Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

PATIENT INFORMATION & HEALTH HISTORY

The following information is important to the maintenance of your account and or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

Name:	Date of Birth:	Age:
Address: _____ City: State: Zip Code:	Sex: M _____ F_____ Social Security: - -	Height: _____ Weight:
Home Phone: _____ Work Phone: _____ Cell Phone:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
Employer: _____ Occupation:	Emergency Contact: (relationship) _____ Name: Phone:	
Email:	Insurance Company: _____	
Referred by: _____ Primary Physician:	Insurance ID #: _____ Customer Service Phone Number:	

What is/are the main problem(s) you would like us to help you with? _____

_____

_____

_____

How long ago did this problem begin (be specific)? _____

_____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

_____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

_____

What kinds of treatment have you tried? _____

_____

_____

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

Family Medical History (please check all that applies)

___Diabetes
___High Blood Pressure
___Stroke
___Asthma
___Cancer
___Heart Disease
___Seizures
___Allergies

Past Medical History (please include date)

___Cancer _____
___High Blood Pressure _____
___Thyroid Disease _____
___Diabetes _____
___Seizures _____
___Hepatitis _____
___Rheumatic Factor _____
___Venereal Disease _____
___Other _____

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Significant Dental Work (type and date if applies): _____

Allergies (drugs, chemicals, foods): _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Occupational Stress (physical, psychological, chemical, etc.): _____

Do you have a regular exercise program? Yes / No Please describe: _____

_____

Have you ever been on a restricted diet? Yes / No Please describe: _____

_____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

How much alcohol do you drink per week? _____

How much coffee, tea, or soda do you drink per week? _____

Do you smoke? Yes / No Please describe any use of drugs for non-medical purposes: _____

_____

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

Please check any symptoms you have had in the last three months:

For Re-Exam Only:

Date:_____

GENERAL:

___Chills
___Localized Weakness
___Lack of Thirst
___Tremors
___Fevers
___Bleed or Bruise Easily
___Fatigue
___Poor Balance
___Sweat Easily
___Peculiar Tastes or Smells
Time of Day_____
___Edema
Where_____
___Night Sweats
___Strong Thirst (Hot /Cold)
___Poor Sleep
___Cravings
___Change in Appetite
___Weight Gain
___Weight Loss
___Poor Appetite

SKIN AND HAIR:

___Rashes
___Itching
___Change in Hair or Skin
___Ulcerations
___Eczema
___Oozing on Skin Lesion
___Hives
___Pimples
___Recent Moles
___Loss of Hair
___Dandruff
___Other

RESPIRATORY:

___Cough
___Asthma/Wheezing
___Pain and Deep Breath
___Difficulty Breathing When Lying Down
___Production of Phlegm
Color_____
___Coughing Blood
___Pneumonia
___Bronchitis
___Other Lung Problems

For Re-Exam Only:

Date:_____

HEAD, EYES, EARS, NOSE AND THROAT:

___Dizziness
___Migraines
___Headaches
When_____
Where_____
___Facial Pain
___Glasses
___Poor Vision
___Night Blindness
___Blurry Vision
___Color Blindness
___Blind Field
___Excessive Tears
___Discharge from Eyes
___Poor Hearing
___Ringing in Ears
___Earaches
___Discharge from Ear
___Nose Bleeds
___Sinus Congestion
___Nasal Drainage
___Grinding Teeth
___Teeth Problems
___Jaw Clicks
___Concussions
___Recurrent Sore Throat
___Hoarseness
___Sores on Lips or Tongue
___Other Head or Neck Problems

CARDIOVASCULAR:

___High Blood Pressure
___Low Blood Pressure
___Chest
___Discomfort/Pain
___Heart Palpitations
___Cold Hands or Feet
___Swelling of Hands or Feet
___Swelling of Feet
___Blood Clots
___Fainting
___Difficulty Breathing

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

For Re-Exam Only:

PREGNANCY AND GYNECOLOGY:

___Number of Pregnancies
___Number of Births
___Number of Premature Births
___Number of Miscarriages
___Number of Abortions
___Age at First Menses
___First Date of Last Menses
___Heavy Periods
___Light Periods
___Painful Periods
___Irregular Periods
___Changes in Body/Psyche Prior to Menstruation
___Clots
___Menopause
Age_____
Year_____
___Vaginal Discharge
___Post-coital Bleeding
___Vaginal Sores
Date of Last PAP_____
___Breast Lumps
___Nipple Discharge
___Do you practice birth control?
What Type_____
___How long have you practiced your current form of birth control?_____

GASTROINTESTINAL:

___Bad Breath
___Nausea
___Vomiting
___Heartburn
___Belching
___Indigestion
___Diarrhea
___Constipation
___Chronic Laxative Use
___Blood in Stools
___Black Stools
___Abdominal Pain or Cramps
___Gas
___Rectal Pain
___Hemorrhoids

Date:_____

For Re-Exam Only:

GENITO-URINARY:

___Pain on Urination
___Urgency to Urinate
___Frequent Urination
___Blood in Urine
___Decrease in Flow
___Unable to Hold Urine
___Dribbling
___Kidney Stones
___Impotency
___Change in Sexual Drive
___Sores on Genitals
___Do you wake up to urinate?
___Other Genital or Urinary Problems

NEUROPSYCHOLOGICAL:

___Seizures
___Areas of Numbness
___Weakness
___Sleep Disorder
___Concussion
___Bad Temper
___Loss of Control/Violence Potential
___Vertigo
___Lack of Coordination
___Depression
___Easily Susceptible to Stress
___Loss of Balance
___Poor Memory
___Anxiety
___Substance Abuse
___Have you ever been treated for emotional problems?_____
___Have you ever considered or attempted suicide?_____

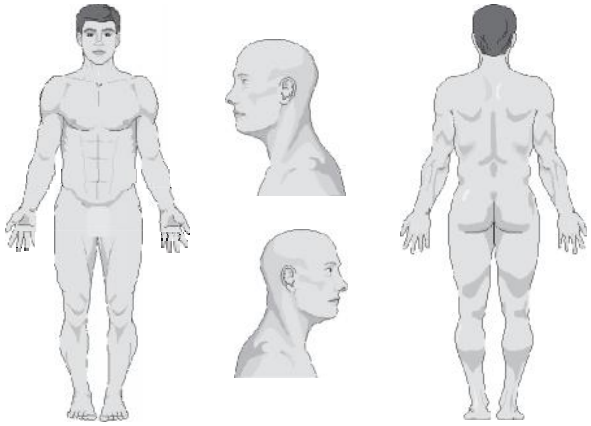
MUSCULOSKELETAL:

___Neck Pain
___Shoulder Pain
___Back Pain
___Elbow Pain
___Hand/Wrist Pain
___Hip Pain
___Knee Pain
___Foot/Ankle Pain
___Muscle Pain
___Muscle Weakness

Date:_____

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

On the figures below, please mark clearly any areas of pain and indicate any scars.



For Re-Exam Only:

___
___
___
___
___
___
___
___

Date:_____

Describe your pain:

___Sharp
___Fixed
___Burning
___Moving
___Cramping
___Aching
___Dull
___Other_____

What makes the pain better?

___Soft Pressure
___Hard Pressure
___Cold
___Heat
___Excercise
___Rest
___Other_____

What makes the pain worse?

___Soft Pressure
___Hard Pressure
___Cold
___Heat
___Excercise
___Rest
___Other_____

Please describe any functional difficulties related to the areas of pain mentioned above (for example: sitting, walking, bending, lifting, moving, smiling, etc.): _____

_____

_____

_____

Please circle the number corresponding to the severity of the functional difficulties mentioned above:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

NOTICE OF PRIVACY PRACTICES

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.

The Seattle Acupuncture Wellness Center respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request;
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosure to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months;
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hour, please contact:
Office manager/HIPAA Officer at (206) 522-1509.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling and asking for it or to pick one up.

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

To ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Office Manager/HIPAA Officer at (206) 522-1509.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Office Manager/HIPAA Officer at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

Other Disclosures and Uses of Protected Health Information Notification of

Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- [Hospitals] Information may be provided to people who ask for you by name. we may use and disclose the following information in a hospital directory:
    - Your name,
    - Location,
    - General condition, and
    - Religion (only to clergy)

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- With Medical Researchers-if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researcher preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating problems with food, supplements, and products.
- To Comply with Workers' Compensation Laws—if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
    - To prevent or reduce a serious, immediate threat to the health or safety of a person
    - Or public.

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

- To public health or legal authorities
  - To protect public health and safety
  - To prevent or control disease, injury, or disability
  - To report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For examples, we may share information for national security purposes.

Other Uses of Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- We have a Web site that provides information about us.

Effective Date:

January 1, 2014

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to other unless you direct us to do so or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Offices.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name and signed on behalf of the patient Relationship
Parent, legal guardian or representative

_____
Witness/Staff Member

(Notation, if any, by staff)
This form will be retained in your Seattle Acupuncture Wellness Center medical record.

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

Consent Form for Traditional Methods

I, the undersigned hereby authorize Hyejung Hayes, E.A.M.P., who received her Master of Acupuncture in June 2002 from the Northwest Institute of Acupuncture and Oriental Medicine (currently Bastyr University) and who is currently licensed in the State of Washington (Lic # 00002067) to perform the following acupuncture procedures:

- **Acupuncture**: the insertion of special sterilized and disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Cupping**: a technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.
- **Moxabustion (moxa)**: the burning of herbs on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms such as a stick, string, ball, cone, or rice grain.
- **Dietary Advice**: food and herbal advice based on traditional Chinese medical theory.
- **Electro –Acupuncture**: the running of very low electrical current through one or more needles to help heal the body.

I recognize the potential risk and benefit of these procedures as described below.

Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, **minor bruising**, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders, pace-makers, or who are pregnant should inform their practitioners prior to treatment.

Potential benefits: drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the Client's main complaints.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Hyejung Hayes, E.A.M.P., regarding the cure or improvement of my conditions.

I hereby release Hyejung Hayes, E.A.M.P., from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

I understand that I am free to discontinue participating in these procedures at any time.

Patient Signature:_____ Date:_____

Clinic Verification of Signatures:_____ Date:_____

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

Written Waiver to Continue East Asian Medical Treatment

Washington State law requires acupuncturists to receive a written diagnosis or to consult with a primary care provider (MD, DO, ND, PA, ARNP) before treating patients with any of the following potentially serious disorders. This consultation requires your authorization; if you refuse the authorization or do not provide a recent diagnosis from the physician, you will have to sign this waiver so that treatments may continue.

I, the undersigned patient, acknowledge I may have a potentially serious disorder. The nature of the disorder is:

(Initial each applicable disorder, or circle N/A if none of the mentioned applies)

____ Cardiac conditions including uncontrolled hypertension
____ Acute abdominal symptoms
____ Acute diagnosed neurological changes
____ Unexplained weight loss or gain in excess of 15% body weight within a three month period
____ Suspected fracture or dislocation
____ Suspected systemic disorders and infections
____ Any serious diagnosed hemorrhagic disorder
____ Acute respiratory distress without previous history or diagnosis

N/A None of these symptoms apply to me (**Initial** _____)

Because of the above disorder, Seattle Acupuncture Wellness Center and the undersigned practitioner requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder.

I acknowledge that failure to pursue treatment from my primary health care provider may involve risks not limited to as death, additional distress, and aggravation of underlying condition, disability, pain, and impairment.

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment. I further understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s).

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE TERMS

_____
(Please Print) Name of Patient

_____ _____
Signature of Patient or Representative (if patient is a minor or handicapped) Date

_____ _____
Clinic Verification of Signatures Date

Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

PATIENT FINANCIAL AGREEMENT

It is important that our patients clearly understand their financial responsibility before their treatment begins. We offer the following financial agreements to help make your financial responsibilities as easy as possible:

1. Patients with insurance: Estimated portion not covered is your responsibility and due within 30 days of the generated billing statement.
2. Patients without insurance: Payment is due at the time of service.
3. Patients with treatment related to an accident must inform SAWC at the time of the first appointment.
4. **Balances due that are not paid within 90 days will be sent to collections.**
5. A 1.5% service charge will be attached to any unpaid balances past 30 days.

PATIENTS WITH INSURANCE:

- As a courtesy we bill your insurance carrier. However, it must be understood that the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay.
- Our office does not guarantee that your insurance will pay. Some insurance companies do not cover acupuncture services. We will assist you, if necessary, in making every attempt to receive verification of your policy. If for any reason your claim is denied, you are responsible for the full amount of your bill.
- Our office will not enter into a dispute with your insurance company over any unpaid claim.
- If your insurance requires a referral from your primary care physician for treatment, you will be responsible for payment of all services until our office has received a hard copy of the referral. If at a later date your insurance reimburses for services that you paid for at the time of the visit, that amount will be refunded to you.
- Failure to provide us with adequate information regarding your insurance may result in a denial from your insurance carrier and you will be responsible for any unpaid balance. Please make sure that we have all the necessary information to process your claim.

I HAVE READ AND UNDERSTAND THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Patient Signature:_____ Date:_____

CANCELLED/MISSED APPOINTMENT AGREEMENT

1. All appointments that are cancelled or rescheduled with less than 24 hour advance notice, or appointments missed, will be charged a $45 cancellation fee. Patient payment of fee is due at the time of notice or next visit.
2. The $45 cancellation fee will be waived if the patient were to reschedule on the same day of their original appointment, if the opening is available.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE OFFICE POLICIES DESCRIBED ABOVE.

Patient Signature:_____ Date:_____

Clinic Verification of Signatures:_____ Date:_____