Dear New Patient –

We would like to take this opportunity to welcome you to WellPoint Acupuncture and Chinese Herbal Medicine. We know that you have many options when it comes to choosing your healthcare providers and we thank you for giving us the opportunity to serve your healthcare needs.

This letter will outline our office policies in order to help things run as smoothly as possible for you at your first visit and going forward. Enclosed in this packet are: New Patient Information and Policies, Health History Form and Consent Form. Please read and fill out all of the required forms and initial where indicated to show that you have read and understood the office policies.

We look forward to meeting and working with you,

The WellPoint Team

New Patient Information and Policies

Welcome to WellPoint. We are here to help you receive the best care possible in a comfortable setting. If you have questions regarding any aspect of your visit, please don't hesitate to ask. Please initial each section below where indicated to show that you have read, understood and agree to each policy.

Your First Visit

- Please refrain from eating or drinking anything that will alter the color of your tongue for several hours before your appointment. The reason for this is that we will inspect your tongue for diagnostic purposes (this would include coffee, hard candies, fruit juices, etc).
- Please ensure that you have eaten some food on the day of treatment – do not arrive with an entirely empty stomach.
- Please wear loose, comfortable clothing. If you are coming in for musculoskeletal issues, please bring a pair of shorts (and women, a sports bra or something similar).
- Please refrain from wearing strong perfumes, oils or lotions, as some people have chemical sensitivities to these strong smells.

Appointments

Please respect our schedule and arrive on time for your appointments. We try very hard to minimize wait times for our patients and we can do this more effectively if everyone arrives on time.

- Please call and inform the front desk if you are running late. If you are going to be more than a few minutes late, we will determine if there is enough time to see you.
- Please make your appointments as far in advance as possible – this will ensure that you get the best appointment time available for your personal schedule.

Initial _____

Cancellation Policy

In the event that you need to cancel or reschedule an appointment, we require at least 24-hours notice. If you cancel or reschedule with less than 24-hours notice, you will be billed for the full cost of the visit. (Those with Medicaid Health Partners Insurance, please read and sign the separate Health Partners cancellation policy.)

Initial _____

Payment

Payment, including co-pays/co-insurance, is due in full at the time of service. If you have insurance coverage please see the next section for further information, and understand the fees may be different from the ones listed below.

- The out-of-pocket fee for non-insured patients for the initial visit is $160, and the fee for follow-up visits is $95.
- We accept: cash, personal checks, credit cards (no AmEx), and flex spending/health savings accounts.
- There will be a $30 charge for returned checks.

Initial _____

Health Insurance

Many health insurance policies cover acupuncture. However, policies can vary greatly in terms of deductibles, co-pays, and percentage of coverage for treatments. As a courtesy to you, we will verify your coverage as well as submit your claims. We suggest, however, that you also verify your insurance benefits with your carrier, as quoted benefits are not a guarantee of coverage. In certain cases, we will require that you pay us in full for services until your policy begins to reimburse us. At that point, we can credit your account to be applied to subsequent co-pays or issue the appropriate refund.

Initial _____

Release of Information

Your insurance company may require medical reports to document the treatments and progress. Your initials below authorize the release of medical information necessary to process your claims, if requested.

Initial _____

Financial Agreement/Assignment of Benefits

I, (print full name) _____, am receiving or am about to receive health care services in this office. I understand that I am responsible for paying all non-insurance related fees when services are rendered, including herbal medicines, etc. If I choose to use my health insurance, I understand I will be responsible for all "non-covered" services and /or co-insurances/co-pays associated with my office visits. In addition, I authorize insurance payments of medical benefits to WellPoint Acupuncture.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Signed: _____ Date: _____

Health History Questionnaire

Name: _____ Home Phone: _____

Address: _____ Mobile Phone: _____

City: _____ State: ___ Zip: _____ Work Phone: _____

E-Mail:_____ Occupation:_____

Date of Birth:_____ Age:___ Height:_____ Weight:_____ Marital Status: _____

Physician:_____ Phone: _____Referred by: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

Reason for today's visit? (include relevant medical diagnoses)

_____

_____

_____

_____

When and how did this condition start? Have you ever had it before?

_____

_____

_____

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

_____

What makes your condition better (heat, cold, damp, pressure, movement, etc)? _____

_____

What makes your condition worse? _____

Is your condition: stable_____ getting worse_____ getting better_____ comes & goes_____

Have you tried other forms of treatment for this condition? Have they helped? _____

_____

If you are having pain, circle your average pain level: mild - 1 2 3 4 5 6 7 8 9 10 – extreme

Are you under the care of a physician for this condition? For any other conditions? _____

_____

Have you ever had acupuncture or taken Chinese herbs before? _____

When was your last physical exam? _____ Any new medical issues? _____

Significant illnesses or surgeries (please include types and dates of procedures) _____
_____
_____

Traumatic accidents? When? _____
_____

Allergies (environmental, food, drugs, etc) _____

Medications/Vitamins/Supplements/Herbs (attach separate sheet if necessary) _____
_____
_____

Do you have a family history of any of the following? If yes, indicate who:

Diabetes:	Heart Disease:	Hypertension:	Stroke:
Cancer:	Thyroid:	Kidney Disease:	Gastrointestinal:
Skin Conditions:	Allergies:	Asthma:	Mental Health:

How do you feel about your occupation?_____

How do you reduce stress? What brings you joy? _____
_____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Have you ever been treated for substance abuse? _____

Exercise: Type: _____ Frequency: _____

How would you rate your overall energy (1 = low to 10 = high)_____

How many meals do you eat/day: ____ How much water/fluids:_____ Caffeinated drinks: _____

How much do you consume/day: Cigarettes: _____ Alcohol: _____ Recreational drugs:_____

Describe your typical daily diet:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Please indicate if you have had any of the following in the past 3 months:

Skin & Hair
- ☐ Rash/itching
- ☐ Dandruff
- ☐ Dry skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Acne
- ☐ Herpes
- ☐ New moles
- ☐ Bruise easily
- ☐ Hair loss
- ☐ Nail fungus
- ☐ Other _____

Head
- ☐ Migraines
- ☐ Headaches
- ☐ Facial pain
- ☐ Poor vision
- ☐ TMJ
- ☐ Floaters/spots
- ☐ Dry eyes
- ☐ Blurry vision
- ☐ Sinus problems
- ☐ Nasal discharge
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Recurrent sore throat
- ☐ Sores in mouth
- ☐ Teeth/gum problems
- ☐ Concussions
- ☐ Other _____

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Cold hands/feet
- ☐ Swollen hands/feet
- ☐ Fainting
- ☐ Irregular heartbeat
- ☐ Blood clots
- ☐ High cholesterol
- ☐ Anemia
- ☐ Pacemaker
- ☐ Stroke/CVA

Respiratory
- ☐ Asthma
- ☐ Allergies
- ☐ Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Coughing blood

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Heartburn/reflux
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Belching
- ☐ Bloating
- ☐ Indigestion
- ☐ Flatulence
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Incomplete BM
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Gallstones
- ☐ Eating disorder
- ☐ Other_____

Urogenital
- ☐ Painful urination
- ☐ Difficult urination
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Overnight urination
- ☐ Decreased urine flow
- ☐ Dribbling
- ☐ Impotency
- ☐ Change in libido
- ☐ Kidney stones
- ☐ Genital sores
- ☐ Prostatitis/BPH
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ STD: _____

Gynecological
- ☐ Age first menses ___
- ☐ Duration menses ___
- ☐ Date last menses ___
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Heavy/light flow
- ☐ PMS – Circle: bloated, emotional, headache, bowel changes, fatigue, breast tenderness, abdominal cramps, back pain
- ☐ Vaginal discharge
- ☐ # live births _____
- ☐ # miscarriages ____
- ☐ # abortions ____
- ☐ Menopause, age ____ Symptoms? _____
- ☐ Last PAP _____
- ☐ Birth control: _____
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Fibroids
- ☐ Breast lumps
- ☐ PCOS

Neurological

- ☐ Seizures
- ☐ Fainting
- ☐ Numbness
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Tremors

Emotional

- ☐ Depression
- ☐ Anxiety
- ☐ Frequent anger
- ☐ Repress emotions
- ☐ Mood swings
- ☐ Manic episodes
- ☐ Obsessive behaviors
- ☐ Grief
- ☐ Susceptible to stress

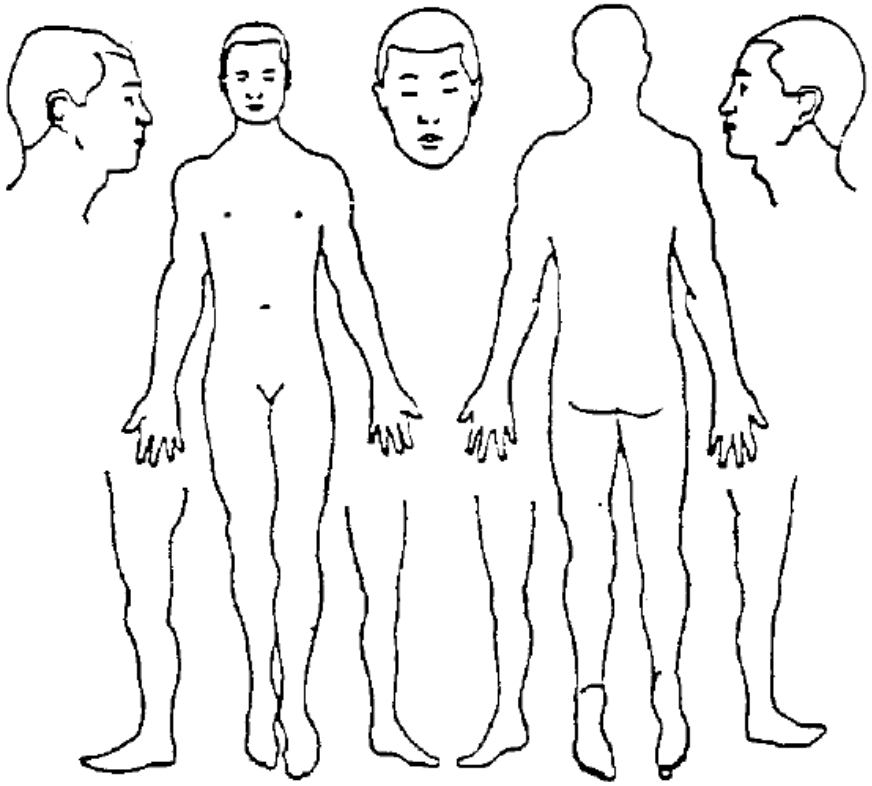
General

- ☐ Chills
- ☐ Fever
- ☐ Sweats Easily
- ☐ Night sweats
- ☐ Strong thirst
- ☐ Dizziness
- ☐ Fatigue, low energy
- ☐ Change in appetite
- ☐ Weight gain/loss
- ☐ Tremors
- ☐ Sudden energy drop
- ☐ Frequent colds
- ☐ Swollen lymph nodes
- ☐ HIV
- ☐ Hepatitis
- ☐ Lyme disease
- ☐ Cancer: Type _____

Sleep

- ☐ Insomnia – hard to fall/stay asleep
- ☐ # Hours/night ___
- ☐ Nightmares
- ☐ Snoring
- ☐ Hard to wake in AM
- ☐ Need naps in day
- ☐ Sleep walking/talking
- ☐ Sleep apnea

Please indicate any areas of pain or discomfort and rate pain levels at each specific area.



Consent to Treatment

I, _____, hereby authorize the practitioners of WellPoint Acupuncture and Chinese Herbal Medicine to administer any modality of Chinese Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations. There is the possibility of bruising or localized tenderness at the sites of needle insertion.
2. Heat treatments using the herb *Artemesia vulgaris* (moxibustion, "moxa") or a heat lamp. Indirect moxibustion treatments involve putting moxa on the head of a needle or on top of a barrier such as salt or ginger. When direct moxa is used, it is placed directly on the skin. The heat from moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat there is always the risk of a burn.
3. A Chinese massage technique called *gua sha* may be used. This treatment leaves redness on the skin that can last from 1-5 days. Bruising and tenderness may persist for a short time after treatment.
4. Cupping may be used to promote blood circulation. Cups may produce a red/purple color on the treated area that can last 1-5 days. Bruising and tenderness may persist for a short time after treatment.
5. Electrical stimulation of the needles may be used which produces a vibration or tapping sensation.
6. Bloodletting, or microbleeding, may be used to improve circulation in specific areas. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.
7. Manual manipulation or massage of the body may be performed using *tuina*, myofascial release or a variety of other massage techniques.
8. Chinese herbs may be prescribed. The herbs will be tailored to your specific condition. Possible side effects include but are not limited to: nausea, bloating, diarrhea, sweating, or an exacerbation of current symptoms.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of unforeseen or unexpected complications and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient: _____ Date:_____

Printed name of patient: _____

Clinician signature: _____