Inland Empire Acupuncture & Herbs, Inc.

7177 Brockton Avenue, Suite 333
Riverside, CA 92506

951-444-8340 (phone)
951-742-4623 (fax)

This is a confidential questionnaire used to develop a treatment plan.

Name: _____ Date of Birth: _____ Age: ___

Home Address: _____

City: _____ State: _____ Zip: _____

Relationship: Single (◯) Married (◯) Partnered (◯) Divorced (◯) Widowed (◯) Other (◯)

Gender: Male (◯) Female (◯) In Transition (◯) Height: _____ Weight: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Occupation:_____

Emergency Contact Name & Phone: _____

Referred by: Google ☐, Yelp (☐), Facebook (☐), Ads (☐), Family / Friend (☐), Other: _____

Main Reason for Today's Office Visit: _____

If there is any pain please circle (1 = mild, 10 = extreme): 1 2 3 4 5 6 7 8 9 10

Do you have a history of taking anticoagulants or antidepressant medication? Yes (◯) No (◯)

Do you have any allergies? _____

List all medications & supplements you are currently taking:

Medication	Dosage	How long	Prescribed by
1			
2			
3			
4			
5			
6			
7			
8			

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General Health History (√ Past or Present or both as appropriate)

Past	Present	Condition	Past	Present	Condition
		Abnormal Menstruation			Hepatitis
		Abnormal Weight Loss			High Blood Pressure
		Alcohol/Drug/Tobacco Dependence			High Cholesterol
		Allergies			HIV
		Angina (Chest Pain)			Hospitalizations/Surgical Procedures
		Arthritis/Rheumatoid Arthritis			Infectious Disease
		Artificial Joints			Insomnia
		Asthma			Kidney Disease
		Blood Disorder			Liver Problems
		Breast Lumps			Pacemaker
		Cancer/Tumor			Painful Menstruation
		Convulsions/Seizures			Palpitation/Arrhythmia
		Diabetes			Peptic Ulcer
		Diarrhea/Constipation			Post Menstrual Syndrome
		Digestion Issues			Pregnancy
		Excessive Thirst			Prostate Problems
		Fainting or Dizziness			Seizures
		Fatigue			Sinusitis
		Frequent Urination			Skin Disorder/Issues
		Headache			Stroke
		Heart attack			Thyroid Disease
		Heartburn or Indigestion			Yeast Infection

Family History

Arthritis (☐) Cancer (☐) Diabetes (☐) Heart Diseases (☐) Hypertension (☐)
Hyperlipidemia (☐) Lupus (☐) Mental Disorders (☐) Thyroid Disorders (☐)
Other: _____

For Women

Have you been diagnosed with the following:
Fibroids (☐) Endometriosis (☐) Ovarian Cysts (☐) Infertility (☐) Fibrocystic Breasts (☐)
Polycystic Ovary Syndrome (☐) Fibromyalgia (☐) STD's (☐) Other: _____

Do you have a history of breast augmentation? Yes _____ If so, what year? _____ No _____

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ACUPUNCTURE INFORMED CONSENT AND DISCLOSURE

I,_____, hereby consent to Edward Choi, a licensed Acupuncturist in the State of California, performing treatment according to the professional standards of the Acupuncture Practice Act of the State of California. This consent is extended to include Mr. Choi designated associates and assistants. This consent shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Mr. Choi has discussed with me the treatment of my condition including (1) the nature and purpose of the proposed procedures, (2) the benefits and risks of the proposed procedures, and (3) the benefits and risks of no treatment.

I acknowledge that (1) Mr. Choi is not a physician and that I will always consult my physician with regard to medical conditions, and (2) there are no guarantees, warranties, or representations regarding the success of the treatments and procedures that have been or may be given to me.

I acknowledge that I have been given the opportunity to discuss my condition and proposed treatments and procedures and that all my questions have been answered to my satisfaction, so that I have sufficient information to make an informed decision to undergo the proposed treatments and procedures.

I consent to additional procedures from those described herein that the named acupuncturist and his associates and assistants deem necessary and appropriate during the course of the proposed treatments and procedures. I understand that there are possible side effects to my treatment that may include, but are not limited to, the following:

- ✔ Minor pain or soreness in the treatment areas
- ✔ Transient bruising
- ✔ Needle sickness (dizziness, nausea, fainting)
- ✔ Sensations of heat, cold, tingling or numbness
- ✔ Skin irritation or slight bleeding at needle site
- ✔ Generalized fatigue
- ✔ Gastrointestinal disturbance from herbal remedies

I hereby acknowledge that the information described herein has been explained by Mr. Choi, that I have read and fully understand this consent document, and that this consent is given voluntarily and without reservation.

_____ _____

Signature of Patient/Guardian/Representative Date

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Patient Financial Responsibility

Disclaimer: Eligibility verification is not a guarantee of payment. Coverage is subject to all of the terms and conditions of the member's description of benefits. Please review your own client summaries under your health plan.

I understand that it is my responsibility to know and understand my health insurance coverage and benefits.

✔ You, as the patient or guardian of the patient, are responsible for the cost of all services rendered.

✔ If insurance eligibility cannot be verified prior to services being rendered, or if you do not have insurance, then full payment is due prior to the treatment.

✔ Deductibles, co-insurance, and/or co-payments are due at the time of your office visit.

✔ If your health insurance requires a referral or prior authorization then you are required to receive that referral or prior authorization before treatment. If a referral or prior authorization is not received before treatment, then full payment for treatment will be due in advance.

✔ **For Kaiser members:** If your health insurance requires a referral or prior authorization, and it is ***not a covered diagnosis*** when billed then you will be responsible for the full cost for the services rendered unless it is rectified by your doctor who had initially given you the referral or prior authorization. It will be your responsibility to request for a corrected diagnosis code that is covered for acupuncture through American Specialty Health (ASH).

For members with greater than one health insurance carriers:

1) It is the patient or guardian of the patient to inform the practitioner if one has more than one health insurance carrier.
2) If **Medicare** is your primary insurance, please note that we are not a provider for the Centers for Medicare and Medicaid Services (CMS). Therefore, it requires you and the provider to submit a letter explaining to CMS the following:
    - The provider is unable to file a claim for a Medicare-covered service and is not enrolled with Medicare.
    - The claim for each date of service(s) rendered is being sent for a denial of acupuncture so that a secondary payer with acupuncture benefits may be billed.
- Once processed you will be receiving a letter from CMS with the denied explanation of benefits for each date of service(s). <u>It will be your responsibility to bring that letter back to us so that we may bill the secondary payer with acupuncture benefits.</u> Failure to do so, we will charge you for the balance owed.
3) For **other health insurance carriers** as your primary insurance, please note that we will bill the primary insurance first, wait for the denied explanation of benefits for each date of service(s), and then submit the claim to the secondary carrier with acupuncture benefits.

I understand and agree that, regardless of my insurance status, I am responsible for the balance on this account for any professional services rendered. I will notify you of any changes to Edward Choi, LAc., including insurance coverage.

Print Name: _____Signature:_____Date: _____

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Missed Appointment Policy

Thank you for choosing Inland Empire Acupuncture & Herbs, Inc. as a part of your health care. Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable clients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or canceled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

In order to provide the highest quality services to our clients, we have enforced a Missed Appointment Policy. Please review the following agreement and sign the signature line, indicating that you understand our policy.

As a patient or a guardian for patient receiving services from Inland Empire Acupuncture & Herbs, Inc., I understand and agree with the following:

- I am responsible for canceling appointments **24 hours prior** to the appointment.
- Should I fail to attend my appointment or cancel my appointment within a 24-hour period to my appointment, Inland Empire Acupuncture & Herbs, Inc. will charge me of the missed appointment fee on the day of or at the time of rescheduling.
- I will be charged **$20.00** for the initial missed appointment and **$35.00** for every following missed appointment.
- Appointments missed due to illness, adverse weather conditions, or other conditions that **reasonably** prohibited me from canceling the appointments will NOT be considered missed appointments. I must notify Inland Empire Acupuncture & Herbs, Inc. of such an occurrence. However, should I miss my appointments on a **regular basis** for the aforementioned reasons, I will be charged **$35.00** for every following missed appointment.

Patient Name: _____

Signature of Patient/Guardian: _____

Date: _____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to start or resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let our office know if you have any questions. When you sign this document, it will be an official agreement between us.

Our Commitment to Minimize Exposure

Thank you for your continued trust in our practice. As with the transmission of any communicable diseases such as a cold or the flu, you may be exposed to COVID-19, also known as the "Coronavirus," at any time or in any place. Be assured that we have always followed state/federal regulations and recommended universal personal protection/disinfection protocols to limit the transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or from public transportation. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedure we provide, it is not possible to maintain social distancing between the patient, licensed acupuncturists, staff, and sometimes other patients at all times within the office setting. Although exposure is unlikely, a risk still exists.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk).

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, our office team members and other patients) safer from exposure, sickness and possible death. Please INITIAL to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. If you have any flu-like signs or symptoms (fever, sore throat, cough, runny nose, etc.), please call our office to cancel your appointment.
- You will use alcohol-based hand sanitizer when you enter the office.
- You will adhere to the safe distancing precautions of 6feet we have set up in the waiting room and therapy room.
- If you plan or have traveled to high-risk areas for transmission of COVID in the past 14 days, you will immediately let our office know.
- If you have had close contact with anyone who is confirmed or is being evaluated/quarantined for COVID, you will immediately let our office know.

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- You will take necessary steps between appointments to minimize your exposure to COVID.

Initial:_____

We may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, our office may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that our office may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Date