Acupuncture By Homa, Inc.

Tel: (310) 372-5555
Fax: (310) 923-7689
234 S. Pacific Coast Highway, Suite 205
Redondo Beach, CA 90277
www.AcuByHoma.com
Facebook.com/AcuByHoma

PATIENT CONFIDENTIAL INFORMATION

Last Name:_____ First Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Best phone # to reach you: ☐Home / ☐Work / ☐Cell: (_____) _____-_____

May we use email communication pertaining to your appointments and for occasional announcements pertaining to our practice? ☐Yes / ☐No email:_____

Age:_____ Date of Birth:_____ / _____ / _____ Gender: ☐ Male / ☐ Female

Marital Status: ☐ Single / ☐ Married / ☐ Domestic Partnership / ☐ Divorced / ☐ Widowed

Occupation:_____ Employer:_____

If patient is a **minor**, name and relationship of person legally responsible:

Name: _____ Relationship: _____

EMERGENCY CONTACT

Name:_____ Relationship to you:_____

Best phone # to reach: ☐Home / ☐Work / ☐Cell: (_____) _____-_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

At Acupuncture by Homa, Inc., we respect your privacy and follow the guidelines provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Notice of Privacy Practices explaining these guidelines is available to you to review and keep. By signing below, you acknowledge that you have read the Notice of Privacy Practices and are aware of how your medical records may be used.

PATIENT'S SIGNATURE:_____ DATE:_____
(Signature of legal guardian or person authorized to sign on behalf of the patient)

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HEALTH AND MEDICAL HISTORY

What is your chief complaint? _____

When and how did this condition begin? _____

Has a diagnosis already been made by another health care practitioner? ☐ Yes / ☐ No

If yes, what was the diagnosis?_____

List any treatments you have received for this condition: _____

Date of Most Recent Physical Exam:____ / _____ / _____

Family Physician: _____ Referred by:_____

What are your top 3 primary health goals?_____

_____

Surgeries: _____

Hospitalizations: _____

Allergies and sensitivities: _____

Are you pregnant? ☐ Yes / ☐ No. Date of last menstruation: _____

Do you exercise regularly? ☐ Yes / ☐ No. If so, how often? _____

Do you smoke cigarettes? ☐ Yes / ☐ No. If so, how much and how often? _____

Do you drink alcohol? ☐ Yes / ☐ No. If so, how much and how often? _____

Do you use recreational drugs? ☐ Yes / ☐ No. If so, how much and how often?_____

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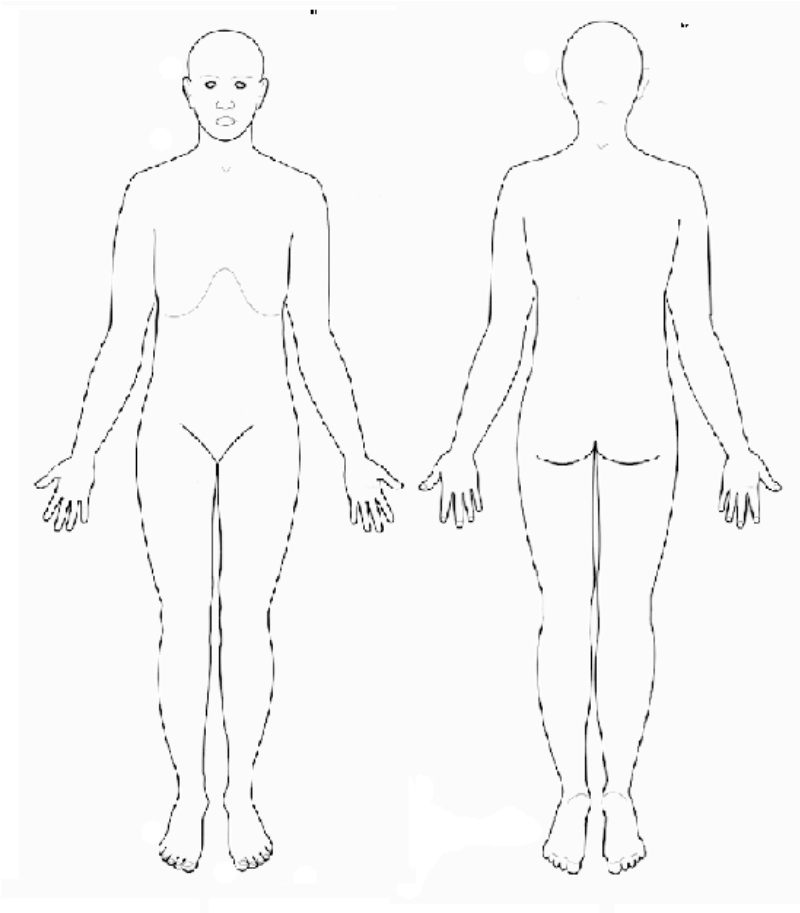
HEALTH AND MEDICAL HISTORY (cont'd)

Chinese Medicine takes the *whole* person into consideration in order to diagnose and treat the root cause of symptom(s). Although some of the questions below may not seem relevant to your chief complaint today, they complete your story and help identify patterns of disharmony that provide a more comprehensive understanding of your health.

Using the scale below, how would you rate your pain? _____

Using the diagram below, please draw an X on any areas that you experience discomfort and describe the sensation:



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HEALTH AND MEDICAL HISTORY (cont'd)

Check if *You* or a *Blood Relative* have been diagnosed with any of the following:

[ ] Allergies
[ ] Anemia or Other Blood Disorder
[ ] Asthma
[ ] Bleeding Disorder
[ ] Cancer
[ ] Depression
[ ] Diabetes
[ ] Epilepsy or Seizures
[ ] Fibromyalgia
[ ] Gout
[ ] Heart Disease
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Irritable Bowel Syndrome
[ ] Kidney Disease
[ ] Liver Disease
[ ] Migraine Headaches
[ ] Numbness
[ ] Scoliosis
[ ] Skin Rashes or Diseases
[ ] Stroke
[ ] Thyroid Disorders
[ ] Tumors
[ ] Ulcers

Check if you experience difficulty with any of the following:

[ ] Sleep
[ ] Excessive/Vivid Dreams
[ ] Mouth Sores
[ ] Frequent Urinary Tract Infections
[ ] Palpitation
[ ] Dry Eyes/Blurry Vision
[ ] Anger/Irritability
[ ] Lumps
[ ] Muscle Spasm
[ ] Dizziness/Vertigo

[ ] Low Energy
[ ] Poor Digestion/Bloating
[ ] Prolapse/Hemorrhoids
[ ] Bleeding Gums
[ ] Excess Thirst/No Thirst
[ ] Worry/Pensiveness
[ ] Cough/Phlegm
[ ] Shortness of Breath
[ ] Spontaneous Sweating
[ ] Dry Skin
[ ] Frequent Colds
[ ] Sadness/Grief

[ ] Hearing/Tinnitus
[ ] Cold Hands & Feet
[ ] Stiff Joints
[ ] Night Sweats
[ ] Frequent/Urgent/Difficult Urination
[ ] Poor Memory
[ ] Impotence/Low Libido
[ ] Edema

Any other conditions not listed above? _____

_____

_____

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MEDICATIONS, SUPPLEMENTS, HERBS

Please list ALL *medications*, *supplements*, *herbs*, and *vitamins* that you are currently taking.

#	Name	Since When	Why
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
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INFORMED CONSENT TO RECEIVE TREATMENT & CARE

You are always welcome to ask for more details if you wish. Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

- **Acupuncture:** I understand that it is a technique using small, sterile, single use, disposable, surgical stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief discomfort, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection.
- **Cupping**: I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.
- **Gua Sha:** I understand that this is a healing technique very similar to cupping, except that it involves pressured strokes along the affected area with a round-edged instrument in order to promote circulation. Similar to cupping, gua sha produces a deep redness and discoloration which may persist for up to a week, resolve on their own and are not indications of complications or injury.
- **Herbs and Nutritional Supplements**: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them. I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters

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are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment.

- **Acupressure/Tui Na Massage**: I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that side effects that may result from this treatment include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.
- **Moxibustion**: I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.
- I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.
- I have provided a full history and description of the complaints and health status which is complete and accurate.
- I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.
- I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM).
- I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.
- I understand that while this document describes major risks of treatment, other unforeseeable side effects and risks may occur.
- I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which she feels at the time, based on the facts known to her, is in the best interest of me as a patient.
- I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

PATIENT NAME:_____ DATE:_____

PATIENT'S SIGNATURE:_____
(Signature of legal guardian or person authorized to sign on behalf of the patient)

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FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

Please read thoroughly. Your signature at the bottom of this page is your acknowledgement and agreement that you will adhere to the following:

1. **Payment:** I am responsible for paying all fees in full at the time of service. Accepted forms of payment are cash, personal checks, Visa, and MasterCard.
2. **Non-sufficient Funds:** I will be responsible for a $25.00 service charge for non-sufficient funds.
3. **Cancellation/No-Show:** I will inform Acupuncture by Homa, Inc. 24 hours in advance, should I need to cancel or reschedule an appointment, or I will be responsible for a $25.00 late cancellation, no-show or rescheduling fee.
4. **Assignment of Benefits/ Release of Information:** To provide timely and accurate payment to Acupuncture By Homa, Inc. for any services furnished the patient by the provider:
   - I certify that any insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
   - I assign my right to receive payment of authorized benefits to Acupuncture By Homa, Inc.
   - I request that payment of authorized benefits be made on my behalf to Acupuncture By Homa, Inc. for any services furnished to me by the provider.
   - If my Health Insurance Plan will not direct payment to Acupuncture By Homa, Inc., I agree to forward to Acupuncture By Homa, Inc. all health insurance payments which I receive for the services rendered by Acupuncture By Homa, Inc. and its health care provider.
   - I authorize Acupuncture By Homa, Inc. or any holder of medical information about me to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.
   - I am responsible for and agree to pay all charges for services provided which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
   - I further agree that, if permissible by law, I will reimburse Acupuncture By Homa, Inc. for all costs, expenses and attorney's fees that may be incurred by Acupuncture By Homa, Inc. to collect those charges.
   - That this financial form with assignment of benefits applies and extends to all visits and appointments at Acupuncture By Homa, Inc.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above. A copy of this form shall be deemed as valid as the original.

PATIENT NAME:_____ DATE:_____

PATIENT'S SIGNATURE:_____
(Signature of legal guardian or person authorized to sign on behalf of the patient)