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

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)

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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, but will accept most other PPO insurance as an out-of-network provider. If the patient would like us to bill their insurance, 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.

_____

Patient's Initials

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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 provider 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 $45 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 $45**.

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: _____

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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:

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:

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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.

Healing with Zen

Patient Name: _____ Date: _____

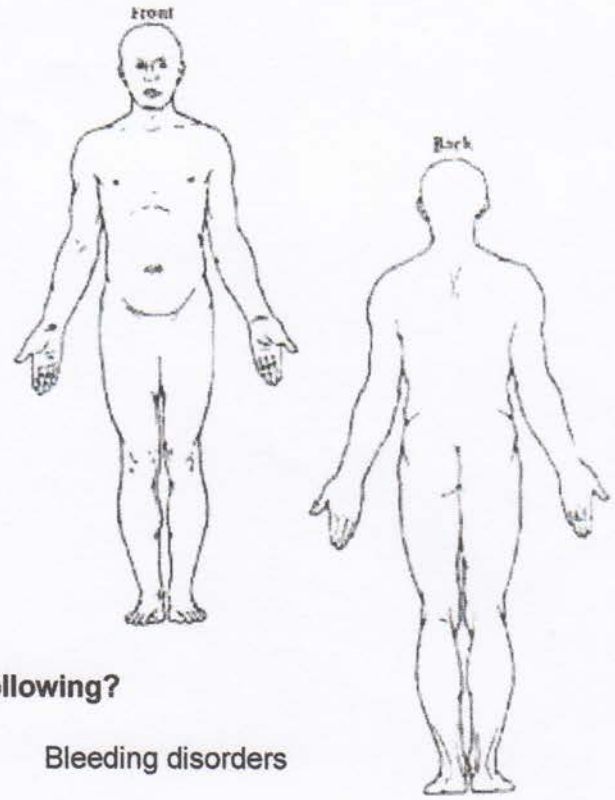
PRESENT CONDITION:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

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



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 erythematosis
_____ Other

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