EASTGATE
• ACUPUNCTURE •

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WWW.EASTGATEACUPUNCTURE.COM

PERSONAL INFORMATION (CONFIDENTIAL)

Name_____Date_____

Home Address _____

City_____ State_____ Zip_____

Tel:(Cell) _____ Tel:(Home) _____

Email _____ Occupation _____

Date of Birth _____ Age _____ Height _____ Weight _____

Marital (Relationship) Status _____ Number of Children _____

Emergency Contact _____ Telephone _____

Referred by _____

Main Complaint: _____

_____

What other forms of treatment have you sought? _____

What makes the condition better or worse? _____

_____

Have you received acupuncture before? _____

What would you like to improve most about your physical or emotional health or your lifestyle?

_____

_____

_____

Chronic health problems: _____

_____

Serious illnesses (age): _____

_____

Please list any medications/vitamins/supplements you are currently taking:

Medication	Dosage	Reason

IF YOU ARE USING YOUR INSURANCE FOR TODAY OR WANT US TO CHECK FOR ACUPUNCTURE BENEFITS YOU CAN EITHER SUBMIT YOUR INSURANCE TO OUR SECURE BILLING PORTAL AT

WWW.EASTGATEACUPUNCTURE.COM

OR FILL OUT THE INFORMATION BELOW AND MAKE SURE TO COMPLETE PAGE 1 OF INTAKE FORMS:

please print legibly

Primary Insurance Company:_____

- Member ID: _____
- Phone number for provider services or eligibility _____
- Are you the policy holder (primary insured)? Y___ N___
- If not please fill out the following information:
  - Primary Insured Name:_____
  - Date of Birth:_____

Do you have another Insurance policy/ Secondary Policy? Y___ N___

If Yes please fill out the following information:

- Secondary Insurance Company:_____
- Member ID: _____
- Phone number for provider services or eligibility _____
- Are you the policy holder (primary insured)? Y___ N___
- If not please fill out the following information:
  - Primary Insured Name:_____
  - Date of Birth:_____

Please list your history of surgeries and hospitalizations:

Surgery / Hospitalization	Age	Outcome

Please check all that apply:

☐ I have a pacemaker
☐ I have known allergies
☐ I am taking coumadin/warfarin
☐ I am taking lithium (Eskalith, Lithobid, Lithonate etc.)

PAST MEDICAL HISTORY

Have you or your immediate family had any of these conditions? Please check all that apply:

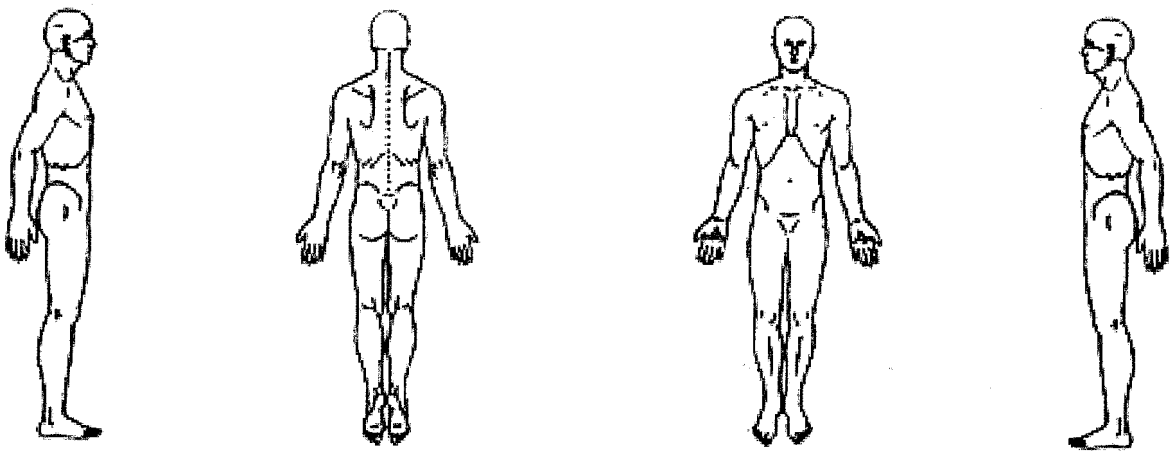
You	Relative		You	Relative		You	Relative		You	Relative	
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	HIV positive	☐	☐	Polio
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Kidney disease	☐	☐	Psychiatric care
☐	☐	Anorexia	☐	☐	Epilepsy	☐	☐	Lung disease	☐	☐	Rheumatic fever
☐	☐	Appendicitis	☐	☐	Goiter	☐	☐	Liver disease	☐	☐	Suicide attempt
☐	☐	Asthma	☐	☐	Gout	☐	☐	Miscarriage	☐	☐	STDs
☐	☐	Bleeding disorder	☐	☐	Heart disease	☐	☐	Mononucleosis	☐	☐	Stroke
☐	☐	Bronchitis	☐	☐	Hepatitis	☐	☐	Multiple sclerosis	☐	☐	Thyroid disease
☐	☐	Bulimia	☐	☐	Hernia	☐	☐	Osteoporosis	☐	☐	Other
☐	☐	Cancer	☐	☐	High blood pressure	☐	☐	Pacemaker			
☐	☐	Drug dependency	☐	☐	High cholesterol	☐	☐	Pneumonia			

PAIN, MUSCLES, JOINTS & BONES

Have you experienced any of the following? Please check all that apply:

☐ Broken bones
☐ Tendonitis
☐ Repetitive strain injury
☐ Meniscus tears
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Swollen joints
☐ Fibromyalgia
☐ Muscle cramps
☐ Slipped disc
☐ Bone pain
☐ Other

Please indicate areas of sharp stabbing pain with an (X). Please indicate other aches or dull heavy pains with a circle. If the pain radiates or follows a path please mark that path with a line.



Describe the pain, please check all that apply:

☐ Sharp
☐ Dull
☐ Better with heat
☐ Worse with heat
☐ Superficial
☐ Deep
☐ Worse in evening
☐ Worse in morning
☐ Aching
☐ Burning
☐ Better with cold
☐ Worse with cold
☐ Numbness / Tingling
☐ Worse with humidity
☐ Better with exercise
☐ Worse with exercise

For Men

Date of last prostate exam _____ PSA results _____
Manual Prostate exam results_____
Other exam or lab results_____

Have you experienced any of the following? Please check all that apply:

☐ Prostate problem	☐ Delayed stream	☐ groin pain	☐ Decreased libido
☐ Nocturnal emission	☐ Painful erections	☐ Inguinal hernias	☐ Swollen testes
☐ Itching or rash in groin	☐ Varicocele	☐ Blood in urine or ejaculate	☐ Impotence
☐ Erectile dysfunction	☐ Increased libido	☐ Testicular pain	☐ Dribbling
☐ Retention of Urine	☐ Premature ejaculation	☐ Diagnosed Infertility	☐ Other

If seeking fertility treatment, have you had a sperm analysis? ☐ Yes ☐ No
If so, what were the results?
Volume _____ Count _____ Motility _____ Morphology _____

For Women

At what age did you start menstruating? _____
Date of last menstrual period? _____
Number of pregnancies? _____Number of miscarriages? _____Number of abortions? _____
Number of days of menstrual cycle (i.e. 28 or 32) _____
Number of days of menstrual flow(1-5?)_____
How many pads or tampons do you use on your heaviest day?_____
Color of blood: Brown, Brownish red, Red, Bright Red, Purple
Describe the quality of the flow: Grainy, Mucous, Fleshy, Clots, Liquid, Other_____
Do you feel weepy or angry before your period?_____
Please describe any PRE-menstrual symptoms, when they appear and when they are alleviated:
_____
_____

Please describe any symptoms that occur during menstruation and when they are alleviated:
_____
_____

Please describe any POST-menstrual symptoms, when they appear and when they are alleviated:
_____
_____

Are you on the pill or other hormone based contraceptives? If yes, for what purpose?
_____
_____

Have you frequently experienced . . . (check all that apply):

☐ Fibroids	☐ Skipped periods	☐ Bleeding between periods	☐ Hot flashes
☐ Ovarian cysts	☐ Light flow	☐ Diarrhea w/ period	☐ Night sweats
☐ Endometriosis	☐ Heavy flow	☐ Constipation w/ period	☐ Painful intercourse
☐ Fibrocystic breasts	☐ Clots in flow	☐ Yeast infections	☐ Fatigue after sex
☐ Breast lump	☐ Mid-cycle pain	☐ Vaginal discharge	☐ Strong libido
☐ Breast tenderness	☐ Nipple discharge	☐ Other infections	☐ Weak libido
☐ Irregular cycles	☐ Pain before period	☐ Itching or burning	☐ Low lubrication
☐ No periods	☐ Pain during period	☐ Abnormal Pap test	☐ IUD

PREGNANCY- ONLY FILL OUT IF APPLICABLE

Are you currently pregnant? ☐ Yes ☐ No If yes, How many weeks?_____
Please circle one - Single child, Twins or Triplets?
Any medical complications during pregnancy? _____
_____

Number of Previous pregnancies? _____ Delivery method? Please circle: Vaginal or C-section

FERTILITY- ONLY FILL OUT IF APPLICABLE

Have you been having regular, unprotected intercourse with the goal of becoming pregnant? If so, for how long?
_____

Have you been medically evaluated by a gynecologist/ obstetrician / reproductive endocrinologist for fertility? ☐ Yes ☐ No
If so, have you received any medical diagnosis relating to fertility?
_____

Have you ever experienced or been diagnosed with the following? Please check all that apply:

☐ Ectopic pregnancy	☐ Uterine fibroids	☐ Pelvic adhesions
☐ Pelvic inflammatory disease	☐ Uterine or cervical polyps	☐ Polycystic ovary syndrome
☐ Chlamydia	☐ Endometriosis	☐ Pelvic abnormalities
☐ Thyroid condition	☐ Pituitary conditon	☐ Premature ovarian failure

Have you had any surgeries in the lower abdomen or pelvic area (for any reason)? ☐ Yes ☐ No
If so, please describe: _____

Have you had your hormone levels checked by blood test? ☐ Yes ☐ No
If so, what were the results?

FSH (Day 3) _____ LH _____ TSH _____ Estradiol (Day 3)_____

Progesterone (7 days past ovulation) _____

Have your fallopian tubes been evaluated by hysterosalpingogram? ☐ Yes ☐ No
If so, what were the results? _____

Have you tried any of the following to help you time intercourse? Please check all that apply:
☐ Basal body temperature ☐ Ovulation predictor ☐ Checking cervical fluid
☐ Other? _____

Have you had any fertility treatments? ☐ Yes ☐ No If so, please check all that apply:
☐ Clomid ☐ Intrauterine insemination (IUI) ☐ In Vitro Fertilization (IVF)
or other assisted reproductive technology

Have you used any of the following for birth control?
☐ Birth control pill/patch ☐ IUD ☐ Depo-Provera☐ Diaphram/Cervical cap ☐ Other

Has your partner had a sperm analysis? ☐ Yes ☐ No
If so, what were the results?
Volume _____ Count _____ Motility _____ Morphology _____

Please sign below:
Financial Agreements

Assignment of Benefits - Allows your insurance company to pay us…
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Eastgate Acupuncture P.C. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Patient/Responsible Party Signature Date

Authorization to Release Information - Allows us to submit reports when asked by the insurance companies…
I hereby authorize Eastgate Acupuncture P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Eastgate Acupuncture P.C. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

Financial Responsibility
I understand that information provided to me by this office is not a guarantee of payment by my insurance company and that I am responsible for all professional services rendered in the event of non-payment, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

_____ _____
Patient/Responsible Party Signature Date

CANCELATION POLICY

As a courtesy we ask for at least 24 hour notice of cancelation or rescheduling. Same day cancelations or no-shows will be charged at 50%.

_____ _____
Patient/Responsible Party Signature Date

Please sign below:
Medical Agreements

Patient Advisory to Consult a Physician

As a healthcare provider, my primary concern is in your health and well-being. While Oriental Medicine has a great deal to offer as a health care system, it does not replace the abilities of the Western biomedical system.

Therefore, I highly recommend that you consult a physician for any condition or conditions for which you are seeking acupuncture or herbal treatment.

In order to comply with Article 160, Section 8211.1 (b) of the New York State Education Law, I request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____ (patient's name) HAS BEEN ADVISED TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____

Patient Signature Date

_____ _____

Licensed Acupuncturist Signature Date

Notice of side effects related to acupuncture

Acupuncture may result in temporary soreness, bruising, redness or puffiness at the site of insertion, muscle twitching, temporary fatigue, light headedness or emotional release. Many of these are positive signs that the acupuncture is working as intended.

_____ _____

Patient Signature Date

HIPPA Notice Of Privacy Practices

I HAVE READ AND UNDERSTAND THE HIPPA PRIVACY PRACTICE NOTIFICATION. (See next page)

_____ _____

Patient Signature Date

Notice Of Privacy Practices (HIPPA Notification)

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.

I am required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice of my legal duties and privacy practices in regard to your protected health information.

Disclosure of your Health Care Information

Treatment: Your health care information may be disclosed to other health care professionals within my practice if I am working in tandem with another acupuncturist or assistant for the purpose of treatment, payment, or health care operations.

Workers' Compensation: I may disclose your health care information as necessary to comply with State Workers' Compensation Laws.

Emergencies: I may disclose your health care information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency, or of your death.

Public Health: As required by law, I may disclose your health care information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administration Proceedings: I may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement: I may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, missing person or material witness, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons: I may disclose your health information to coroners or medical examiners.

Organ Donation: I may disclose your health information to organizations involved in the procuring, banking, or transplanting of organs and tissues.

Research: I may disclose your health information to organizations conducting research that has been approved by an institutional Review Board.

Public Safety: It may be necessary to disclose your information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health and safety of a particular person or to the general public.

Specialized Government Agencies: I may disclose your health information for military, national security, prisoner and government benefits purposes.

Scheduling and Appointments: I may call your home or e-mail you to confirm your scheduled appointments. If you are not home, I will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during the recording or message other than the date and time of your appointment.

Your Health Information Rights

-You have the right to request restrictions on certain uses and disclosure of your health information. Please be advised that I am not required to agree to the restrictions that you requested.

-You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

-You have the right to inspect and request a copy of your health information.

-You have the right to request that I amend your protected health information. I am not required to agree to amend your protected health information. If your request is denied, you will be provided with an explanation of my reasons for denial and information about how you can disagree with the denial.

-You have the right to receive an accounting of disclosures of your protected health information made by me.

-You have the right to receive a paper copy of this Notice of Privacy Policy.

Changes to the Notice of Privacy Policy

-I reserve the right to amend this Notice of Privacy Policy at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, I am required by law to comply with this notice. If you have any questions about this notice please ask me.

Complaints

Complaints about your privacy rights can be directed formally to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509 HHH Building, Washington D.C. 20201