAYMENT POLICIES, TERMS & CONDITIONS

Thank you for choosing L.A Wellness and Acupuncture Clinic, Inc. ("L.A. Wellness") as your holistic health care provider. L.A. Wellness is committed to the highest levels of integrity and quality in everything that we do, including our payment, credit and insurance policies, terms, and conditions. Fees for acupuncture services fall into two categories: (i) "Prompt Pay Fees," where fees are paid in full at the time of service; and (ii) "Invoiced Fees," where fees are NOT paid in full at the time of service.

Description	Prompt Pay Rates (a)	Standard / Invoiced Rates
Initial Consultation & Treatment – Regular	$150	(c)
Basic 45 Minute Follow-Up Treatment	$90	(c)
Additional Services (b)	(varies)	(c)

(a) Subject to change at any time and from time-to-time without notice from L.A. Wellness.

(b) Fees for Additional Services may be assessed above and beyond the basic services, for example, myofascial release, cupping, electro-acupuncture, extensive consultation, etc. Note: your verbal approval will be obtained prior to rendering services and such Additional Services.

(c) Each component of the Consultation, Treatment, and Additional Services are required to be itemized and each item is invoiced at the maximum allowable rate.

Fees for Services are to be paid at the time service is rendered, unless alternate arrangements have been made with L.A. Wellness in advance. If payment is not made in full at the time of service, then the higher Standard / Invoiced Rates will apply.

PAYMENT POLICIES, TERMS & CONDITIONS (contd.)

Insurance Benefit-Rated Terms and Conditions: If you have insurance benefits, we prefer that you pay the "Prompt Pay Rates" at the time of service, and L.A. Wellness will provide you with a "superbill" for you to submit to your insurance provider for reimbursement of charges in excess of your applicable co-pay. If you have insurance benefits, and you specifically request that L.A. Wellness collects a co-pay from you and bills your insurance company: you acknowledge that the Standard / Invoiced Rates will be higher than the Prompt Pay Rates; you agree that you will be responsible for any portion of the Standard / Invoiced Rates that are not reimbursed by your insurance company, even though such amounts may be in excess of the Prompt Pay Rates; be advised that your insurance company is likely to send a check directly to you for the allowed amount(s) that is / are invoiced in excess of your co-payment(s); as such, you agree to promptly remit and endorse any such insurance check that you receive along with the EOB (Explanation of Benefits) to L.A. Wellness (or pay L.A. Wellness the amount of money you receive from your insurance company) promptly upon receipt; you acknowledge and agree that any dispute between your insurance company and you regarding the amount of your benefits and/or allowed amounts is strictly between you and your insurance company and that L.A. Wellness is not responsible for what your insurance company may decide to pay; in the event that your insurance company informs L.A. Wellness that you are eligible for reimbursement for acupuncture services rendered at our office, you agree that L.A. Wellness is not responsible for any action that it takes in good faith on your behalf based on such information; for example, L.A. Wellness shall have no responsibility whatsoever if the claims submitted are subsequently denied for any reason, including, without limitation: the treatment(s) is / are deemed medical unnecessary; your deductible has not been met; you have exceeded your benefit limit; a subrogation of claims; medical notes requested are not received and / or deemed insufficient; service is required to be performed by a medical doctor to qualify for coverage; and/or any other reason.

We bill all major carriers and most secondary carriers ONLY when all necessary information is provided by you to do so. We make no representation whatsoever regarding, and do not guarantee, insurance benefits are available to you. You acknowledge and agree that, regardless of insurance coverage, all services provided by L.A. Wellness are your financial responsibility as a patient or as the parent(s)/guardian(s) of a patient. You acknowledge and agree that your insurance coverage and benefits are an arrangement between you and your insurance carrier. You are solely responsible to be aware of your benefits and to contact your carrier directly when any issues arise regarding timely payment of claims, denials, rebilling, and other similar issues. Be advised that many insurance plans have limitations on benefits, especially when it comes to holistic health care. Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions.

You understand and acknowledge that your co-payment may be an estimated amount collected at the time of service, and may not reflect exact amount of co-payment due. Upon receipt of payments from your insurance carrier by our office, you will be notified of any overpayment that you have made, which will be credited or refunded to you at your request, and you acknowledge and agree that any underpayments will be invoiced to you by L.A. Wellness and such amounts will be due and payable upon receipt.

Miscellaneous Payment Policies: You understand, acknowledge and agree that: all balances are due within 30 days of service being rendered; you may pay with cash, personal check, Visa /MasterCard/Amex, or bank debit card. If you are unable to pay in full within 30 days for any reason, please contact our office immediately; for any "no show" or patient that does not keep his/her scheduled appointment time and did not cancel with at least 24 hours prior notice, that patient's account will be assessed for the appointment based on the Prompt Pay Rates for the scheduled service.

I have read and received a copy of this L.A. Wellness Payment Policies, Terms and Conditions. I understand, acknowledge and agree to the Policies, Terms and Conditions set forth herein. I understand that every future authorization by me for treatment from L.A. Wellness constitutes my re-acknowledgement and agreement with such terms and conditions.

Patient Name (printed): _____ Relationship to Patient: _____

Signature of Responsible Party:_____ Date: _____