WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: _____ Last Name: _____

Nickname: _____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Preferred: _____ (circle: Home Cell Work)

Other: Home _____ Cell: _____

Work: _____ Date of Birth: _____

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? **Yes** _____ **No** _____
We will not sell or give your email to any other agency.

Email Address: _____

Emergency Contact:

Name: _____ Telephone: _____

Relationship: _____

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)
Friend or Family (name) _____ Internet Search Facebook Radio Physician (name) _____ Our Website Sign holder Newspaper Walk-in Insurance Company _____ Health Fair _____ Other _____

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and is responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _____ **Date**: _____

Acupuncture Patient Information

First Name _____ Last Name _____ Date _____

Gender (Please circle): M F Date of Birth _____ Age _____

Marital Status (Please circle): Single Married Partnered Separated Divorced

Place of Employment _____ Occupation _____

Who referred you to us? _____

Chief Complaint: _____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)? _____
Describe the worst it can be: _____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
_____
Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #2: _____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)? _____
Describe the worst it can be: _____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
_____
Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #3: _____
How long? _____ How often: _____
What caused this (accident, lifestyle, drug, etc.)? _____
Describe the worst it can be: _____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
_____
Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
How does this affect your life? _____
Affect your family? _____ Affect your sleep? _____
Affect your work? _____ Affect your hobbies? _____
What is your goal/plan if the problem continues 5/10/20 years? _____

Other Complaints: _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____
Have you had acupuncture before? _____
If yes, where/who _____
Any concerns or fears about the needles? _____
If yes, what? _____
What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – ****NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

BODY TEMPERATURE

Please check all the apply:

_____ Cold entire body
_____ Cold extremities
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

***ENERGY LEVEL** – Please circle:*

Low 1 2 3 4 5 6 7 8 9 10 High

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

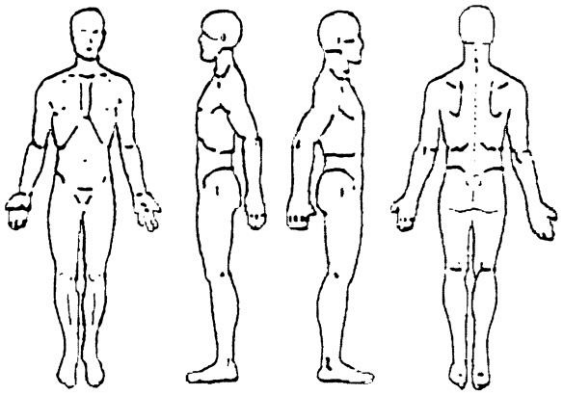
_____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period end? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*

- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*

- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflam. Disease ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ M stitis ☐ Breast Cysts

☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet & Lifestyle

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

Please tell us about your exercise (regular, minimal, etc.):

_____

Please list what you ate yesterday:

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

ACID-ALKALINE QUESTIONNAIRE

SECTION A – HISTORY

Circle the number score for each **yes** answer.

1. Have you taken tetracyclines (Sumycin, Panmycin Minocin, Vibramycin, etc.) or other antibiotics for one month or longer? **35**
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory, or other infections for two months or longer, or in shorter courses, four or more times in a one-year period? **35**
3. Have you ever taken a "broad spectrum" antibiotic? **6**
4. Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems? **25**
5. Have you been pregnant two or more times? **5**
   One time? **3**
6. Have you taken birth control pills for more than two years? **15**
   For six months to two years? **8**
7. Have you taken Prednisone, Decadron, or other cortisone-type drugs for more than two weeks? **15**
   For two weeks or less? **6**
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke moderate to severe symptoms? **20**
   Mild symptoms? **5**
9. Are symptoms worse on damp, muggy days, or in moldy places? **20**
10. Have you had severe or persistent athlete's foot, ring worm, jock itch, or chronic fungus infections of the skin or nails? **20**
    Mild to moderate? **10**
11. Do you crave sugar? **10**
12. Do you crave breads? **10**
13. Do you crave alcoholic beverages? **10**
14. Does tobacco smoke *really* bother you? **10**

SECTION A TOTAL _____

SECTION B – MAJOR SYMPTOMS

Enter the appropriate score for each symptom below. If a symptom is *occasional* or *mild*, score **3** points. If a symptom is *frequent* or *moderately severe*, score **6** points. If a symptom is *severe* or *disabling*, score **9** points.

1. Fatigue or lethargy _____
2. Feeling of being "drained" _____
3. Poor memory _____
4. Feeling "spacey" or "unreal" _____
5. Depression _____
6. Numbness, burning, or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Joint pain _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis _____
17. Impotence _____
18. Loss of sexual drive _____
19. Endometriosis _____
20. Premenstrual tension _____
21. Spots in front of eyes _____
22. Erratic vision _____

SECTION B TOTAL _____

SECTION C – OTHER SYSTEMS

Enter the appropriate score for each symptom below. If a symptom is *occasional* or *mild*, score **1** point. If a symptom is *frequent* or *moderately severe*, score **2** points. If a symptom is *severe* or *disabling*, score **3** points.

1. Drowsiness _____
2. Irritability or jitteriness _____
3. No coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headaches _____
7. Dizziness/loss of balance _____
8. Pressure above ears, head tingling _____
9. Itching _____
10. Rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Joint swelling or arthritis _____
20. Nasal congestion or discharge _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infections or fluid in ears _____
32. Ear pain or deafness _____

SECTION C TOTAL _____

GRAND TOTAL SCORE _____

Your Grand Total Score will help determine if your health problems are yeast-connected.

Yeast-connected health problems are:	**Women**	**Men**
almost certainly present with scores over	180	140
probably present with scores over	120	90
possibly present with scores over	60	40

Women with scores less than **60** and men with scores less than **40** are less apt to have yeast-connected health problems.

Women's Fertility History (If Applicable)

Name of your doctor / fertility specialist: Conceptions / CCRM / CRE / Kaiser / University Hospital / Other OBGYN doctor: _____ Name of person who told you about us? _____

Start date: _____ month/year Current Month Treatment Plan _____ (IVF / IUI / Natural / Tests / Etc.)

1. Please list below all pregnancies and fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

2. Do you have any of these diagnoses?

	High FSH / AMH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level
Date						

Others:

3. Have you ever have any of these infertility tests or procedures?

	Laparoscope	HSG-Hysterosalpingography	Others:
Date			

4. Do you have any of these? If yes please list how many.

Pregnancies	Children	Miscarriages	Abortions	Ectopic	D&C	Abnormal Pap Smear	Others

5. Other:

Age at which menses began? _____ Do you take birth control? _____ If yes, how long? _____ List name of birth control _____ Has your husband been checked out for fertility problems? ____ How long have you been trying to get pregnant? _____ At Day 3_____ at Day 10_____ at _____(month/year) Do you get recurrent yeast infections? _____ How often? _____	Do you have to do a Clomid challenge test? _____ Do you ovulate on your own? _____ How can you tell you ovulate? _____ Which day of your cycle _____ to _____ Have you done BBT testing? _____ Typically, how many days are there from one period to the next _____ to _____ days? Today is which day of your cycle? _____

6. List any PMS symptoms before period:

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

7. How is your period each day? Please check each day:

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramp (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

COLORADO MANDATORY DISCLOSURE STATEMENT

Acupuncture Associates
9075 Forsstrom Drive Lone Tree, CO 80124
303 470-1995

Paul V. Murray, L.Ac., CNC **Joong Yeon Kim, L.Ac.** **Leilani Houston, L.Ac.**
Wenying Lin, OMD, L.Ac. **Keiko Barringer, L.Ac.** **Naomi Campbell, L.Ac.**
Kerry Briggs, L.Ac.

Paul V. Murray received his degree at the Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). He was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. He also studied 5-element acupuncture, and earned a certificate in nutritional counseling. He studied Chinese medicine in China to earn additional experience. Paul is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). He is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2002. Paul is COO of ABORM, first fertility board in the U.S. He wrote and received a grant from the National Institutes of Health for a study on acupuncture and spinal cord injuries. Paul has not had any license, registration, or certification revoked or suspended.

Wenying Lin received her medical degree from Beijing University of Traditional Chinese Medicine in China (a credentialed 6-year program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. Dr. Lin is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). She is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture 1992. She is also a FABORM fellow to the American Board of Acupuncture and Oriental Medicine. Dr. Lin has not had any license, registration, or certification revoked or suspended.

Joong Yeon Kim received his degree from the Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). He was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. Joong Yeon is certified by the National Certification Commission for Acupuncture and Oriental Medicine. He is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2009. Joong Yeon has also studied Korean Hand Acupuncture. He has not had any license, registration, or certification revoked or suspended.

Keiko Barringer received a Master's degree from Pacific College of Oriental Medicine (a credentialed 44-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Keiko is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2011. Keiko has special training in Japanese Meridian Therapy. Keiko has not had any license, registration, or certification revoked or suspended.

Kerry Briggs received a Master's degree from Pacific College of Oriental Medicine (a credentialed 44-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Kerry is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice acupuncture in the states of Colorado and New York, and has been practicing acupuncture since 2010. She has received advanced training in the treatment of sports injury, women's fertility, and is a Star Symmetry certified practitioner. Kerry has not had any license, registration, or certification revoked or suspended.

Leilani Houston received a Master's degree from Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Leilani is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2015. Leilani has not had any license, registration, or certification revoked or suspended. Leilani has also studied Master Tung Acupuncture.

Naomi E. Campbell received a Master's degree from the Southwest Acupuncture College in Boulder, Colorado. She was trained in the recommendation and application of adjunctive therapies and herbs as defined by Traditional Oriental medicine concepts. Naomi is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice acupuncture in the state of Colorado, and has been practicing acupuncture since 2013. Naomi has special training in Yin Style Bagua family medicine including medical Qi gong techniques, and classical acupuncture skills. She is also a certified Reiki Master, and has advanced training in sports medicine/pain management, neurological disorders, cancer, and fertility for men and women. Naomi has not had any license, registration, or certification revoked or suspended.

COLORADO MANDATORY DISCLOSURE STATEMENT
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9075 Forsstrom Drive Lone Tree, CO 80124
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Paul V. Murray, L.Ac., CNC **Joong Yeon Kim, L.Ac.** **Leilani Houston, L.Ac.**
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Kerry Briggs, L.Ac.

This office complies with all rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized; and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

Cash at Time of Service Fee Schedule

Initial Acupuncture Evaluation and Treatment	$ 160*
Follow-up Acupuncture Treatment	$ 90
Prepaid Family Plans:	
5-visit package	$ 400
10-visit package	$ 750
20-visit package	$ 1,300

*Coupons or other special discounts may apply.
Herbs are purchased separately.
Insurance is billed by code; payment varies by plan.

Patient's Rights

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies. The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: 303 894-7800.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Please print): _____

_____ _____

Signature of patient or legal guardian **Date**

Acupuncture Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

Payment Practices

Acupuncture Associates gladly accepts health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

Payment Agreement

I authorize Whole Health Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to Whole Health Center. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to Acupuncture Associates. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Acupuncture Associates. I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to Acupuncture Associates for any reason within a reasonable time (as determined by Acupuncture Associates). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

Cancellation Notice

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

Patient's Name (Please print): _____

Signature of patient or legal guardian_____ Date_____

Acupuncture Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Whole Health Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Whole Health Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Whole Health Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Whole Health Center and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Whole Health Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Whole Health Center for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Acupuncture Associates may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Whole Health Center is not required to agree to the restrictions that I may request. However, if Whole Health Center agrees to a restriction that I request, the restriction is binding on Whole Health Center. I have the right to revoke this Consent, in writing, at any time, except to the extent that Whole Health Center has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

Patient's Name (Please print): _____

_____ _____

Signature of patient or legal guardian **Date**

Financial Policy for Patient Care Services

Whole Health Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1) Provide us with accurate and updated information on yourself and your insurance company.
2) Pay at the time of service for your entire balance.
3) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

Insurance Patients:
We are happy to file insurance claims as a courtesy to you. It is your responsibility to see that the claims are paid. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 60 days.

Whole Health Center sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

1) You are authorizing Whole Health Center, Acupuncture Associates, their providers, and employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment. You are giving authorization to submit your claims without obtaining your signature on each and every claim submitted.
2) You are authorizing your insurance company and your medical provider to release your medical records to Whole Health Center and Acupuncture Associates for the purpose of claim(s) payment.
3) You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to Whole Health Center and/or Acupuncture Associates.
4) You are giving Whole Health Center and Acupuncture Associates the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5) You agree that a photocopy of any document is as valid and effective as the original.

Whole Health Center, Acupuncture Associates, and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. Whole Health Center and its providers are willing to extend the expectation of payment within 60 days for worker's compensation and auto accident insurance when Med-Pay is not available.

If you prefer that we do not file insurance claims for you, you may pay the time-of-service discounted rate and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a super bill, but cannot assist you in filing your claims.

Self-Pay Patients:
If you do not have insurance or our services are not covered by your insurance company, you will be considered a "self-pay" patient. Family plans and discounts must be applied at the time of service and cannot be back-dated. If you have a financial hardship, an application for financing or a financial hardship discount must be completed before or at the time of service. It is important to Whole Health Center that you become well now, even if we need to work with your financial budget.

Cancellation Policy:
In order to provide you with the best care, please arrive 10 minutes prior to your appointment—late arrival may result in cancellation. We require 24 hours' notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:
Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account over to a collections agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees. The responsibility for payment of medical services for you or your dependents is yours; due and payable at the time services are rendered unless financial arrangements have been made. You are responsible for all costs of collection, including attorney fees, collection fees, and court costs. Any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

Payment Options:
For your convenience, we are happy to keep your credit card on file and secured for payment of all services and products.

Please ask the front desk if you would like to apply for Care Credit financing and/or financial hardship.

Healthy People are Happy People

_____
Patient's Name (please print)

_____ _____
Responsible Party or Authorized Person Signature Date

_____ _____
Whole Health Center Signature Date

If you would like to keep your credit card on file in a secured location in our system, please tell the front desk.