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HEALTH INTAKE FORM

Patient Information:

Last Name: ________________ First: ________________ Mid. Initial: _______

Date of Birth: _____ /_____ /_____ [ ] Male [ ] Female Weight:____________ Height: _____ Feet _____ Inches

Relationship Status: [ ] Single [ ] Married [ ] Widowed

Address: ________________ City ________________ State _______ Zip __________

Home # (_____)________________ Cell# (_____)________________ Email ________________

May we leave confidential messages at any of the above? Please check [ ] Home [ ] Cell [ ] Email

Are you currently employed? [ ] Yes [ ] No Employer & Occupation: ________________

Emergency Contact: ________________ Relationship____________ Phone (_____)____________

Referring Doctor: ________________ Phone (_____)________________

Insurance Name: ________________ Insurance Phone (_____)________________

Policy ID/Claim #: ________________ Group #: ________________

Guarantor Information:

Required if someone other than the patient is financially responsible for the patient's account.

Last Name: ________________ First: ________________ Mid. Initial: _______

Address: ________________ City ________________ State _______ Zip __________

Home # (_____)________________ Cell# (_____)________________ Email ________________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient and that I am subject to all financial terms listed below.

Guarantor's Signature: ________________ Date: __________ Relationship Status:______________

Terms of Admission:

Financial Terms – I understand that if I am insured with a Herban Qi Eastern Medicine & Herbs (HQEMH) contracted insurance company; HQEMH will submit claims on my behalf. I authorize the release of any medical or other information necessary to process insurance claims related to treatment to HQEMH. I also understand that I will be responsible for all charges whether or not they are covered by my insurance. Some procedures may be considered non-covered services and I will be required to make full payment in full at time of service. I understand that there is a cancellation policy and that I may be billed for missed appointments or appointments cancelled with less than 24 hours notice. I understand that finance charges will begin accruing on accounts that are 60 days past dues at a rate of 1.5% per month. I further understand that overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms – We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your records is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to other unless you direct us to do so or applicable laws authorize or compel us to do so. HQEMH is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at HQEMH, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call us at 206-697-9540. I hereby acknowledge that I have received a copy of HQEMH "Notice of Privacy Practices". Should I fail to sign this form, I acknowledge that HQEMH has made a good faith effort to obtain my acknowledgement.

Patient's Signature: ________________ Date: __________

Guardian's Signature: ________________ Date: __________ Relationship Status:______________

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HEALTH HISTORY

Please check if you are having or have had in the past three months:

General:

[ ] Anemia
[ ] Fatigue
[ ] Fever
[ ] Frequent cold/flu
[ ] Bleed or Bruise Easily
[ ] Crave Peculiar Tastes or Smells
[ ] Diabetes (Type:______)
[ ] Alcoholism or Drug Addiction
[ ] Sudden Weight Loss
[ ] Sudden Weight Gain
[ ] Poor Sleep or Insomnia
[ ] Other: ___________________________

Musculoskeletal:

[ ] Neck Pain
[ ] Shoulder Pain
[ ] Arm or Elbow Pain
[ ] Hand or Wrist Pain
[ ] Chronic/Acute Back Pain
[ ] Sciatica
[ ] Leg or Knee Pain
[ ] Foot/Ankle Pain
[ ] Joint Pain (Where:___________________)
[ ] Muscle Weakness (Where:_____________)
[ ] Muscle Soreness (Where:_____________)
[ ] Other:___________________________

Gastrointestinal:

[ ] Nausea
[ ] Vomiting
[ ] Bad Breath
[ ] Abdominal Pain or Cramps
[ ] Constipation or Diarrhea
[ ] Irritable Bowel Syndrome (IBS)
[ ] Black or Blood in Stools
[ ] Hemorrhoids
[ ] Indigestion
[ ] Ulcer
[ ] Poor Appetite
[ ] Other:___________________________

Pregnancy and Gynecology (female only):

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[ ] Breast lumps
_______ Age at 1st Menstruation
_______ Time between Menstruation
_______ Duration of Menstruation
_______ First Date of Last Menstruation
[ ] Hot Flash/Night Sweats
[ ] Irregular Periods
[ ] Painful Periods/Cramps
[ ] Endometriosis or Uterine Fibroids
[ ] Use of Birth Control (What: ____________)
[ ] Other: ___________________________

Skin and Hair:

[ ] Rashes
[ ] Dry or itching skin
[ ] Change in hair/skin texture
[ ] Open sores
[ ] Acne
[ ] Eczema or Psoriasis
[ ] Hair Loss or Alopecia
[ ] Changes in Nail
[ ] Other:___________________________

Head, Eyes, Ears, Nose and Throat:

[ ] Dizziness/Vertigo
[ ] Poor Vision or Night Blindness
[ ] Migraines/Headaches
[ ] Eye Strain/Pain
[ ] Ringing in ears or pain
[ ] Earaches
[ ] Floaters
[ ] Nasal Congestion
[ ] Sinus Problems
[ ] Post Nasal Drip
[ ] Recurrent Sore Throats
[ ] Other: ___________________________

Cardiovascular:

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Cold hands/feet
[ ] Irregular Heartbeat
[ ] Chest Pain
[ ] Coronary Heart Disease
[ ] Palpitations
[ ] Varicose Veins
[ ] Blood Clots
[ ] Phlebitis
[ ] Edema
[ ] Other:___________________________

Respiratory:

[ ] Cough
[ ] Bronchitis
[ ] Difficulty breathing lying down
[ ] Emphysema
[ ] Pneumonia
[ ] Asthma
[ ] Pain w/ deep breath
[ ] Production of Phlegm
[ ] Pleurisy

Genitourinary:

[ ] Kidney Infections/Stones
[ ] Bladder Infections
[ ] Genital Herpes
[ ] Blood in Urine
[ ] Painful Urination
[ ] Incontinence
[ ] Frequent Urination
[ ] Venereal Disease
[ ] Other:___________________________

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HEALTH HISTORY CONT.

Please check if you are having or have had in the past three months:

Neuropsychological:

[ ] Seizures
[ ] Numbness (___________)
[ ] Concussion
[ ] Tremors
[ ] Dizziness or Vertigo
[ ] Loss of Coordination or Balance
[ ] Poor Memory or Forgetfulness
[ ] Frequently Angry
[ ] Depression
[ ] Easily susceptible to stress
[ ] Anxiety
[ ] Other:___________________________

Infections:

[ ] Measles
[ ] Mumps
[ ] Herpes
[ ] Flu
[ ] Tuberculosis
[ ] Chicken Pox
[ ] HIV/AIDS
[ ] Hepatitis A/B/C
[ ] Other:___________________________

Other:

Are you allergic to any of the following? If yes, please specify:

[ ] Medicine/Supplements___________________________

[ ] Food___________________________

[ ] Other:___________________________

Social History:

	No	Yes	Date Started	Date Stopped	Amount per Day
Coffee	[ ]	[ ]	________	________	________
Tea	[ ]	[ ]	________	________	________
Alcohol	[ ]	[ ]	________	________	________
Tobacco	[ ]	[ ]	________	________	________
Other	[ ]	[ ]	________	________	________

Family History (please indicate the relationship to you):

[ ] Migraines ________________
[ ] Heart Disease ________________
[ ] Allergies ________________
[ ] Asthma ________________
[ ] Arthritis ________________
[ ] Diabetes ________________
[ ] Stroke ________________
[ ] High Blood Pressure ________________
[ ] Mental Illness ________________
[ ] Seizures ________________
[ ] Cancer ________________
[ ] Thyroid Disease ________________

List Any Medications and/or Supplements being taken (include dosage and frequency):

1. ___________________________

2. ___________________________

3. ___________________________

4. ___________________________

5. ___________________________

6. ___________________________

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INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of east Asian medicine (EAM) treatments and other procedures within the scope of the practice of EAM on me (or on the patient named below, for whom I am legally responsible) by the licensed East Asian Medicine Practitioner (EAMP) named below and/or other licensed EAMP who now or in the future treat me while employed by, working or associated with or serving as back-up for the EAMP named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that EAM methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or 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 it may have some side effects, including bruising, 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 uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are 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 Chinese 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 occurs 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 may review my patient records and lab reports, but all my records will be kept confidential and will not be release 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 or Legally authorized individual signature Date

____ ________________________
Print Name if signed on behalf of the patient Relationship

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SHORT MESSAGE SERVICE (SMS) CONSENT

(1) Individual Information:

(PRINT) Name of Patient:____Birth Date:______/______/______.

(2) SMS Consent:

[ ] I agree to receive text messages to this mobile phone number (________) ________---___________ reminding me about my upcoming appointments with Herban Qi Eastern Medicine & Herbs. I understand that Short Message Service (SMS) reminders are optional and that message & data rates may apply.

(3) Signature: ____ **Date:** ______/______/______.
(Patient or Member, Guardian*, or Authorized Representative*).
[*Documentation may be required to prove authority to sign on behalf of the patient.]

(4) Minor Signature: ____ **Date:** ______/______/______.
(Signature of minor is also required if minor is age 13-17).

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Herban Qi Eastern Medicine & Herbs respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing my care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Operations:
1. **For treatment:** Information obtained by a nurse, physician, or other member of my health care team will be recorded in your medical record and used to help decide what care may be right for you. Information to other providing you care. This will help them stay informed about your care.
2. **For payment:** Requesting payment from your insurance. Insurance companies need information from us about your medical care; information that we provided to insurance companies may include your diagnoses, procedures performed or recommended care.
3. **For health care operations:** We use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. We may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services. We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan, accounting, legal, risk management and insurance services; audit functions, including fraud and abuse detection and compliance programs.

Other Disclosures and Uses of Protected Health Information:
1. **Notification of Family and Others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. You have the right to object to this use or disclosure of your information.
2. **We may use or disclose your protected health information without your authorization as follows:**

-To the Food & Drug Administration relation to problems with food, supplements and products.
-To Comply With Workers' Compensation Laws – if you make workers' compensation claim.
-For Public Health and Safety Purposes as Allowed or Required by Law to prevent or reduce a serious, immediate threat to the health or safety; to public health or legal authorities; to protect health and safety; to prevent or control disease, injury or disability.
-To Report suspected Abuse or Neglect to public authorities
-To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
-For Law Enforcement Purposes such as when we receive a subpoena, court order or other legal process, or you are the victim of a crime.
-For Health & Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
-For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
-In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
-For Specialized Government Functions. For example, we may share information for national security purposes.

Your Health Information Rights: The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to receive, read and ask questions about this Notice and ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But, we will comply with any request granted. Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information. Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing.

Have us review a denial of access to your health information-except in certain circumstances; Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records. When you request, we will give you a list of disclosure of your health information. The list will not include disclosures of third-party payers. You may receive this information with out charge once every 12 months. We will notify you of the cost involved if you request information more than once in 12 months. Ask that your health information be given to you by another means or at another location. Please sign, date and give me your request in writing. Cancel Prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometime you cannot cancel an authorization if its purpose was to obtain Insurance.

Our Responsibilities: Keep your protected health information private; Give you this Notice; Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up. If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: **Herban Qi Eastern Medicine & Herbs at (206) 697-9540.** If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Herban Qi Eastern Medicine & Herbs at 1904 3rd Ave. Ste. #635, Seattle, 98101.** You may also file a complaint with the U.S. Secretary of Health and Human Services.