Welcome to Wang's Acupuncture!

Our Purpose is to help as many people as possible.
We are compassionate about the unique quality of care we offer.

Thank You for choosing Wang's Acupuncture for your healthcare needs. We would like to take a moment to implement a few office policies that are fair and simple, revolving around the care of our patients.

Please read each section and initial and then sign at the bottom.

Cancellations: If you need to reschedule or cancel an appointment, please call our office at least 24 hours in advance. Cancellations 24 hours before your appointment are accepted. Cancellations on the day off the appointment will be billed a cancellation fee of **$20**. Exceptions can be made for certain circumstances. As a courtesy to us and other patients, please call our office.

_____ I acknowledge and accept the cancellation policy.

Patient Education: Our practice is unique because we educate our patients on natural medicine. The purpose of this education is to help you understand how Acupuncture works and answer any questions or concerns you may have. Patient Education will also help the doctor move the initial visit along, confident that you understand the basics of Chinese medicine. Patient Education is recommended for all of our patients, especially for those who have never experienced Acupuncture.

_____ Yes, I am interested in the patient education that you offer. I understand that this will not cost extra or be counted as my time with the doctor.

_____ No thank you, I am not interested in patient education. I had received acupuncture before or understand the general concept.

Payment: Payment for services is due in full at the time services are rendered. We accept cash, check, visa, and master card. Please note that if you wish to file a claim with your health insurance, this is the patient's responsibility. We will provide any necessary paperwork to enable you to file your claim. However, you are still responsible to Wang's Acupuncture for the full payment of services.

_____ I have read and understand the payment policy.

Please sign and print your name with today's date stating you have read and acknowledge our policies.

X_____
(Signature)

_____ Date:_____
(Print)

WANG'S ACUPUNCTURE

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a significant role in your diagnosis and treatment.

General Patient Information

Name_____ Date_____

Street Address_____

City_____ State_____ Zip_____

Social Security #_____ Date of Birth_____

Age_____ Gender: Male_____ Female_____ Married_____ Single_____

Home/Cell Phone_____E-Mail address:_____

Place of Employment_____

Emergency Contact/Relation_____Phone_____

How did you hear about us? Referred by_____

Yellow pages_____ Web-site_____ Drive-by_____ Other_____

Medications (if any):_____

_____

Supplements (if any vitamins, herbs, etc.):_____

_____

Major Complaint(s), in order of significance to you:

1. Major Complaint:_____
2. Secondary Complaint:_____
3. Other Complaint:_____
4. Other Complaint:_____

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 on following page)

☐Physical ☐Cholesterol ☐Blood ☐Prostate ☐HIV ☐STD ☐Pap Smear

☐Mammography ☐Other_____

Test Results and Date:_____

Check any you have had in the past:

☐Diabetes	☐Allergies	☐Rheumatic Fever	☐Bleeding tendency
☐Heart Disease	☐Thyroid Disorder	☐Asthma	☐Multiple Sclerosis
☐CVA (stroke)	☐Tuberculosis	☐Jaundice	☐High Blood Pressure
☐Vein Condition	☐Gonorrhea	☐Mumps	☐Cancer
☐Measles	☐Chicken Pox	☐Nervous Disorder	☐Migraines
☐HIV	☐Hepatitis	☐Epilepsy	

Other:_____

Surgeries:_____

Family Medical History

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

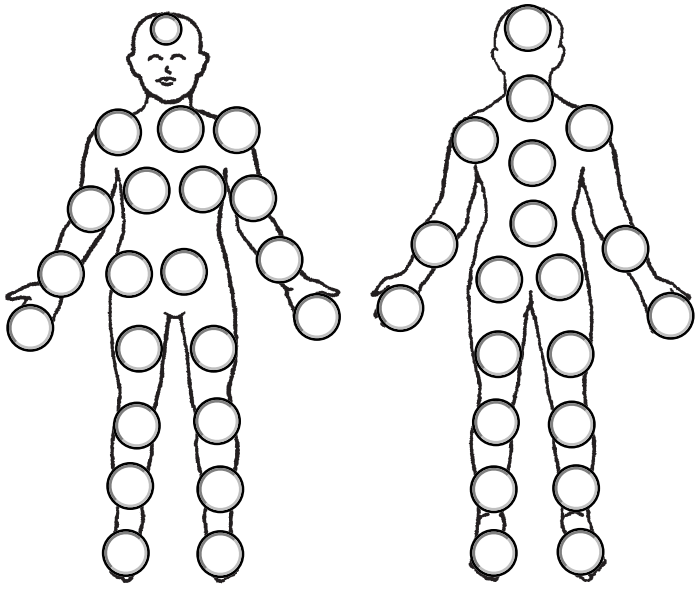
Please clearly mark any areas of pain on the diagram below:

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 ☐Exercise ○Other:_____

Overall Temperature (Kidney function):

☐cold hands & feet ☐sweaty hands & feet ☐night sweats ☐hot sensation
☐afternoon flushes ☐hot flushes ☐lack of perspiration ☐vaginal dryness
☐cold sensation ☐perspire easily ☐thirsty ☐low energy

Heart function:

☐palpitations ☐anxiety ☐restlessness ☐memory problem
☐mental confusion ☐vivid dreams ☐chest pain ☐insomnia
☐mental fogginess ☐mental sluggishness ☐wake unrefreshed

Lung function:

☐cough ☐sinus congestion ☐nose bleeds ☐dry mouth
☐dry throat ☐dry nose ☐dry skin ☐sneezing
☐difficult breathing ☐chills & fever ☐stiff neck ☐sore throat
☐nasal discharge /color:_____ ☐cough with sputum/color:_____
☐allergies/to what:_____

Spleen function:

☐low appetite ☐bloating ☐abrupt weight change ☐mucous in stools
☐gurgling stomach ☐gas ☐fatigue after eating ☐blood in stools
☐diarrhea ☐constipation ☐undigested food in stools ☐incomplete stools
☐loose stools ☐hemorrhoids ☐alternating diarrhea & constipation
☐swollen hands ☐swollen feet ☐heavy body sensation ☐nausea

Stomach function:

☐burning ☐bad breath ☐very large appetite ☐canker sores
☐acid reflux ☐belching ☐stomach pain ☐vomiting
☐bleeding or swollen gums

Liver/Gallbladder function:

☐over thinking ☐anger easily ☐tightness in chest ☐bitter taste
☐frustration ☐depression ☐frequent headaches ☐irritability
☐tingling ☐numbness ☐muscles spasms ☐ringing in ears
☐drink alcohol ☐lump in throat ☐muscle tension

Kidney/Bladder function:

☐sore/weak knees ☐low back pain ☐high libido ☐normal libido
☐excessive hair loss ☐fearful ☐low libido ☐lack of bladder control

Urination:

☐frequent ☐urgent ☐dark yellow color ☐strong odor ☐cloudy
☐scanty ☐burning ☐painful ☐difficult

Men only:

☐testicular pain ☐swollen testes ☐premature ejaculation ☐impotence
☐coldness or numbness in genitalia
☐other:_____

Women only:

Age of first menses:_____ Number of children:_____
Are you pregnant now?_____ Age of menopause:_____
Vaginal discharge: color:_____ thin/thick:_____ strong odor:_____

Do you experience any of the following pre-menstrual symptoms:

☐nausea ☐food cravings ☐depression ☐vomiting
☐headaches ☐irritability ☐water retention ☐migraines
☐anxiety ☐cramps ☐breast tenderness ☐emotional

Days in menstrual cycle:_____ Average number days of flow:_____

Menstrual Chart

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (bright red, pale, dark)							
Amount of flow(heavy, light)							
Cramps (dull, sharp)							
Clots (large, small, purple, red)							
Nause or vomiting							
Mood							
Breast soreness							

Wang's Acupuncture and Chinese Medicine

6001 Brick Court, Suite 117 • Winter Park, FL 32792 • 407-681-3800

Patient Consent to Treatment

I hereby consent to the following:

Patient's Name (Please Print):_____

A. Treatment: Any and all health care treatment, which may include acupuncture, herbal formulas, TuiNa, cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.

B. Financial Information: All professional fees are due in full at the time services are rendered, unless prior arrangements have been made with the patient's health insurance company. I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to WANG'S ACUPUNCTURE for the amount due after services have been rendered. Payment can be made by major credit cards, cash, or check.

C. Authorization to Use and Disclose Health Information: I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care.

Patient or Representative Signature:_____Date:_____

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation) :

_____

2. Please list the family members or significant others, if any, whom we may inform about your Medical condition ONLY IN AN EMERGENCY_____

3. Please print the **telephone number(s) where you want to receive calls** about your appointments, lab and x-ray results, or other information:_____

(Check one)

☐ Okay to leave message with detailed information ☐ Leave message with callback number only

It is the responsibility of the patient to notify Wang's Acupuncture if this information should change

Wang's Acupuncture and Chinese Medicine

6001 Brick Court, Suite 117 • Winter Park, FL 32792 • 407-681-3800

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

Patient or Representative Signature:_____Date:_____

Relationship to Patient (if other than patient):_____Date:_____

Witness_____Date:_____

(Printed Name Wang's Acupuncture Representative)