Confidential

Patient Information Sheet

Chinese Acupuncture Center at Princeton | 330 North Harrison St. Suite 5, Princeton, NJ 08540 | Phone: 609-683-9599 | www.chineseacupunctureprinceton.com

Last Name:	First Name:	Preferred Name:	Occupation:	Referred By:
Gender M ☐ F ☐	Date of Birth:	Age:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐	Tel:
Address:		City:	State:	Zip:
Home Phone:		Work Phone:	Cell Phone:	
Emergency Contact & Relationship:		Phone Numbers of Emergency Contact: Primary:	Alternate:	
Who Is Responsible For Your Bill: Self/Spouse ☐ Parents ☐ Work's Comp ☐ Auto Injury with Med Pay ☐ Other _____ Major Medical Insurance ☐ Name_____ and ID # _____				
Email Address: Please be assured that your e-mail address will only be used by our office for your needs and will not be sold to another company or individual.				
Primary Care Doctor: Name:	Tel:	Specialty:		
Other Doctor You See: Name:	Tel:	Specialty:		
Major Complaints:				

Please Answer the Following Question:

	Yes	No		Yes	No
Do you have a tendency to faint?	☐	☐	Are you HIV+?	☐	☐
Do you have a pacemaker?	☐	☐	Are you pregnant? (women)	☐	☐
Do you bleed for a long time?	☐	☐	Have you ever had Hepatitis?	☐	☐

Medication: Please list all prescription medications you use. If you need more space, please attach a separate sheet.

Prescription Name	Purpose:	How Long	Dose	How Often	Last Dose

Why Acupuncture? People go to Acupuncture for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Acupuncture care (Comprehensive Care). Your practitioner 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 _____ Comprehensive Care

_____ Check here if you want the practitioner to select the type of care appropriate to your condition.

Patient Financial Agreement

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Thank you for choosing **Chinese Acupuncture Center at Princeton** for your health care needs. We are committed to your improved health by providing high quality, comprehensive health care that is appropriate for you. Here are our **Financial Policies**:

1) We require payment in full when service is rendered. We accept cash and checks. **NO CREDIT CARDS ARE ACCEPTED AT THE PRESENT TIME.**
2) We do not bill insurance, but will gladly provide you with a statement, which you can submit to your insurance carrier for reimbursement.
3) Fees for Acupuncture Services:

   $125 First appointment, which includes evaluation and treatment

   $100 Follow up visits
4) **MEDICARE DOES NOT COVER** acupuncture treatments.
5) If you need to cancel an appointment, *please inform us **at least 24 hours** in advance to avoid a full charge of service*. A missed appointment will also be charged at full fee. Exceptions include family emergency and/or inclement weather.
6) There is a service charge of $35 for every returned check. This fee must be payable in cash or certified check.

I acknowledge that I have read and understood this information. I understand that I am financially responsible for any and all charges incurred for services provided.

_____	_____	_____
Patient/ Guardian's Signature	Print Name	Date

Patient's Name:_____ Date:_____

PATIENT'S MEDICAL HISTORY

- The following is a list of symptoms that you may or may not have.
- Please mark any symptoms you are experiencing at the present time.
- Leave blank if N/A

Cardiovascular
(TCM: Heart/Small Intestines)
___Heart palpitations
___Chest pain or pressure
___Dizziness
___Shortness of breath
___Irregular heart beat
___High blood pressure
___Leg cramps
___Lack of joy in life
___Craving/aversion to bitter food

Gastrointestinal
(TCM: Spleen/Stomach)
___Indigestion
___Bloating
___Gas/belching
___Abdominal pain or cramps
___Gallstones
___Diarrhea
___Constipation
___Black stool
___Hemorrhoids
___Excessive appetite
___Decreased appetite
___Anorexia
___Nausea and vomiting
___Colitis or Diverticulitis
___Heartburn
___Acid reflux
___Fatigue
___Cold hands and feet
___Heaviness anywhere in body
___Hard to wake up in the morning
___Edema/swelling
___Bad breath
___Tendency towards hypoglycemia
___Muscle fatigue
___Difficulty digesting oily food
___Tendency to become obsessive
___Craving/aversion to sweets

Muscular-Skeletal
___Back pain
___Neck pain
___Arthritis
___Disc problem
___Painful joints
___Muscle pain/cramps
___Scoliosis

Respiratory
(TCM: Lung/Large Intestines)
___Dry cough
___Cough with sputum
___Cough with blood
___Sore throat
___Nasal problems
___Nose bleeds
___Nasal discharge
___Asthma or wheezing
___Poor sense of smell
___Pneumonia
___Hay-fever
___Bronchitis
___Allergies
___Low resistance to colds or flu
___Low physical stamina
___Itchy skin
___Grief/sadness
___Craving/aversion to spicy foods

Genitourinary
(TCM: Kidney/Urinary Bladder)
___Frequent urination
___Painful urination
___Bloody discharge from anus
___Incontinence
___Pain in the genital area
___Decreased/excessive sex drive
___Kidney stone
___Kidney failure
___Neuritis
___Weakness/low back pain
___Achy bones
___Poor memory
___Hair loss
___Hearing problems
___Ringing in ears
___Craving/aversion to salty foods

Liver / Gallbladder (TCM Equivalent)
___Jaundice
___Hepatitis A
___Hepatitis B
___Hepatitis C
___Cirrhosis
___Irritability
___Depression
___Headache/migraine
___Visual problems
___Red eyes
___Itchy eyes
___Clenching of teeth at night (TMJ)
___Muscle twitching
___Joint tightness/stiffness
___Soft brittle nails
___Craving/aversion to sour food

Males only
___Prostate problems
___Pain in testicles
___Low sperm count

Females only
___Menstrual pain
___Irregular menstrual cycle
___Swelling/pain in breast
___Lower back/sacrum ache
___Menopause/perimenopause
___Heavy bleeding
___Vaginal discharge -excessive
___Vaginal yeast infection
___Vaginal dryness
___Endometriosis
___Polycystic ovary syndrome
___Uterine Myoma
___HPV
___Genital warts
___Breast cancer
___Ovarian cancer
___Osteoporosis
___Night sweats/hot flashes

Miscellaneous
___Psoriasis
___Eczema
___Skin rash
___Lupus
___Rheumatoid Arthritis
___Parkinson's syndrome
___Reynard's syndrome
___Diabetes
___Epilepsy
___Multiple Sclerosis
___Varicose veins
___Blood clotting
___Cancer
___Genital Herpes
___HIV +

HIPAA NOTICE OF PRIVACY PRACTICES

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This notice explains how your medical information may be used, disclosed, and your access to this information.

Please review it carefully before your first visit.

Under the **Health Insurance Portability and Accountability Act (HIPAA)** of July 1, 1997, it is our legal duty to make sure your protected health information (PHI) is safe.

Our office respects your right to privacy. Information regarding your therapy is strictly confidential and is only used to communicate with your doctor, case worker and claims representative for payment or for pre-authorization. Should any other official party request information about you, we would need to see a signed authorization request to release information. All other uses of this protected health information will be made only with your authorization which you have the right to revoke at any time. If a claim is unpaid due to the unavailability of the requested information, you will be responsible for payment to us.

Evaluation reports, treatment plans and copies of prescriptions for the therapy and progress notes are sometimes mailed to the insurer (case worker) to carry out treatment and receive payment for our services. In settlement cases, your attorney can request copies of your file with a written request from you. A subpoena would be issues by the other party's attorney. A subpoena is a legal demand for information which we must comply.

Marketing:

The Chinese Acupuncture Center at Princeton will not use or disclose your PHI for marketing communication without your written authorization. This office may send birthday cards, thank you cards, newsletters, email, notice of events and/or appointment reminders to you.

Disclosure:

The Chinese Acupuncture Center at Princeton may use or disclose your PHI without your consent or authorization when required by law.

Patient Rights of Privacy Policy:

- A patient may request restrictions on certain uses and disclosure of protected information.
- You have the right to receive confidential communication of protected health information
- You have the right to inspect and request a copy of protected health information and medical records.
- You have the right to an accounting of disclosures of protected health information.
- You have to amend protected information (there is an appeal process).

The Chinese Acupuncture Center at Princeton reserves the right to change our Privacy Policy in accordance with HIPAA and would send such notices to your last known address. This is in compliance with HIPAA following April 13, 2003 except for emergency treatment situations.

If you have any questions about this notice or any complaints about our privacy practices please contact our office.

I have read and understood my rights regarding privacy of information and when this information may be shared with others.

I acknowledge that I have received the HIPAA notice and I will ____ will not ____ take a copy with me. _____initials

Print Name: _____**Date**:_____
Patient or Authorized Person

Signature: _____
Patient or Authorized Person

INFORMED CONSENT FOR ACUPUNCTURE THERAPY

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Patient's Name:_____ Date:_____

I, the undersigned (patient/ on behalf of the patient), do request and give my consent to the administration of acupuncture and related therapies as required by Section 45: 2C-5(2) of Professions and Occupations Code of the State of New Jersey. I hereby authorize **Fen Xie, L.Ac**., a Licensed 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 above, including those working at the clinic or office listed above, whether signatories to this form or not, to treat me in accordance within the scope of practice for acupuncture in the State of New Jersey. The nature, consequences and benefits of these procedures have been explained to me completely and in detail by the acupuncturist and are reiterated below.

A. I understand the methods of treatments may include, but are not limited to, acupuncture, moxibustion, cupping, thermal methods, electro-stimulation, Tui Na (Chinese massage), Chinese herbs and nutritional counseling.

B. I have been informed that acupuncture is a generally safe method of treatment, but potential risks include discomfort at the site of needle insertion, irritation, pain, bruises, redness, blisters, weakness, fainting, nausea, and possible temporary aggravation of symptoms. These risks may be minimized by proper nutrition and rest prior to treatment, and close communication with the acupuncturist with regards to any uncertainty on the part of the patient.

C. 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.

D. Potential benefits are enhanced by avoiding bathing or showering for several hours after treatment, resting appropriately and following such general recommendations as the therapist may make. Acupuncture may allow for painless and drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem as well as other health enhancing effects.

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's/ Guardian's Signature_____ Date _____

Chinese Acupuncture Center At Princeton
COVID-19 Informed Consent to Treat

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care. I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent / Guardian	Witness
Signature: _____	Signature: _____	Signature: _____
Name: _____	Name: _____	Name: _____
Date: _____	Date: _____	Date: _____