



**DESERT RIDGE ACUPUNCTURE
CHINESE MEDICINE**

5820 S. Pecos Rd. Ste.#100 Las Vegas, NV 89120 : (P)702 704-1567 (F) 702-637-0619

Patient Information Form

Full Name: _____ **Date** _____

Preferred Language: _____

Do you have health insurance: Yes No **Insurance Provider** (e.g. Aetna): _____

Insurance Member ID: _____

Secondary Provider and Insurance ID: _____

Cell Phone Number: _____ **Home Phone Number:** _____

Primary Email: _____ **Secondary Email:** _____

Contact Preference: Cell Home Email DO NOT CONTACT

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth (DOB): _____ **Age:** _____ **Height:** _____ **Weight:** _____

Sex assigned at birth: (useful for medical purposes) Male Female Other / Prefer not to answer

Employment:

Occupation _____ **Employer Name** _____

Marital Status: Married Single Other _____

Primary Care Physician (PCP): _____

PCP Phone Number: _____ **Last Exam Date:** _____

Emergency Contact: _____ **Relation:** _____

Emergency Contact Phone: _____

Referred by: _____



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Welcome to Desert Ridge Acupuncture. Our goal is to provide high-quality care in a comfortable and supportive setting. Please feel free to ask any questions regarding treatment, billing, or office policies at any time.

FEES

Fees are comparable to other licensed healthcare providers in the area. A fee schedule is available on the Nevada Disclosure Form. Payment is due at the time services are rendered. We accept cash, credit cards, and debit cards.

Initial _____

INSURANCE COVERAGE & VERIFICATION

Insurance coverage for acupuncture varies by policy and is not guaranteed. As a courtesy, our office may verify benefits and submit claims on the patient's behalf; however, verification of benefits and submission of insurance claims does not guarantee payment. The patient is financially responsible for all services rendered, including any charges not covered, denied, or unpaid by the insurance carrier. **Any remaining balance will be billed directly to the patient.**

Initial _____

RELEASE OF INFORMATION

I authorize Desert Ridge Acupuncture, LLC to release necessary medical information, including medical records to my insurance carrier for claims processing and reimbursement or continuation of care.

Initial _____

CANCELLATION POLICY

Please provide at least 24 hours' notice to cancel or reschedule an appointment. Missed appointments or late cancellations will result in a \$25 fee, which is not billable to insurance.

Initial _____

PERSONAL INJURY NOTIFICATION

I agree to notify Desert Ridge Acupuncture, LLC if services are related to any private injury or legal claim, including auto or personal injury cases. **Services related to such claims are not covered at Desert Ridge Acupuncture, LLC and are the patient's financial responsibility.**

Initial _____

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

I, _____ (print name), acknowledge and accept full financial responsibility for all services rendered, including acupuncture treatments, herbal medicine, supplements, copays, coinsurance, and any balances not paid by insurance. I understand that insurance benefits and reimbursement are determined solely by my insurance carrier and are not the responsibility of Desert Ridge Acupuncture, LLC. I authorize direct payment of applicable insurance benefits to Desert Ridge Acupuncture, LLC and authorize the use of this signature for insurance submissions. By signing below, I confirm that I have read, understand, and agree to all policies outlined above.

Signature _____

Date _____



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Nevada Disclosure Form

Education and Experience

Desert Ridge Acupuncture providers are certified as Diplomates in Oriental Medicine by the National Certification Commission Board for Acupuncture and Herbal Medicine (NCBAHM). This includes certification in Chinese Herbology and Clean Needle Technique. Providers' training includes adjunctive therapies such as, but not limited to, Moxibustion, Cupping, Gua Sha (scraping), Tui Na, Electrical Stimulation, TDP and Far Infrared heating lamps, Bleeding (bloodletting), and dietary and lifestyle recommendations.

This clinic complies with the rules and regulations enforced by the Nevada Board of Oriental Medicine, including the proper cleaning and sterilization of acupuncture needles and the sanitation of acupuncture offices. Only single-use, disposable factory-sterilized needles are used.

Fee Schedule:

\$130 Initial Treatment

\$90 Subsequent Follow Up Treatment

*(Payment is required at time of services)

*(Price of herbs not included in treatment price)

*(All prices are subject to change at any time for any reason)

*(Appointments may be cancelled or rescheduled at anytime for any reason)

Patient's Rights

The patient is entitled to receive information about the methods of therapy, the techniques used, 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 Executive Director of the Nevada Board of Oriental Medicine.

The practice of acupuncture and Acupuncture regulated by the Nevada State Board of Oriental Medicine. If you have comments, questions, or complaints, contact the Nevada Board of Oriental Medicine, 3191 E. Warm Springs Road Las Vegas, NV 89120 (702) 675-5326

\$25 Fee will be charged for missed appointments and late cancellations (less than 24 hours notice).

By signing below, I acknowledge that I have read and understand this document. I have had the opportunity to ask questions and that all questions have been answered to my satisfaction.

Signature: _____

Date: _____



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**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Health Care Operations**

Acknowledgement of Receipt of Notice of Privacy Form

Name: _____

Date of Birth (DOB): _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I understand and have been provided with a *Notice of Privacy Form* that provides a more complete description of the privacy practices of Desert Ridge Acupuncture LLC.

I understand that this information serves as:

A basis for planning my care and treatment.

A means of communication among the many healthcare professionals who contribute to my care.

A source of information for applying my diagnosis and health information to my bill.

A means by which a third-party payer can verify that services billed were actually provided.

A tool for routine health care operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

To object to the use of my health information for directory purposes. To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that Desert Ridge Acupuncture LLC is not required to agree to the restrictions requested. To revoke this consent in writing, except to the extent that Desert Ridge Acupuncture LLC has already taken action in reliance thereupon. The right to review the Notice of Privacy Form prior to signing this document

I request the following restrictions to the use of disclosure of my health information:

Signature: _____

Date: _____



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CONSENT TO TREATMENT

I, the undersigned, understand and voluntarily consent to methods of treatment used by licensed acupuncturists at Desert Ridge Acupuncture LLC and may include, but are not limited to, acupuncture, moxibustion, auricular therapy, cupping, electrical stimulation, heat therapy, herbal therapy, tuina massage, and nutritional counseling. I understand that acupuncturists practicing in the state of Nevada are not primary care providers, and the above methods of treatment are not a substitute for western medical care. We recommend that you **Consult Your Physician** and get at least two medical opinions.

I understand that these are all safe methods of treatment. Potential risks include temporary pain, discomfort, hematoma, swelling, bleeding, numbness, tingling, dizziness, weakness, aggravation of present symptoms and soreness at the needling site that may last a few days. Unusual risks include, hyperventilating, fainting, nerve damage or pneumothorax. Although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment, infection is possible. Instances of adverse reactions to acupuncture needles are infrequent, but can occur intermittently. There is a possibility that a needle might inadvertently be overlooked during the removal process post-treatment. Should such an occurrence transpire, we kindly request that you promptly inform your acupuncture provider. While we strive for excellence in our services, we acknowledge the possibility of unforeseen incidents.

Potential risks of moxibustion include burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. Potential risks of heat therapy include burns or blistering. Potential risks electrical stimulation include pain, discomfort, nervous system stimulation, dizziness, electrical shock. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could cause complications, or miscarriage during pregnancy.

I will notify my practitioner of any and all western physician prescribed medications I am currently taking, or changes of thereof medication or doses as to avoid and possible drug/herb interactions. I will only take the recommended doses of nutritional and herbal supplements recommended to me by my practitioner. Doses of herbs taken without my practitioner's recommendation may be toxic and may be inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my practitioner as soon as I experience any discomfort or adverse reactions.

The Practice of acupuncture means the insertion and removal of acupuncture needles, the application of heat therapies to specific areas of the human body, and traditional oriental adjunctive therapies. Traditional oriental adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical and electromagnetic treatment, the recommendation of oriental therapeutic exercises, and subject to federal law, the recommendation of herbs and dietary guidelines." The "Practice of Oriental Medicine" shall be defined by the scope of practice as set forth Nevada Administration Code NAC634A "Practice of Acupuncture" does not mean: Osteopathic medicine and manipulative treatments; Chiropractic medicine or Chiropractic medicine or adjustments; or Physical therapy.

In signing this form, I have read and understand all of the above information. I acknowledge any inherent risks and understand I may ask my practitioner for more detailed explanation of any of the above. I give permissions and consent to treatment; payment and healthcare operations received, incurred or carried out at this practice.

Signature: _____

Date: _____



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Name: _____ Date: _____ Age: _____

Chief Complaint (Reason for Visit): _____

Complaint History (e.g., start date, severity, worse in AM): _____

Past / Current Medical History & Surgeries (e.g., pneumonia @ 38 y.o., surgery @ 16 y.o.):

Family Medical History (e.g., diabetes on father's side):

Have you had acupuncture before: Yes No Are you currently sick? Yes Cold/Flu Other _____ No

Allergies: Medications Latex Essential Oils Foods Other: _____

Cardiovascular Problems: Pacemaker Palpitations Irregular heart beat Fast heart beat Slow heart beat

High Blood Pressure Cardiovascular disease Cold hands Cold feet Numbness/tingling Loss of feeling None

Do you have: Headaches Dizziness Migraines If yes, how often per week/month: _____

Respiratory Problems: Shortness of breath Asthma Cough Mucus Blood Wheezing Chest pain None apply

Do you exercise? Yes No Frequency: _____

Do you smoke, drink alcohol, or use recreational drugs? How often?

• Cigarettes: Yes No | Frequency if applicable: _____

• Alcohol: Yes No | Frequency if applicable: _____

• Recreational Drugs: Yes No | Frequency if applicable: _____

• Caffeine: Yes No | Frequency if applicable: _____

Are you willing to take Chinese herbs if recommended? Yes No

For Women Only:

Are you currently pregnant or trying to become pregnant? Yes No | If yes, how far along? _____

Last Menstrual Cycle: _____ Cycle Length (days between cycles): _____



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Patient Medication / Supplement / Herbal List

<u>Name</u>	<u>Reason</u>	<u>Start Date</u>	<u>Dose</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			



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Patient Name: _____

Date: _____

Please mark X for past conditions. Circle current concerns.

GENERAL: Fatigue Insomnia Stress Anxiety Depression Weight Loss Weight Gain
 Fever/Chills Frequent Colds Tremors Spontaneous Sweating Night Sweats Forgetfulness
 Paralysis Other: _____

CARDIOVASCULAR: High Cholesterol Low Cholesterol Previous Stroke Varicose Veins Anemia
 Chest Pain Poor Circulation Swelling Other: _____

DIGESTIVE: Poor Appetite Excessive Hunger Acid Reflux Indigestion Heartburn Gas Bloating
 Nausea Abdominal Pain Constipation Diarrhea Blood/Mucus Indigestion Hemorrhoids
 Gallstones Gallbladder Removed Other: _____

GENITOURINARY: Frequent Urination Painful Urination Urinary Tract Infections Incontinence
 Kidney/Bladder Issues Blood in Urine Kidney Stones Other: _____

MUSCLE & JOINT: Neck Pain Shoulder Pain Back Pain Sciatica Knee(s) Pain Arthritis
 Spinal Curvature Weak Muscles Other: _____

SKIN / HAIR / NAILS: Rash Itching Dryness Easy Bruising Hives Other _____

EAR/NOSE/THROAT: Vision Changes Eye Dryness/Pain Ear Ringing Hearing Loss Sinus Issues
 Allergies Other _____

WOMEN (if applicable): PMS Heavy/Irregular Cycle Hot Flashes Menopause Vaginal Discharge
 Abnormal Pap Smear Reduced Libido Pregnancy Complication Other _____

MEN (if applicable): Prostate Issues Erectile Dysfunction Reduced Libido Premature Ejaculation
 Impotence Discharge Other _____

OTHER: Edema Hepatitis Herpes Cancer Diabetes TB/Epilepsy Alcoholism/Substance Abuse
 HIV/Aids Venereal Disease

Additional Concerns: _____