Lao Lao Acupuncture Center
1754 Technology Drive, 128, San Jose, CA 95110
Tel: 408-392-8281 Fax: 408-673-8803
www.laolaoacu.com

PATIENT INFO

Last Name:_____ First Name:_____ MI:_____ Sex: ☐M ☐F

Age:_____ Birth Date:_____ Social Security #_____ Driver's Lic #_____

Home Address:_____

City:_____ State:_____ Zip:_____ Email:_____

Home Phone:_____ Cell:_____ Work Phone:_____

(If patient is a minor, give parent/guardian employment information)

Are you employed? Yes_____ No_____ If yes, name of Employer:_____

Occupation/Job Description:_____

Employer Address:_____ Phone:_____

If married, Spouse's name:_____ Spouse's work #_____

Spouse's Employer Name & Address:_____

If the patient is a minor, parent(s) name(s):_____

Name of person child currently lives with:_____ Relationship:_____

Name of nearest relative not living with you:_____ Relationship:_____

Address:_____ Phone:_____

PRIMARY INSURANCE INFORMATION

☐Medicare ☐Medicaid ☐PPO ☐HMO ☐POS

Insurance Company Name & Address:_____

Policy holder's Name:_____ Birth date:_____

Relationship to patient:_____ Social Security #:_____

Phone #:_____ Identification#:_____ Group#:_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name & Address:_____

Policy Holder's Name:_____ Birth Date:_____

Relationship to Patient:_____ Social Security #:_____

Phone #:_____ Identification #: _____ Group #:_____

Referred by: ☐Friend ☐Physician ☐www.AustinAcupuncture.com ☐Other:_____

Have you or any of your family been previous patients? ☐ Yes ☐ No

If yes, Name of Patient:_____ When?_____

Referring Phyician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

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FINANCIAL POLICY

- PLEASE READ CAREFULLY -

Co-Payments and payment for services not covered by your insurance will be due at your visit. For your convenience, we accept cash, check, debit or credit card (MasterCard, Visa, and Discover).

We do not accept insurance forms in lieu of payment but will provide you with a receipt that will assist you in collecting payment from your insurance carrier. We are providers for several PPO and HMO insurance plans. **You are responsible for obtaining necessary referrals prior to your visits or you will be asked to reschedule your appointment.** All health plans are not the same and do not cover the same service. In the event your health plan determines that a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will expect payment from the adult accompanying a minor for all services rendered to minor patients.

We do not file third party insurance for your motor vehicle accidents or liability claims. We do not wait for claims to be settled in or out of court. We expect payment from you until a settlement is made.

Medicare: We will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your deductible if not met at the time, as well as your 20 percent.

Please sign here that you have read this office policy and agree to it. If there is a problem, please speak to the cashier before seeing the doctor.

X_____ _____
Patient or Parent/Guardian Signature Date

RELEASE INFORMATION

I hereby authorize Austin Acupuncture Clinic to furnish medical information concerning my present illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Austin Acupuncture Clinic.

X_____ _____
Patient or Parent/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I request payment of medical benefits, otherwise payable to me, directly to Austin Acupuncture Clinic for services provided by them. I understand that I am financially responsible to Austin Acupuncture Clinic for charges not covered by this Assignment of Benefits.

X_____ _____
Patient or Parent/Guardian Signature Date

CONSENT OF TREATMENT

I hereby authorize evaluation and treatment by _____

X_____ _____
Patient or Parent/Guardian Signature Date

MEDICAL EVALUATION, REFERRAL, OR RECOMMENDATION

I (patient's name) _____ am notifying the Acupuncturist of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture.

Note: In the case of patients seeking treatment for smoking addiction, weight loss, alcoholism, chronic pain (defined as pain lasting longer than 6 months), or substance abuse, referral by a physician, dentist, or chiropractor is not required.

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

Optional Form to be Completed by Patient, Attesting that the Acupuncturist Has Referred Him/Her

(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

Acupuncturist's signature _____ Date _____

Neither Clinic nor Acupuncturist is liable for errors or false statements on this form.

New Patient Information/Policies

How did you find out about our clinic?	
Yellow Pages	☐ *Direct Mail*
☐ *Websites*	☐ *Friends/Relatives (name)*_____
☐ *Location or walk by*	☐ *Referred by* _____
☐ *Periodicals*	☐ *Other (please specify)*_____

Cancellation Policy: Treatments are by appointments. If you find that you need to cancel an appointment, it is important that we receive 24-hour notice. This enables us to fill the time slot. **We reserve the right to charge your standard fee for all appointments canceled without a 24-hour notice or for a "no show" appointment.**

Payment for Clinic Services Rendered: Payment is due at the time of service and may be paid in cash, by check or by major credit card. We also accept most insurance and will file your claims. However, the patient is liable for all services not covered or paid by private insurance companies. We are however, not a Medicare/Medicaid provider.

Herbal Refills: Please call no less than 24 hours before you wish to pick up herbal refills to allow time to process your request.

I have read the New Patient Information/Policies and agree to their terms and conditions.

_____

Patient's Signature Date

NOTICE OF PRIVACY POLICIES

Austin Acupuncture is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers;
- Information we receive from third-party payors.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations.

You may specifically authorize us to use Protected Health Information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your protected health information.

Marketing: This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, or appointment reminders by calls, postcards, or letters. This office may send you information to support your health care, information about alternative treatments, and health-related services that may be of interest to you. Please advise this office if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office in writing at our contact address.

Disclosure: This office may use or disclose your Protected Health Information when required by law. Without your consent or authorization, this clinic may disclose information about you only for the following purposes:

- To a public health agency, for the purpose such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if your are incapacitated or if it appears necessary to prevent serious harm to you or others.
- To health oversight authorities for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United State military, national security or intelligence, or Foreign Service, to your authorized superiors or other authorized federal officials.

We may not disclose information about you for any other purpose without your written authorization, provided separately from your written consent.

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.

If you have questions, complaints or want more information, please contact this office. Contact: Privacy Officer.

Complaints: Complaints about your privacy rights or how your privacy is handled at this office can be directed to the privacy officer by calling this office or directing a letter to his or her attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave., S. W., Room 509F HHH Building, Washington, D.C. 20201.

I, _____ (Printed Name),

have read, reviewed, understand, and agree to the Notice of Privacy Policies for healthcare and/or other services provided through this office.

This office has attempted to provide each patient with a Notice of Privacy Policies.

X _____

Patient Signature or Signature of Parent/Guardian if under the age of 18 **Date** *HIPAA Form A*

PATIENT'S CONSENT
FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ (Printed Name) give consent to _____ the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the service this office has rendered to me;
C. The general administrative operations this practice provides to me.

The Purpose of this Consent:

Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present or future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations will include quality assessment activities, credentialing, business management, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, and other general operations procedures or activities.

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

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form 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 Clinic has acted in reliance on this consent.

_____ _____

Signature of Patient/Personal Representative or Signature of Parent/Guardian if under the age of 18 **Date**

_____

Description of Personal Representative's Authority

ANNUAL HISTORY AND PHYSICAL

MAIN PROBLEMS:

(1)_____

(2)_____

(3)_____

MEDICAL HISTORY: Mark ☐ for current problems. Check ☐ box and indicate age when you previously had any of the following symptoms or diseases.

☐ Decreased Hearing
☐ Ringing in Ear
☐ Ear Infections- Frequent
☐ Dizzy Spells
☐ Failing Vision
☐ Double or Blurred Vision
☐ Eye Pain
☐ Eye Infections - Frequent
☐ Nose Bleeds - Recurrent

☐ Sinus Trouble

☐ Sore Throats - Frequent

☐ Hay Fever/Allergies

☐ Hoarseness - Prolonged

☐ Pneumonia/Pleurisy
☐ Bronchitis/Chronic Cough
☐ Asthma/Wheezing/Shortness of Breath
☐ on Exertion ☐ Lying Flat

☐ Chest Pain
☐ High Blood Pressure

☐ Heart Murmur

☐ Palpitations

☐ Irregular Pulse

☐ Swollen Ankles

☐ Fainting Spells

☐ Leg Pain when Walking
☐ Varicose Veins/Phlebitis
☐ Lose of Appetite - Recent
☐ Difficulty Swallowing
☐ Indigestion or Heartburn
☐ Persistent Nausea/Vomiting
☐ Peptic Ulcers
☐ Abdominal Pain- Chronic
☐ Change in Bowel Habits - Recent
☐ Diarrhea ☐ Constipation

☐ Diverticulitis

☐ Bloody or Tarry Stools

☐ Hemorrhoids

☐ Gall Bladder Trouble
☐ Jaundice/Hepatitis
☐ Hernia

☐ Urinary Infections - Frequent

☐ Painful Urination
☐ Blood in Urine

☐ Overnight Urination – More than 2 times
☐ Control in Urination

☐ Decrease in Force of Urination
☐ Kidney Stones

☐ Venereal Disease
☐ Urethral Discharge

☐ Chronic Fatigue
☐ Weight Loss-Recent
☐ Anemia
☐ Bruise Easily
☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Convulsions/Seizures
☐ Stroke

☐ Tremor/Hands Shaking

☐ Muscle Weakness

☐ Numbness/Tingling Sensations
☐ Pain/Cramps with Menstrual Flow
☐ Headaches - Frequent
☐ Arthritis/Rheumatism
☐ Back Pain - Recurrent

☐ Bone Fracture/Joint Injury
☐ Gout
☐ Foot Pain ☐ Cold Numb Feet
☐ Rashes ☐ Hives

☐ Psoriasis

☐ Sleeping Difficulty

☐ Nervousness ☐ Depression
☐ Memory Loss
☐ Moodiness - Excessive
☐ Phobias
☐ Mental Illness

☐ Chicken Pox
☐ Measles
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Mumps
☐ Tuberculosis
☐ Alcohol _____ oz. per week
☐ Smoking _____ cig. per day
☐ Coffee/Tea _____ cups/day

FEMALES – MENSTRUAL HISTORY

Age of Onset____ ☐ Reg. ☐ Irreg.
Flow ☐ Heavy ☐ Mod. ☐ Light
☐ Pain/Cramps with Menstrual Flow
☐ _____Days of Flow
☐ _____Length of Cycle
☐ Pain/Bleeding After Sex

# of Pregnancies _____

# of Live Births _____
# of Miscarriages_____

Birth Control Method

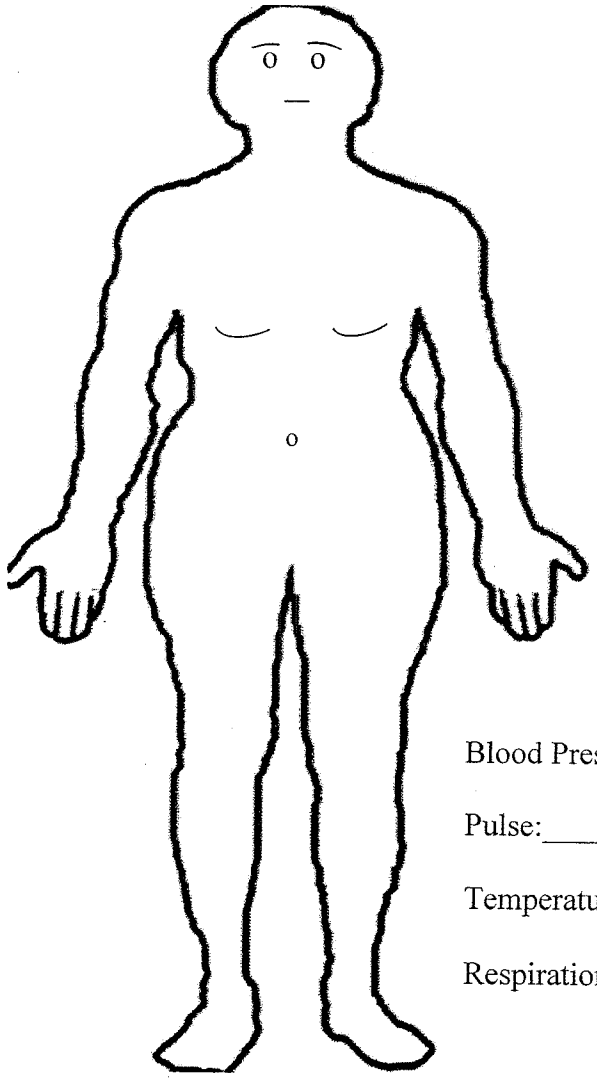
_____
☐ B.C. Pill (Name)

_____
☐ Flushing/Menopause

☐ H.I.V.

Other Symptoms of Diseases
☐ _____
☐ _____
☐ _____

SYNOPSIS:_____

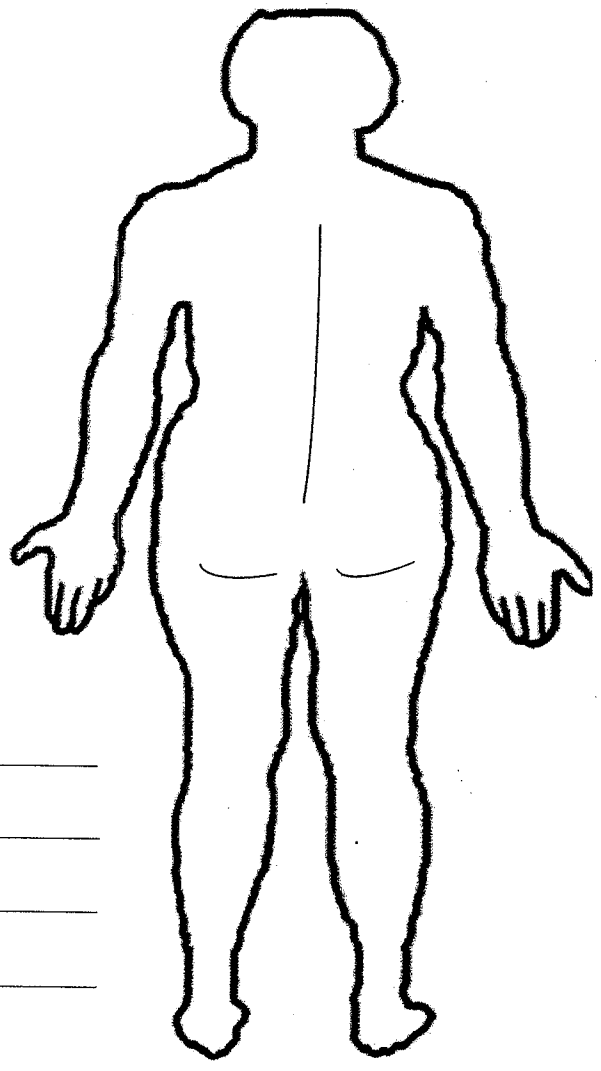


Blood Pressure:_____

Pulse:_____

Temperature:_____

Respiration:_____



Front View

Back View