BEND SPORTS ACUPUNCTURE

How to prepare for your appointment:

Wear loose clothing that can be rolled up on the legs and arms

Because many of our patients are sensitive to perfumes, lotions and scented beauty products, please refrain from using these products on the day of your appointment.

Please have your paperwork filled out and ready by the time of your appointment or come in 20 minutes before your appointment to fill it out.

Prior to your Appointment

If you would like us to bill your insurance – **Call the Customer Service number** on the back of your Insurance Card & confirm directly with them if your Health Plan covers Acupuncture or Alternative Care

_____Confirm that the Acupuncturists you will be seeing is a "Participating Provider" or "In-Network" with your Health Plan
_____Confirm whether or not your Health Plan requires "Referrals" or "Pre-authorizations"
_____Confirm - Does your Health Plan combine Acupuncture, Chiropractor, Massage & Naturopath all together

Does your Health Plan waive the deductible for Alternative Care or Acupuncture: Yes or No
Do you need to meet your deductible before they pay: Yes or No
How much is your deductible?
_____
How much of your deductible has been met? _

Does your Health Plan have a Co-Pay (flat fee) that you pay: Yes or No Co-pay Amount: $_____
Does your Health Plan have a Co-Insurance % (Ex 80%/20%) Yes or No % Insurance: _____ & % You: _____
Does your Health Plan have a Maximum ($ amount) or (# of visits) allowed during the year: Yes or No

Does your Health Plan have any special restrictions or guidelines to follow: Yes or No
If Yes – Please list: *(Example: must be provided by MD only, diagnosis specific such as only covers pain, etc.)*

All accident claims such as MVA's. Workers Compensation & Personal Injury **require prior authorization** from the Insurance Company before your first appointment. Please call us and provide us with:

- Claim #
- Date of injury
- Insurance company and contact information
- Adjuster's name and contact information

Things to bring to your first appointment:
_____ Insurance Card so we can copy for your file
_____ Identification such as Driver's License so we can copy for your file
_____ Prescription from your doctor for acupuncture (Required for MVA, W/C & PI)

If you are not make it to your appointment, please give us 24 hours notice. If you have any questions or would like help with your insurance information please call our main office at 503-756-5602.

Financial Policy

I understand and agree that all services rendered to me by Almine Barton, LAC are charged directly to me and that I am personally responsible for payment.

I understand that I am responsible for contacting my Insurance Company directly and confirming if my Health Plan covers Acupuncture or Alternative Care benefits. I further understand that benefits quoted to me by my Insurance Company or to Almine Barton are not a guarantee of payment and I am ultimately responsible for all charges incurred. _____ Initials

Some Insurance Plans combine Acupuncture, Massage Therapy, Chiropractor and Naturopath all under Alternative Care. I understand that I am responsible for knowing and keeping track of my benefits. _____ Initials

I am responsible to find out if my Health Plan has a deductible, if the deductible has been met or if the deductible is waived for Acupuncture and/or Alternative Care benefits. I further understand that I am responsible for knowing what the Co-Pay or Co-Insurance amount is for my plan. I am also responsible to find out if there are any limitations on my plan such as maximum benefits or number of visits for a plan year or calendar year. _____ Initials

I understand that I am responsible to pay for my deductible, co-pay and estimated co-insurance amounts at the time of service and that I may be billed for charges not covered by my insurance company. **If my insurance company denies payment of a claim or procedure, I am responsible to pay for the billed charges.** _____ Initials

I understand that as a courtesy, Almine Barton will bill my Primary Insurance only; I am responsible for submitting bills to my Secondary Insurance. _____ Initials

I agree to allow Almine Barton to bill my primary insurance company and authorize that the payments be made directly to Almine Barton. I authorize Almine Barton to release any information that is required or necessary for my claim to an Insurance Company, Adjuster or Attorney involved in this case; and hereby release this office of any consequences thereof. _____ Initials

For Motor Vehicle Accidents, Worker's Comp or Personal Injury claims, I understand that I am responsible to pay for any charges that are denied or not paid for any reason by the insurance company. _____ Initials.
I will provide a copy of my personal health insurance card to be billed in the event the claims are denied. _____ Initials

I understand that Almine Barton provides discount for payment in full at the time of service for patients that do not have health insurance. To qualify, no insurance processing will be honored. The discounted amounts have no procedure codes or diagnosis codes and are non-billable to my Insurance. Upon request Almine Barton will provide me with a receipt showing the date of visit and payment amount. _____ Initials

I have carefully read and understand the above information and agree to the Financial Policy.

X_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name Relationship

*** 24-Hour Cancellation Policy ***

We understand that unplanned issues and events can come up and you may need to cancel an appointment. ***If that happens, we respectfully ask that you give us at least 24 hours notice.*** This policy is in place out of respect for our Acupuncturists and our Patients. Our Acupuncturists want to be available for your needs and the needs of all our Patients. By giving last minute notice or no notice at all, you prevent someone else from having the opportunity to be seen. **There will be a fee of $35 if we do not receive a call to cancel an appointment or if an appointment is cancelled at the last minute.**By signing below you acknowledge that you understand the cancellation policy. X

X_____ _____
Signature of Patient or Authorized Representative Date

Informed Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medicia by a licensed acupuncturist at Bend Sports Acupuncture LLC. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by Bend Sports Acupuncture LLC.

Acupuncture/Moxibusion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to local bruising, minor bleeding, fainting, pain or disco mfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping: I understand that if I receive cupping as part of therapy, there is a risk of temporary bruising, reddening of the skin or blistering from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow directions for administration and dosage if I do decide to take them . I am aware that certain adverse side effects may result from taking these substances. These could include but are not limited to, changes in bowel movement, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. Sh ould I experience any problems, which I associate with these substances, I should suspend taking them and call Almine Barton Licensed Acupuncturist at 503-756-5602 as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Laser Therapy: I understand that I may also be given Laser Therapy and there is a risk of reddening of the area or possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information an am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed Name of Patient Date

X_____ _____
Signature of Patient *(If minor. signature of parent or guardian)*

Privacy Policy

I understand I have the right to review Bend Sport's Acupuncture LLC's Privacy Policy prior to signing this document. The Privacy Policy describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or the performance of healthcare operations of Bend Sports Acupuncture, LLC. The Privacy Policy is also provided at the front desk. This Privacy Policy also describes my rights and the duties of Bend Sports Acupuncture, LLC with respect to my identifiable health information.

Bend Sports Acupuncture, LLC reserves the right to change information contained in the Privacy Policy at anytime. I may obtain a revised Privacy Policy by requesting the most current notice during any office visit.

Who else may we speak to regarding your account: _____

X_____ _____
Signature of Patient or Authorized Legal Representative Date

General Patient Information

First Name:_____ Initial:___ Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell #:_____ Work #:_____

*** Please circle the **Primary Phone #** you would like us to use ***

Do we have permission to leave a Voice Mail regarding your Appt. or Account: Yes_____ No_____

Email Address:_____

Would you like to receive emails for Specials, Promotions and Newsletters? Yes or No

Date of Birth:_____ Age:_____ Sex: M___ F___

How did you hear about us? Website___ Phonebook___ Insurance Co.___ Referral___ Friend___

*Please tell us who referred you so that we may thank them:*_____

_____

Name of Primary Physician:_____

Names of other Healthcare Providers you have seen for your condition:_____

_____

Does your Health Insurance cover Acupuncture ☐ Y ☐ N If yes, please bring your Insurance Card

Person Responsible for payment on this Account:_____ Phone #:_____

Employer:_____ Occupation:_____

Employer Address & Phone #:_____

Info Entered & Verified by: _____

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosing and treatment.
Please list the reasons you are having Acupuncture in order of significance & date of onset:
#1:
#2:
#3:
#4:
#5:
#6:
How do these conditions impair or affect your daily activities?
List all prescribed medications, over the counter medications, herbs, supplements & reason for taking
1:
2:
3:
4:
5:
6:
7:
8:
9:

Patient Medical History

Were you recently hospitalized? ☐ Yes ☐ No If yes why & when? _____

_____

Other Hospital Visits/Stays & Surgeries: _____

_____

Where were you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only

How was your childhood health: _____

Family health issues: _____

_____

Recent Tests: (Please indicate test results & dates below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?) _____

☐ HIV/STD ☐ Pap Smear ☐ Mammography ☐ Other

Test results & date: _____

Immunizations: _____

Check any of these you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever	☐ Heart Attack
☐ CVA (Stroke)	☐ Vein Condition	☐ Thyroid disorder	☐ Asthma	☐ Pneumonia
☐ Tuberculosis	☐ Emphysema	☐ Jaundice	☐ Gonorrhea	☐ Mumps
☐ Bleeding tendency	☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous D/O
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis	☐ Epilepsy
☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis	☐ Paralysis	☐ Cancer
☐ Migraines	☐ Hypertension	☐ Hypotension	☐ Other Heart/Circulatory	
☐ Other lung	☐ Other Liver	☐ Other spleen	☐ Other stomach	☐ Other kidney illness

☐ Other: _____

Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding Tendency
☐ Kidney Disease	☐ Alcoholism	☐ Nervous Illness	☐ Mental Illness
☐ Stroke	☐ Other: _____		

Patient Profile

Is the pain:

☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other: _____

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other: _____

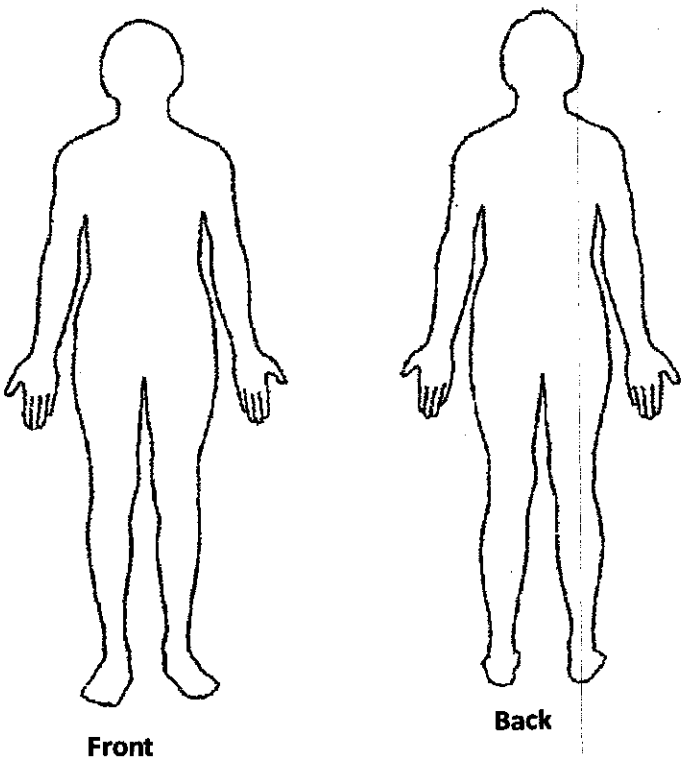
Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Other: _____

Rate your pain on a scale of 1-10, 10 being the worst:

1 2 3 4 5 6 7 8 9 10

Please clearly mark any areas of pain and scars (Indicate which of the areas are scars):



Front **Back**

_____
_____
_____
_____
_____

Please check the following that pertain to you:

Overall Temperature (Kidney Function):

☐ Cold Hands ☐ Hot Body Temperature
☐ Cold Feet ☐ Cold Body Temperature
☐ Sweaty Hands ☐ Heat in hands, feet, chest
☐ Sweaty Feet ☐ Thirsty
☐ Afternoon Flushes ☐ Perspire Easily
☐ Night Sweats ☐ Lack of Perspiration
☐ Hot Flashes any time of day _____
☐ Take water to bed
☐ Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney Function):

☐ Shortness of breath ☐ General weakness ☐ Easily catch colds ☐ Low energy
☐ Feel worse after exercise ☐ Difficulty keeping eyes open in the daytime

Blood (Liver, Spleen, Heart Function):

☐ Dizziness ☐ See floating black spots

Heart Function:

☐ Palpitations ☐ Anxiety ☐ Frequent dreams ☐ Mental Confusion ☐ Restlessness
☐ Chest pain traveling to shoulder ☐ Wake unrefreshed ☐ Drink coffee (# of cups per week: _____)

Lung Function:

☐ Cough ☐ Nose bleeds ☐ Sinus congestion ☐ Dry Mouth ☐ Stiff neck
☐ Dry throat ☐ Dry nose ☐ Dry skin ☐ Sneezing ☐ Sore throat
☐ Difficulty breathing ☐ Stiff shoulders ☐ Melancholy ☐ Sadness
☐ Alternating fever and chills ☐ Overall achy feeling in body
☐ Nasal Discharge (Color: _____) ☐ Headache (Location: _____)
☐ Smoke cigarettes (# of cigarettes per day: _____)
☐ Allergies - To what? _____

Spleen Function:

☐ Low appetite ☐ Abrupt weight gain ☐ Abrupt weight loss ☐ Abdominal bloating
☐ Abdominal gas ☐ Fatigue after eating ☐ Bruise Easily ☐ Hemorrhoids
☐ Over-thinking ☐ Pensive ☐ Gurgling stomach ☐ Worry
☐ Prolapsed organs (Previously diagnosed, which organ? _____)

Spleen, Stomach, Large Intestine, Small Intestine Function:
☐ Loose ☐ Constipated ☐ Incomplete ☐ Diarrhea ☐ Blood in stools
☐ Mucous in stools ☐ Undigested food in stools

Dampness trapped in the body:
☐ Mental Heaviness ☐ Mental sluggishness ☐ Mental fogginess ☐ Swollen hands ☐ Swollen feet
☐ Swollen joints ☐ Chest congestion ☐ Nausea ☐ Snoring ☐ Heaviness in body

Stomach Function:
☐ Large appetite ☐ Bad breath ☐ Heartburn ☐ Belching ☐ Mouth-canker sores
☐ Acid regurgitation ☐ Hiccoughs ☐ Ulcer (diagnosed) ☐ Stomach pain ☐ Vomiting
☐ Burning sensation after eating ☐ Bleeding, swollen or painful gums

Liver, Gall Bladder Function:
☐ Chest pain ☐ Anger easily ☐ Frustration ☐ Alternating diarrhea & constipation
☐ Depression ☐ Irritability ☐ Skin rashes ☐ Tight sensation in the chest
☐ Numbness ☐ Muscle spasm ☐ Muscle twitch ☐ Bitter taste in the mouth
☐ Seizures ☐ Muscle cramp ☐ Convulsions ☐ Headache at the top of the head
☐ Limited range of motion, neck ☐ Lump in the throat ☐ Limited range of motion, shoulder
☐ Shoulder Tension ☐ High pitched ringing in ears
☐ Neck tension ☐ Gall stones (history or current) ☐ Tingling sensation
☐ Frequently unable to adapt to stress What causes stress? _____
☐ Drink alcohol ☐ Recreational drugs Which? _____, Times per week: _____
☐ Sexually transmitted disease Which? _____

Eyes (Liver Function):
☐ Itchy ☐ Bloodshot ☐ Hot ☐ Blurred vision ☐ Watery ☐ Gritty ☐ Dry
☐ Decreased night vision ☐ Near-sighted ☐ Far-sighted

Kidney, Urinary Bladder Function:
☐ Frequent cavities ☐ Sore knees ☐ Weak knees ☐ Cold sensation in knees
☐ Low back pain ☐ Memory problems ☐ Kidney stones ☐ Easily broken bones
☐ Bladder Infections ☐ Excessive hair loss ☐ Fear ☐ Easily startled
☐ Low pitched ringing in ears ☐ Lack of bladder control
☐ Wake during night twice or more to urinate

Urination:
☐ Normal color ☐ Dark yellow ☐ Clear ☐ Reddish ☐ Cloudy ☐ Scanty ☐ Profuse
☐ Strong odor ☐ Burning ☐ Painful ☐ Discharge ☐ Difficult ☐ Urgent ☐ Frequent

Libido:
☐ Normal ☐ High ☐ Low

Women Only:

Regular menstrual cycle? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐

# of children: _____ # of pregnancies: _____ Age at 1st menstruation: _____

Age at menopause: _____ Average # of days of flow: _____ Average # days of entire cycle: _____

Vaginal discharge: Severe ☐ Moderate ☐ Slight ☐ Normal ☐

Bleeding between periods: Severe ☐ Moderate ☐ Slight ☐ Normal ☐

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Food cravings ☐ Depression ☐ Vomiting ☐ Headaches ☐ Irritability

☐ Migraines ☐ Anxiety ☐ Water retention ☐ Breast swelling ☐ Breast tenderness

☐ Other emotions:_____ ☐ Dull pain, where?_____ ☐ Sharp pain, where? _____

Please fill in the following menstrual Chart:	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
Color (Normal, bright red, pale, brown, dark, purple)							
Amount of flow (Normal, heavy, Light)							
Pain/Cramps (Location, dull, sharp)							
Clots (Large, small, black, purple, red)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men Only:

☐ Swollen testes Severe ☐ Moderate ☐ Slight ☐ Normal ☐

☐ Testicular pain Severe ☐ Moderate ☐ Slight ☐ Normal ☐

☐ Premature ejaculation Severe ☐ Moderate ☐ Slight ☐ Normal ☐

☐ Feeling of coldness or numbness in external genitalia Severe ☐ Moderate ☐ Slight ☐ Normal ☐

☐ Other: _____

Patient Comments:
Signature: **Date:**