Chen's Acupuncture Associates

Peishan Chen L.Ac.

13400 Northup Way ▪ Suite 28 ▪ Bellevue WA 98005
1801 NW Market Street ▪ Suite 407 ▪ Seattle WA 98107
Phone: (425) 644-2056 ▪ Fax: (425) 641-7081

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.

PATIENT INFORMATION:

Name ________________ Social Security ________

Age ____ Date of Birth ____________ Male ______ Female ______

Married ___ Divorced ___ Single ___ Separated ___ Widowed ___

Address ______________ City __________ State ____ Zip ____

Home Phone ________ Work Phone ________ Cell Phone ________

Email ______________

Occupation ______________ Employer ______________

RESPONSIBLE PARTY (if under 18):

Name of responsible party ______________ Relationship ________

Address ______________ City __________ State ____ Zip ____

Home Phone ________ Work Phone ________ Cell Phone ________

Email ______________

INSURANCE INFORMATION (Primary Insured):

Subscriber's Name ______________ ID# ________

Address ______________ City __________ State ____ Zip ____

Customer Service phone number ______________

Subscriber's date of birth ________ Relationship to subscriber ________

Secondary Insurance ______________ ID# ________

Address ______________ City __________ State ____ Zip ____

Customer Service phone number ______________

Subscriber's date of birth ________ Relationship to subscriber ________

EMERGENCY CONTACT/ NEXT OF KIN:

Name ______________ Phone ________ Relationship ________

Name ______________ Phone ________ Relationship ________

Whom may we thank for referring you? ______________

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HEALTH HISTORY QUESTIONNAIRE

Important: 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 diagnosis and treatment. *All information is strictly confidential*.

Name of your primary physician: ______________________

Is there anything limiting you from care ____ No ____ Yes - If so, what? ________

Other physicians/therapists seen for the condition: ______________________

How did you hear about the office: ______________________

Medications you are currently taking:

1) ________ 2) ________ 3) ________ 4) ________

5) ________ 6) ________ 7) ________ 8) ________

Prescribed by: ______________________

For treatment of: ______________________

____

Results: ______________________

Supplements (if any, vitamins, herbs, minerals, etc.): ______________________

____

Major complaints in order of significance to you:

1. ______________ 4. ______________

2. ______________ 5. ______________

3. ______________ Additional: ______________

How do these conditions impair your daily activities? ______________________

____

PATIENT MEDICAL HISTORY:

How was your childhood health? ______________________

Hospital Visits / Stays: ______________________

Recent tests: (please indicate test results and date below)

____

____

____

____

____

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PATIENT QUESTIONNAIRE & CONSENT

The law requires patients receiving acupuncture to give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the practitioner's credentials and the scope of the practice of acupuncture in the State of Washington.

Peishan Chen, LAc., is licensed in the State of Washington (# AC536, Aug 16, 1999). She was a physician in the field of Obstetrics and Gynecology at Shantou Hospital in Shantou, China, prior to immigrating to the United States. Peishan Chen received her acupuncture degree from the Northwest Institute of Acupuncture and Oriental Medicine in Seattle from 1996 to 1999. She is not a licensed MD in the U.S.

As stated by law, therapy acupuncturists in the State of Washington are allowed to use the methods listed below. This in no way means that all these methods will actually be used for your treatment. You will be advised before any of these methods are to be applied, and you always have the right to decline.

Use of acupuncture needles to stimulate acupuncture points
Use of electrical, magnetic, or mechanical devices to stimulate acupuncture points
Moxibustion (direct or indirect application of heat on acupuncture points using herbal materials)
Acupressure
Cupping
Dermal friction
Infra-red light
Sono-puncture (ultrasound)
Laser puncture
Dietary advice based on traditional Chinese medical theory
Point injection (use of hypodermic needle to inject solutions)

Side effects may include, but are not limited to, the following:
Some pain following treatment in insertion area, Minor bruising, Infection, Needle sickness; and Broken needle

Patients with the following conditions must inform the practitioner prior to receiving acupuncture treatments. Please check the following that applies.

_____ pregnancy
_____ pacemaker
_____ severe bleeding disorders
_____ hepatitis
_____ AIDS or HIV positive

I, the undersigned, have read and understood the foregoing information and voluntarily consent to the use of the above procedures for treatments. I understand that there is no guarantee implied or expressed regarding the success or effectiveness of a treatment or a series of treatments. I hereby release Peishan Chen, LAc., from all liability in connection with these treatments. I understand further that I am free to withdraw my consent and stop treatment at any time.

Patient Signature ____ Date __________

Patient Name (please print) ____

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A Note on Our Insurance Policies:

We at Chen's Acupuncture would like to maintain a good relationship with our patients when it comes to insurance and billing issues. We have found the most effective way to do this is to outline the responsibilities of the clinic and the responsibilities of you, the patient.

For our cash paying patients:

If you do not have an insurance carrier, payment will be due in full at time of service, as we do not carry over a balance, please see the "No Billing" policy.

For our insurance patients:

While we will call and check your benefits you have better access than we do. It is your responsibility to check your benefits for acupuncture with your insurance company and make sure that you are in compliance with the outlined conditions. We will do what is necessary to receive a referral, send letters of medical necessity and chart notes in order for your insurance company to process your claims. If we are having trouble with payment from your insurance company, we will call up to three times on each problem and send necessary information twice: if the problem is not resolved it will be your responsibility to pay the full amount for the treatments that you have received. This amount will be due within 2 months of notification. If you decided to fight your insurance company or file a complaint with the insurance commissioner we will be more than happy to assist you; however you will still need to pay your balance. If your insurance company pays for the services after you have paid us, the insurance company will reimburse you for the payments you have made. Please note that not all insurance companies cover acupuncture.

For our Personal Injury Protection (PIP) patients:

PIP insurance is required to pay at 100%; however, sometimes they reduce their amounts, delay or deny payment for many reasons. It is because of this that we strongly suggests you seek representation through an attorney. We will work with your attorney to get your claims paid. Please be aware, that if you choose not to seek representation, any and all claims that remain unpaid are your responsibility to pay in full.

It is important to remember that you are ultimately responsible for all payments for all services rendered whether you have health insurance, PIP, or no coverage. If you have any questions regarding this information please ask the receptionist.

By signing this form I, the undersigned, understand and agree to abide by all policies outlined in this statement.

____

Patient's Signature Date

____

Chen's Acupuncture Employee's Signature Date

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Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care) Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective care). Your Acupuncturist will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

____ Relief Care ____ Corrective Care ____ Check here if you want the Acupuncturist to select the type of care appropriate for your condition.

Patient Signature ______________________________ Date __________

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask too see a copy of that record. You may also ask to correct that record. We will not disclose your record to others 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 manager of this clinic,
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.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

____

Patient or legally authorized individual signature Date Time

____

Printed name if signed on behalf of the patient Relationship (Parent, Guardian, Personal Representation)

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AGREEMENT BY THE PATIENT REGARDING CANCELLED/MISSED APPOINTMENTS

Patient understands that a missed appointment (No Show) will result in full charges being issued for that appointment.

Patients arriving later than 15 minutes past the appointment time are not guaranteed their appointment time slot, and will be charged for the appointment in full.

If a patient fails to give the clinic 24 hours notice for the change of appointment, the patient will be charged a $25 fee for that appointment.

Patient Signature ____ Date ___________

AGREEMENT BY THE PATIENT / GUARANTOR TO BE FINANCIALLY RESPONSIBLE FOR FEES

I ________________________________ (patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due.

Patient Signature ____ Date ___________

MEDICAL RELEASE TO INSURANCE COMPANY

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request by insurance company / companies to pay directly to Chen's Acupuncture Associates, PS for those medical services.

Patient Signature ____ Date ___________

Clinical Verification of Signatures ________________________________ Date ___________

This form will be retained in your Medical Record.