



PATIENT CONFIDENTIAL INFORMATION

Name: _____ Male Female

Age: _____ Date of Birth: _____ Marital Status: M S D W

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Place of Birth: _____ Social Security: _____

Occupation: _____ Employer: _____

Primary Physician: _____ Phone: _____

Insurance Provider: _____

Preferred method of communication: Cell Phone Home Phone Email Text Message

Are we authorized to leave a detailed message on your home or cell phone? Yes No

Are we authorized to text message your cell phone? Yes No

Emergency Contact: _____ Phone: _____

Referred by: _____

Please list the Medication, Dosage, and Frequency of any medications you currently use
(ex: Lisinopril, 5mg 3x/day or Dimetapp, 1 tsp 2x/day)



TERMS AND CONDITIONS OF SERVICE

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Healing with Zen if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

MEDICAL CONSENT

I have read and fully understand and consent to any Oriental Medical treatments or procedures that are given by Healing with Zen. The patient accepts the full responsibility to follow up the medical advice given at Healing with Zen. The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

RELEASE OF INFORMATION

Healing with Zen will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

FINANCIAL AGREEMENT

We are currently only in-network with Blue Shield of California. If the patient is covered under a Blue Shield plan, they will need to bring their insurance card and a valid photo ID to their initial appointment. After the initial visit, our office will check their benefits to see if they are eligible for any coverage. Full payment up front is expected for the initial visit, and any covered portion will be reimbursed after the first claim is processed.

It is the patient's responsibility to ensure their insurance and personal information is up-to-date with us. If our office does not receive payment from their billed insurance, the patient is responsible for full payment of services rendered, along with any applicable late or collection fees. Services will not be provided if the patient has a balance owing on their account.

For all other insurance providers, a superbill for reimbursement will be provided on request. Submission of these claims is the patient's responsibility. Please allow a period of three (3) business days processing time for any superbill requests.

The patient or patient's representative agrees to pay Healing with Zen for services rendered in accordance with the regular rates and terms of Healing with Zen. When this agreement is executed by the patient, the patient's representative or a financial guarantor, all shall be jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.



Healing with Zen
(626) 377-9596
healingwithzen@gmail.com
www.healingwithzen.com

MISSED APPOINTMENTS & CANCELLATION POLICY

Your appointments are very important to us. Time allocated for an appointment is reserved especially for YOU. We do understand that sometimes schedule adjustments are necessary; therefore, we respectfully request **at least 24 hours notice** for adjustments to your appointments and for cancellations. All our policies are designed to benefit our patients to provide the best service to our established and future clientele.

Please understand that when you forget or cancel your appointment without sufficient notice, we miss the opportunity to fill that appointment time for clients on our waiting list who may need our services.

We ask that all new and current patients supply a credit card to keep on file. In the event that we do not receive the required notice for schedule adjustments and cancellations, a flat rate charge of \$40 will be applied to your card or alternatively billed out to you.

Notification given at least 24 hours prior to your appointment will receive no charges.

Notification given **less than** 24 hours prior to appointment time, or failure to show up on time for your appointment, will result in a **flat rate charge of \$40**.



CONFIRMATION EMAILS AND TEXTS

We do understand how easy it may be to forget an appointment, therefore all our appointments are confirmed 48 hours prior via email for your convenience. We also send out a confirmation email when the appointment is booked, as well as a reminder email 1 week before your scheduled appointment time. As a courtesy, we may also text message your mobile phone if provided one day prior to your appointment date. Please ensure that we have your current email address and mobile phone number on file.

It remains your responsibility to remember your appointment dates and times to avoid late arrivals, missed appointments and help us service our patients better by providing enough notice to avoid the cancellation fees.

Email Address:

Cell Phone Number:

ACKNOWLEDGEMENT & AGREEMENT OF TERMS

Healing with Zen and the patient’s representative hereby enter into this agreement. The patient or the patient’s representative certifies that he/she has read and accepted the “Terms and Conditions of Service” Full payment is due at the time of your service. We accept cash and credit card.

Patient Signature:

Date:

Patient Representative:

Date:

CREDIT CARD AUTHORIZATION

I authorize Healing with Zen to charge the following credit card for the full amount of costs and fees due for services rendered and missed or cancelled appointments. I understand that it is my responsibility to notify Healing with Zen by phone or email at least 24 hours in advance of my appointment time to cancel or reschedule. If I do not, I will be subject to cancellation fees.

Visa MasterCard American Express Discover

Credit Card #

CVV/CVC:

Exp. Date:

Name as it appears on card:

Card Billing Address:

City:

State:

Zip Code:

Phone Number:

Card Holder Signature:

Date:



INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, included those working at Healing with Zen, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine and nutritional counseling. I understand that the preparation of these herbs will take time and may require waiting beyond the scheduled treatment time and that the teas need to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or bitter taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff of Healing with Zen may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____

Date: _____

Patient Representative: _____

Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible.

Patient Name: _____

Date: _____

PRESENT CONDITION:

What is your chief complaint?

Mark below with an X where you feel pain or discomfort.

When did this condition begin?

What treatment have you received already?

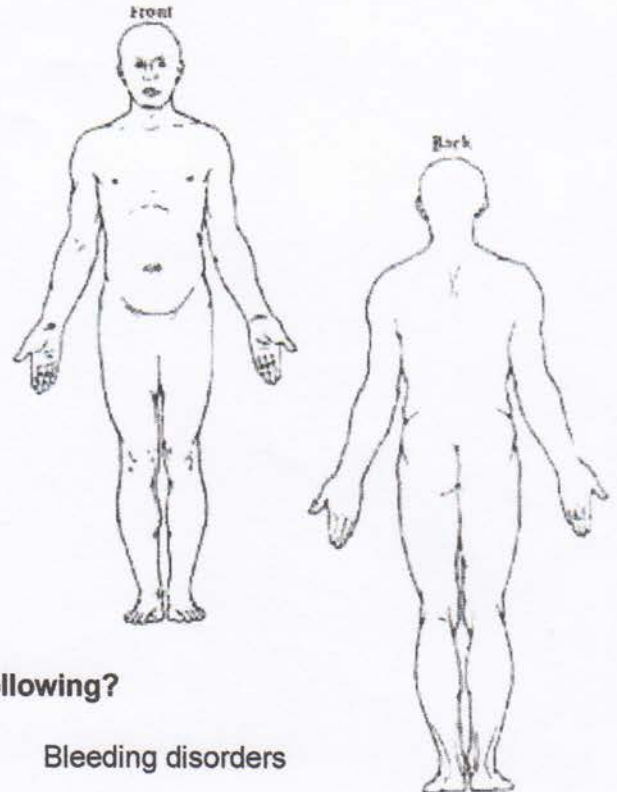
MEDICAL HISTORY:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?



Which, if any, of your blood relatives have had any of the following?

- | | | | | |
|----------|---------------------|---------------|--------------|--------------------|
| Stroke | Cancer | Heart Disease | Tuberculosis | Bleeding disorders |
| Diabetes | High blood pressure | | | |

PLEASE LIST YOUR PRIMARY PHYSICIAN'S NAME AND CONTACT INFORMATION:

Name: _____ Phone: _____

Address: _____

Specialty, if any: _____

MENSTRUAL HISTORY:

Age of your first period: _____
 Vaginal discharge: _____
 Length of cycle, day 1 to day 1: _____
 Length of flow (days): _____
 Date of your last period: _____
 Do you believe you are pregnant? Yes ___ No ___
 Number of pregnancies: _____
 Number of live births: _____

RECREATIONAL SUBSTANCE USAGE:

History of smoking? _____
 how many years? _____
 how many per day? _____
 History of smokeless tobacco use? _____
 History of drinking alcohol? _____
 how many drinks/week? _____
 History of recreational drug use? _____
 How many cups of coffee/day? _____
 How many sodas/day? _____

MEDICAL HISTORY QUESTIONNAIRE

CHECK ALL CURRENT AND PAST CONDITIONS.

(please write the word PAST next to those conditions which you have had only in the past and are no longer present)

HEAD AND NECK:

- Dizziness
- Fainting
- Neck Stiffness
- Enlarged lymph glands
- Headaches
- _____ Other

EARS:

- Infection
- Ringing
- Decreased hearing
- _____ Other

EYES:

- Blurred vision
- Visual changes
- Poor night vision
- Spots/Floaters
- Eye inflammation/Styes
- _____ Other

NOSE, THROAT & MOUTH:

- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Hoarseness
- Changes in taste
- Difficulty swallowing
- Changes in smell
- Oral ulcers/Canker sores
- _____ Other

SKIN:

- Hives
- Rashes
- Eczema
- Psoriasis
- Seborrhea
- Night sweating
- Excess sweating
- Dryness
- Bruises easily
- Changes in moles or lumps
- _____ Other

NEUROLOGICAL:

- Numbness or tingling of limbs
- Seizures
- Tremors
- Pain
- Paralysis
- Epilepsy or Convulsions
- _____ Other

INFECTION HISTORY:

- HIV/AIDS, or HIV risks: Self or partner
- TB: Self or household
- Hepatitis, or Hepatitis risk:
Self or partner.
- History of sexually transmitted
diseases: Self or partner.
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes (oral)
- Herpes (genital)
- MRSA, Staph, CRE, or other Drug-Resistant Infections

RESPIRATORY:

- Chronic cough
- Coughing up blood
- Coughing phlegm frequently
- Difficulty breathing
- Wheezing/Asthma
- Frequent Colds
- Emphysema
- Pneumonia repeatedly
- _____ Other

CARDIOVASCULAR:

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Heart Disease
- Poor circulation
- Swelling of ankles
- Phlebitis
- Cold hands/feet
- Cardiac Pacemaker
- High blood pressure
- Stroke
- _____ Other

GASTROINTESTINAL:

- Indigestion
- Nausea
- Stomach pain
- Irritable bowel disease
- Colitis
- Crohn's Disease
- Pancreatitis
- Celiac Disease
- Recent change in bowel habits
- Diarrhea (___ /day)
- Constipation (___ /week)
- Dry, hard stools
- Soft, difficult, sticky stools
- Irregularly or
poorly-formed stools
- Poor appetite
- Excessive hunger
- Blood in stool or black stools
- Hemorrhoids
- with pain or blood
- Gall bladder disorder
- Vomiting blood
- Peptic Ulcer
- Recent change in weight
- Food cravings
- _____ Other

MUSCLES AND JOINTS:

- Joint disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache
- Back pain
- Fibromyalgia
- _____ Other

MALE:

- Pain/itching of genitalia
- Genital lesions/discharge
- Impotence
- Premature ejaculation
- Prostate problems
- Infertility (e.g., abnormal sperm)
- _____ Other

FEMALE:

- Frequent vaginal infections
- Infertility
- Pain/itching of genitalia
- Genital lesions/discharge
- Pelvic inflammatory disease
- Abnormal Pap smear
- Irregular periods
- Emotional changes with menses
- Clots with menses
- Painful menstrual periods/cramps
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms (hot flashes, etc.)
- Breast lumps/cysts
- Breast swelling and/or pain
- _____ Other

URINARY:

- Frequent urinary tract/bladder infections
- Weak urinary stream
- Recent change in bladder habits
- Kidney Disease
- Frequent day urination (___ X)
- Frequent night urination (___ X)
- _____ Other

GENERAL:

- Fatigue
- Thirst
- Aversion to cold
- Insomnia
- Frequent dreams/nightmares
- Depression
- Agitation
- Irritability
- Anxiety
- History of psychiatric treatment
- Poor memory
- Difficulty concentrating
- Sores that don't heal
- Congenital abnormalities
- Surgical implants
- Unusual bleeding or discharge
- Jaundice
- Hernia
- Epstein Barr virus (EBV)
- Rheumatic Fever
- Diabetes mellitus
- Thyroid Disorder
- Cancer
- Anemia or other blood disorder
- Lupus erythematosus
- _____ Other

TO BE COMPLETED BY PATIENT: Name: _____ Date: _____