SHASTA
ACUPUNCTURE
& HERBAL WELLNESS

NEW PATIENT PAPERWORK

PRICE LIST, HEALTH HISTORY, HIPPA FORM, & OFFICE POLICIES

Shasta Acupuncture Schedule of Fees:
Revised DECEMBER 1, 2016

ACUPUNCTURE

Consultation	$100*
Re- Exam (Limited)	$50*
Re-Exam (Minimal)	$30
Acupuncture	$60
Electro- Acupuncture	$80
Acupuncture (each additional 15 min.)	$35
Electro- Acu (each additional 15 min.)	$35
Emergency Appointment	$75*
Infrared Therapy	$15
Cupping	$45*
Massage 15 min increments	$25*
Taping (Not included in packages)	$25

ACUPUNCTURE PACKAGE

5+1 (6 visit total) $300.00
Breaks down to $50.00 per visit.

10+3 (13 visit total) $600.00
Breaks down to $46.15 per visit

HERBAL CONSULTS INITIAL

Herbal Consult Moderate	$100**
Herbal - Comprehensive	$175**

HERBAL CONSULTS FOLLOW-UP

Herbal Consult – Simple	$30**
Herbal Consult Limited	$75**

HERBAL PACKAGE

Standard Package $500 ***
includes:

1- Comprehensive Consult
2- Limited consultations
2- Months of herbal supplements for condition diagnosed at Comprehensive Consult.

*Acupuncture packages do not include herbal consults, herbal formulas or supplements, supplies/materials or modalities other than Acupuncture.

** Herbal Consults are designed so that the provider can review your symptoms, investigate the pattern shown and construct a custom herbal formula to address the pattern presented. We recommend a follow up herbal consult within 7days to 2 weeks of the initial consult; this will allow the provider to review your progress and to make any modifications necessary to your custom formula. ***Herbal consults will be charged whether performed in the consult room /treatment room or over the phone .***

Financial and Office Policies

Financial Responsibilities

- Payment is due at time of service.
- Cash discount of 20% for senior citizens and military patients without insurance.
- Initial Visit is paid in full at time of service
- We bill Insurance as a courtesy to our patients once insurance has been qualified. This however does not guarantee payment. Patients are ultimately responsible for all Co- insurance, Co-payments and deductibles as well as all services that your insurance has not paid.

- There is a $25 charge for all returned checks. Future payments would then need to be made by cash or credit/debit card.
- If an account has gone 90 days without a payment, the account will be sent to collections. 90 days start after decision is made by insurance company. Payment plan can be arranged.
- If care is discontinued for any reason, account balance is to be paid in full.
- Cancellation Fee of $50 if appointment is cancelled without 24 hours notice. It is your responsibility to keep track of your appointments. After office hours you can leave a message regarding a cancellation on our voicemail.
- We do offer a Remindermate option that will allow for a reminder call to be made to a number designated by you as a way to remind you of the appointed times you have booked. This will allow an option to cancel your appointment or request a call to reschedule and will help to avoid a cancellation fee should you choose to use this service.

SHASTA ACUPUNCTURE & HERBAL WELLNESS
4220 Shasta Way ● KLAMATH FALLS, OR 97603 ● (541) 884-1952

HEALTH HISTORY QUESTIONNAIRE

Some of the questions may seem unrelated to your condition, but may play an important role in diagnosis and treatment.

I. GENERAL PATIENT INFORMATION

Name _____

Address _____

City_____ Zip _____ Date of Birth _____/_____/_____

Best phone # _____ ( ) Alt # _____ Email_____

Emergency Contact_____ Relation _____ Phone _____

Guardian (if under 18 years) _____ Marital Status _____

Gender ▫ M ▫ F Weight ____ lbs. Height ___'___" How did you hear about us? _____

Occupation _____ Employer _____

Family Physician _____ Phone _____

PRIMARY INSURANCE

Insurance Company_____ Insurance Phone#_____

ID#_____ Group#_____

Subscriber's Name (if different from patient) _____

Relationship to Subscriber _____ Subscriber's Date of Birth ___/___/_____

Subscriber's SSN _____

SECONDARY INSURANCE

Insurance Company_____ Insurance Phone#_____

ID#_____ Group#_____

Subscriber's Name (if different from patient) _____

Relationship to Subscriber _____ Subscriber's Date of Birth ___/___/_____

Subscriber's SSN _____

II. MAIN HEALTH CONCERN: _____

Does this problem have an identifiable cause? What? _____

How long have you had this problem? _____

Please rate **(CIRCLE)** the severity of this problem: MILD TOLERABLE/can ignore somewhat DISTRESSFUL/limits physical activity SEVERE/cannot concentrate WORST POSSIBLE

Secondary Health Concern(s): _____

Please list any therapies you have used for current condition(s): _____

III. PATIENT MEDICAL HISTORY

Please List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls (under years of age):

0-6_____ 21-40 _____

_____ _____

_____ _____

7-12 _____ 41-60_____

_____ _____

_____ _____

13-20 _____ 61+_____

_____ _____

Recent Tests (Please indicate year and general test results, e.g., "normal" or "high"):

Physical_____ Cholesterol_____ Prostate_____

Mammography_____ Blood _____ HIV/STD_____

Pap Smear_____ Other: _____

Circle any you have had:		Asthma	Allergies	Bleeding Tendency
Cancer:_____	Chicken Pox	CVA (Stroke)	Diabetes	Emphysema
Epilepsy	Glaucoma	Gonorrhea	HIV/AIDS	High Blood Pressure
Hepatitis	Heart Disease	High Fever	Jaundice	Kidney Disorder
Measles	Liver Disorder	Lung Disorder	Meningitis	Migraines
Mumps	Mononucleosis	Nervous Disorder	Paralysis	Pneumonia
Polio	Rheumatic Fever	Spleen Disorder	Syphilis	Stomach Disorder
Tuberculosis	Thyroid Disorder	Vein condition	Other:_____	

Family Medical History: Please circle all that apply to your blood relatives.

Allergies Asthma Cancer:_____ Diabetes High Blood Pressure

Heart Disease Stroke Seizures Other Major Illnesses _____

IV. PATIENT PROFILE

Medications: Please list all medications taken in last 3 months. _____

_____

Exercise: Please describe the type and frequency of exercise. _____

_____

Nutrition Information: Please describe your Average Daily Diet.

Breakfast_____

Lunch_____

Dinner _____

Snacks (eaten at what time?) _____

How much water do you drink daily (in ounces)? _____

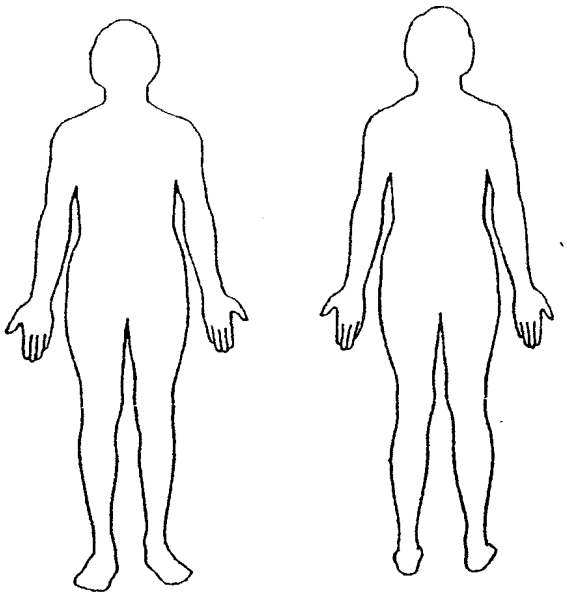
Women only: Do you take birth control pills? ▫ Yes ▫ No Number of children: _____

Is there a chance you are pregnant now? ▫ Yes ▫ No Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable):_____

V. ORGAN FUNCTION

Pain Conditions: Indicate areas of pain ("X") and the location of any scars ("S") on the figures at right.



Describe the pain sensation:

- ▫ Sharp ▫ Burning ▫ Aching
- ▫ Dull ▫ Cramping ▫ Moving
- ▫ Radiating ▫ Other:_____

Circle any below that lessen the pain:

Pressure Cold Heat

Circle any below that worsen the pain:

Pressure Cold Heat

Check the following that pertain to you for the last SIX MONTHS or seasonally:

Overall Temperature (Kidney Function):
- ▫ Cold hands
- ▫ Cold feet
- ▫ Cold body temperature or sensation
- ▫ Hot body temperature or sensation
- ▫ Heat in the hands, feet, and chest
- ▫ Hot flashes
- ▫ Sweaty hands
- ▫ Night sweats
- ▫ Sweaty feet
- ▫ Perspire easily
- ▫ Lack of perspiration
- ▫ Excessive thirst
- ▫ Low libido

Overall Energy (Lung and Kidney Function):
- ▫ Shortness of breath
- ▫ General weakness
- ▫ Feel worse after exercise
- ▫ Easily catch colds
- ▫ Low Energy
- ▫ Hard to keep eyes open during day

Overall Blood Function:
- ▫ See floaters/floating black spots in eyes
- ▫ Dizziness

Office Use Only
Total This Page: 1. ____ 2. _____ 3. _____ 4. _____ 5. _____

Heart Function:
- ▫ Cardiovascular disease
- ▫ Chest pain traveling to shoulder
- ▫ High blood pressure
- ▫ Low blood pressure
- ▫ Palpitations
- ▫ Fainting
- ▫ Sores on tip of tongue
- ▫ Restless sleep
- ▫ Hard to fall asleep
- ▫ Wake during night
- ▫ Wake earlier than you'd like
- ▫ Nightmares
- ▫ Wake unrefreshed
- ▫ Mental Confusion
- ▫ Anxiety
- ▫ Restlessness
- ▫ Drink coffee/soda (cups/day):_____

Spleen, Stomach, Intestinal Function:
- ▫ Diarrhea
- ▫ Black or tarry stools
- ▫ Loose Stools
- ▫ Blood in Stools
- ▫ Constipation
- ▫ Mucous in stools
- ▫ Undigested food in stools
- ▫ Incomplete Bowel Movements
- ▫ Chronic laxative use (type):_____

Lung Function:
- ▫ Cough: Wet or Dry
- ▫ Difficulty breathing
- ▫ Wheezing
- ▫ Nasal Discharge (color):_____
- ▫ Sinus Congestion
- ▫ Sneezing
- ▫ Dry mouth
- ▫ Dry, itchy throat
- ▫ Sore throat
- ▫ Dry skin
- ▫ Nose Bleeds
- ▫ Hives
- ▫ Rashes
- ▫ Eczema
- ▫ Dandruff
- ▫ Achy feeling in body
- ▫ Stiff shoulders
- ▫ Stiff neck
- ▫ Alternating fever/chills
- ▫ Sadness
- ▫ Smoke cigarettes (per day):_____
- ▫ Allergies (to what?):_____

Spleen Function:
- ▫ Low appetite
- ▫ Changes in appetite
- ▫ Fatigue after eating
- ▫ Abrupt weight gain
- ▫ Abrupt weight loss
- ▫ Abdominal bloating
- ▫ Abdominal gas
- ▫ Stomach Gurgling
- ▫ Hemorrhoids
- ▫ Easily bruised
- ▫ Worry
- ▫ Prolapsed organs (which?):_____
- ▫ Cravings, for what? _____

Dampness trapped in body:
- ▫ Mental sluggishness
- ▫ Mental fogginess
- ▫ Snoring
- ▫ Swollen hands
- ▫ Swollen feet
- ▫ Swollen joints

Office Use Only
Total: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

- ▫ Chest congestion
- ▫ Nausea
- ▫ Phlegm production
- ▫ General sensation of heaviness in body

Stomach Function:
- ▫ Stomach Pain
- ▫ Ulcer (if diagnosed)
- ▫ Burning sensation after eating
- ▫ Heartburn
- ▫ Large appetite
- ▫ Bad breath
- ▫ Vomiting
- ▫ Sores on lips, tongue, or mouth
- ▫ Acid regurgitation
- ▫ Belching
- ▫ Hiccoughs
- ▫ Cold sensation in stomach
- ▫ Bleeding, swollen, or painful gums

Liver and Gallbladder Function:
- ▫ Chest pains
- ▫ Tight sensation in chest
- ▫ Bitter taste in mouth
- ▫ Lump in throat
- ▫ Teeth Grinding
- ▫ Skin rashes
- ▫ Numbness
- ▫ Neck tension
- ▫ Shoulder tension
- ▫ Hip pain/Sciatica
- ▫ Muscle spasms
- ▫ Muscle twitching
- ▫ Muscle cramping
- ▫ Seizures
- ▫ Convulsions
- ▫ Anger easily
- ▫ Frustration
- ▫ Depression
- ▫ Irritability
- ▫ Drink alcohol (per week):_____
- ▫ Alternating diarrhea and constipation
- ▫ High pitch ringing in the ears
- ▫ Gallstones, history of or currently
- ▫ Genital sores
- ▫ Dry, brittle nails
- ▫ Headaches (How Often? Where?)

_____

Eyes (Liver Function):
- ▫ Itchy
- ▫ Red or Bloodshot
- ▫ Hot
- ▫ Dry
- ▫ Watery
- ▫ Gritty or sandy feeling
- ▫ Blurry vision
- ▫ Decreased night vision
- ▫ Near-sighted
- ▫ Far-sighted
- ▫ Cataracts
- ▫ Visual Disturbances

Kidney, Urinary Bladder Function:
- ▫ Bladder infections
- ▫ Lack bladder control
- ▫ Sneeze or jump incontinence
- ▫ Kidney stones
- ▫ Easily Broken Bones
- ▫ Foot or ankle weakness or pain
- ▫ Poor hearing
- ▫ Earaches
- ▫ Low-pitch ringing in the ears
- ▫ Painful knees
- ▫ Weak knees
- ▫ Cold in knees
- ▫ Low back pain
- ▫ Memory problems
- ▫ Excessive hair loss
- ▫ Prematurely gray hair
- ▫ Fearfulness
- ▫ Easily startled

Urination:
- ▫ Dark yellow
- ▫ Reddish
- ▫ Cloudy
- ▫ Scanty
- ▫ Profuse
- ▫ Strong Odor
- ▫ Burning
- ▫ Painful
- ▫ Difficult
- ▫ Urgent
- ▫ Waking during night to urinate

Office Use Only
Total: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Activities of Daily Living Affected
- ▫ SLEEP ▫ EXERCISE ▫ SITTING
- ▫ ATTITUDE ▫ PRODUCTIVITY AT WORK
- ▫ HOBBIES ▫ ENERGY LEVEL ▫ CHORES

Men only:
- ▫ Swollen testes
- ▫ Testicular pain
- ▫ Erectile Dysfunction
- ▫ Premature ejaculation
- ▫ Coldness/numbness in genitalia
- ▫ Other_____

Women only:
- ▫ Spotting between periods
- ▫ Irregular menstrual cycle?

Average number of days of flow: _____
Average number of days of cycle: _____

Any pre-menstrual symptoms?
- ▫ Nausea
- ▫ Vomiting
- ▫ Water retention
- ▫ Breast swelling
- ▫ Food cravings
- ▫ Headaches
- ▫ Migraines
- ▫ Breast tenderness
- ▫ Depression
- ▫ Irritability
- ▫ Anxiety
- ▫ Other emotions: _____
- ▫ Dull pain, where? _____
- ▫ Sharp pain, where?_____

_____
Patient Signature Date

_____
Patient Re-Exam Signature Date

_____
Patient Re-Exam Signature Date

_____
Patient Re-Exam Signature Date

_____
Patient Re-Exam Signature Date

Please sign the check the statement that applies and sign below only after you have read the HIPAA Notice of Privacy Practices. SHASTA ACUPUNCTURE & HERBAL WELLNESS is required by law to provide you with a copy of the HIPAA Notice of Privacy Practices if you would like one.

□ **I decline receiving a copy** of the notice, but have read the HIPAA Notice of Privacy Practices from SHASTA ACUPUNCTURE & HERBAL WELLNESS.

□ **I have received a copy** of the notice, and have read the HIPAA Notice of Privacy Practices from SHASTA ACUPUNCTURE & HERBAL WELLNESS.

Print Name_____

Sign Name_____

Date_____

Authorization to Pay – Release Medical Information

I HEARBY AUTHORIZE Greg Enos, L.Ac., the release of any medical information necessary to facilitate payment and continuity of care. I hereby assign payment directly to Greg Enos, L.Ac. all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.

Patient Signature_____ Date_____

Note: Please indicate how you wish to pay for your co-pay services:

Method of payment: ____Cash ____Check ____Visa ____MC

Cancel/No Show Policy: I understand that Greg Enos, L.Ac., requires a 24 hour/one business day notice for all cancelled appointments. Failure to cancel prior to 24 hours or a no show will result in a $50 charge to my account that my insurance will not cover.

My initials here signify that I have read this _____

Informed Consent

I voluntarily consent to be treated with Acupuncture by Greg Enos, L.Ac. at Shasta Acupuncture and Wellness Clinic.

I understand that acupuncture is performed by the insertion of very fine gauge needles through the skin, or by the application of heat to the skin by both, at certain points on or near the surface of the body in an attempt to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological processes. Only disposable needles will be used during each treatment.

I understand that no guarantees concerning the use and effects are given to me, and that I am free to stop acupuncture treatments at any time.

Signature (Patient/Guardian) Date

OFFICE POLICIES AND PROCEDURES

Welcome to Shasta Acupuncture & Herbal Wellness. Please read the following statements and sign below to indicate you understand the terms of our policies.

□ **Financial Responsibility:** Your signature below acknowledges your responsibility for all charges made to your account. All fees are due at the time of service. Attorney fees and a late charge of $25 OR a finance charge of 18% on the unpaid balance (whichever is greater) will be paid by patient for accounts that are 90+ days past due.

□ **Insurance Billing:** Shasta Acupuncture & Herbal Wellness can verify your benefits and bill your primary insurance as a courtesy; however, you are ultimately responsible for verifying benefits and exclusions on your policy.

□ **Treatment Plans:** Acupuncture has a cumulative effect. A specific number of treatments in a set amount of time are necessary to get the best results. If you need to change an appointment time, plan to come as close to the missed appointment as possible.

□ **Cancellation: 24-hour notice is required to cancel a scheduled appointment.** There is no penalty for the first time you cancel on short notice. If you fail again to provide 24-hour notice, you will be billed $50.00. Our office staff will place a courtesy call to the number you provide as a reminder of your scheduled appointment at least 1 day prior to your appointment.

□ **Herbal Pharmacy:** Herbs may be added to your Wellness Routine. Some Custom Blended Formulas require a visit for a Herbal Consultation. Refills for Custom Blended Herbs require 24 hour notice. Most “patent formulas” may be picked up the same day.

□ **Cell phones:** Please refrain from using your cell phone in the waiting area. Unless there is an urgent need, please turn off your cell phone when you arrive. Our goal is to provide a quiet refuge from your busy life outside the clinic.

□ **Clothing:** Please bring a pair of shorts or wear loose-fitting pants that can be easily moved above the knees.

□ **Arrival Time:** We strive to maintain a no-wait office. Please arrive ten to fifteen minutes prior to your appointment time so you may fill out your chart notes and get settled.

□ **Indoor Voices:** Our treatment rooms are not sound insulated. For your privacy, and to maintain a tranquil atmosphere, we ask that you speak softly.

□ **Upsets:** We are here to serve you. Please speak with your acupuncturist about any upsetting matter. We value your feedback and want to know how we can improve.

I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS STATED IN THIS CONTRACT.

_____

Printed Name Signature Date