EARTH MOON ACUPUNCTURE
HEALING FROM THE GROUND UP

GENERAL PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method (check two): ☐ **Home** ☐ **Cell** ☐ **Text** ☐ **Email**

Marital Status : Single __ Married __ Other __

Age: _____ Date of Birth: _____ Place of Birth: _____

Occupation: _____ Employer: _____

Guardian & Phone (if under 18): _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Primary Ins Name & ID: _____

Secondary Ins Name & ID: _____

PCP & Phone Number: _____

Permission to Contact PCP (Signature) : _____

Reason & Date of Last Dr. Appointment: _____

How did you hear about us? _____

Wendy Childs, L.Ac. • Michelle Denker, L.Ac. • Margaret Campbell, L.Ac. • Katharine Stewart L.Ac. • Bryon Leverman, L.Ac.
Pafoua Yang, LMT #24029 • Kylee Veerkamp, LMT #24712 • Kacie Hinojosa, LMT #25401
Earth-Moon Acupuncture • 2365 Grear Street NE Salem, OR 97301-3510
Phone 971-273-7177 • Fax 971-273-6658

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Patient Name: _____
DOB: _____

Massage History / Treatment Information

Have you ever received a professional massage? ☐ Yes ☐ No If yes, how often? _____
Date of last massage
What results do you want from your massage session(s)?

_____

_____

Prioritize the area of your body that you would prefer to be massaged:

_____

_____

Please check the areas of your body that you give permission to receive massage

Back ☐ Legs ☐ Buttocks ☐ Feet ☐ Arms ☐ Abdomen ☐ Chest ☐ Neck ☐ Head ☐
Face ☐ Other: _____

List stress reduction and exercise activities and frequency:

_____

_____

Are you currently seeing a psychotherapist or attending a regular support group?
If yes, please explain. ☐ Yes ☐ No

_____

_____

Current medications, including aspirin, ibuprofen, etc:

_____

_____

Previous History - Please include year and treatment received
Surgeries:

_____

_____

Previous History - Please include year and treatment received
Accidents:

_____

_____

_____

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Patient Name: _____
DOB: _____

Please check all that apply

Musculo-Skeletal

- ☐ Arthritis
- ☐ Bone or joint disease
- ☐ Broken/fractured bones
- ☐ Bursitis
- ☐ Headaches/head injuries
- ☐ Jaw pain/TMJ
- ☐ Low back, hip, leg pain
- ☐ Lupus
- ☐ Neck, shoulder, arm pain
- ☐ Spasms/cramps
- ☐ Sprain/strain
- ☐ Tendonitis

Other: _____

Circulatory

- ☐ Heart condition
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema

Other: _____

Respiratory

- ☐ Breathing difficulty
- ☐ Sinus problems
- ☐ Allergies

Other: _____

Infectious Disease

Disease name(s): _____

_____

Skin

- ☐ Allergies
- ☐ Athletes foot
- ☐ Rashes
- ☐ Warts

Other: _____

Nervous System

- ☐ Chronic pain
- ☐ Fatigue
- ☐ Herpes/shingles
- ☐ Numbness/Tingling
- ☐ Sleep disorders

Other: _____

Digestive

- ☐ Constipation
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Gas/bloating

Other: _____

Reproductive

Pregnant? ☐ Yes ☐ No Stage _____

- ☐ PMS

Other: _____

Other

- ☐ Cancer/tumors
- ☐ Diabetes
- ☐ Drug/alcohol addiction
- ☐ Eating disorders
- ☐ Depression
- ☐ Nicotine/caffeine addiction

Other: _____

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Financial Policy

Our goal is to provide quality individualized care in a timely manner. We would like to inform you of our financial policy regarding your care here at Earth Moon Acupuncture. Thank you for choosing Earth Moon Acupuncture for your health needs.

Missed Appointments/No Show/Cancellations without 24-hour prior notification: No-shows, late arrivals and cancellations without 24 hour prior notification prevents us from providing care to those who need access to acupuncture and massage. In order to be respectful of the needs of other patients, please be courteous and call or email the office if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. We require that you contact our office 24 hours in advance by phone, or via email, info.earthmoon@gmail.com. **Failure to comply will result in a $25 charge**, calling in for day-of appointment availability or dismissal. This charge is not covered by your insurance company.

Late Arrivals: Arriving more than 10 minutes late will result with the need to reschedule your appointment or a reduction of the allotted time for your services.

Copayments and Coinsurance: Copayments are a fixed amount for a covered service paid by the patient each time a medical service is accessed and due at the time of service. Coinsurance is a percentage that is your patient portion and will be billed to you.

Medicare MGD Patients: If the patient has a Medicare Advantage plan, we will check their plan benefits to verify whether or not the plan will pay for Acupuncture or Massage Therapy. If the plan benefit coverage includes these services we will bill the insurance company accordingly. If the plan benefit coverage does not include these services, we do offer our services at a time of service discounted rate for all Self-pay patients.

Payment Plan: Payment plans are arranged based on proof of financial hardship and the patient's financial history with Earth Moon Acupuncture with approval from management staff.

Acupuncture Self-Pay Package Information: The following packages for treatment are as follows for those without Acupuncture Benefits or Self-pay who pay at time of service (These prices and package prices are subject to change without notice):

Initial consultation with treatment - $195.75

Reassessment visit with treatment - $151.50

Follow up visit with treatment - $93.75

6 treatment visits* - $525.00

12 treatment visits* (Includes 2 free visits) - $875.00

*2 visits will be used upon initial consultation or reassessment visit

Bemer Mat Therapy: $25 per treatment or $200 for a package of 10 treatments

Massage Self-Pay Package Information: The following packages for treatment are as follows for those without massage benefits or Self-pay who pay at time of service (These prices and package prices are subject to change without notice):

Massage 15 mins Chair Massage - $22.40

Massage 30 mins Swedish/Reflexology/Chair Massage - $44.00

Massage 60 mins Swedish/Lomi Lomi/Cupping - $77.00

Massage 90 mins Swedish/Lomi Lomi/Cupping - $115.50

Massage 90-105 mins Hot Stone - $135.10

Massage 75 mins Shiatsu - $96.60

Massage 3 treatment package - 60 mins - $ 214.50

Massage 3 treatment package - 90 mins - $ 321.75

Massage 3 treatment package - 90-105 mins Hot Stone - $376.35

Massage 3 treatment package - 75 mins Shiatsu - $269.10

Please sign below signifying that you have read, understand and agree to this financial policy:

Print Name: _____ Date: _____

Signature: _____

2365 Grear St NE Salem, OR 97301
Phone: 971-273-7177 Fax: 971-273-6658

Patient Name: _____DOB:_____ Date: _____

HIPAA Patient Consent

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent. **The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.**

Print Patient/Representative Name: _____

Patient/Representative Signature:_____ **Date:** _____

Right of Access to Medical Information

I direct my healthcare and medical services provider to disclose and release my protected health information described below via verbal, electronic or hard copy to the following person(s):

☐ No one

Name: _____ Relationship: _____

Phone: _____ Email: _____

This authorization shall be effective until **(Check one):**

□ All past, present, and future periods, OR

□ Date or event: _____ unless I revoke it. (You may at any time.)

Name: _____ Relationship: _____

Phone: _____ Email: _____

This authorization shall be effective until **(Check one):**

□ All past, present, and future periods, OR

□ Date or event: _____ unless I revoke it. (You may at any time.)

Patient/Representative Name: _____

Patient/Representative Signature:_____ Date: _____