EARTH MOON ACUPUNCTURE
HEALING FROM THE GROUND UP

PATIENT INTAKE FORM

Name: ____

Address: ____

Email: ____

Primary Phone: _____________________ Secondary Phone: _____________________ Ext__________

Preferred Contact Method (Mark two): ☐ Phone Call ☐ Text ☐ Email

---

Marital Status: ☐ Single ☐ Married ☐ Other

Date of birth: ___________________ Age: ____________ Place of Birth: ______________________________

Gender: _______________ Height: ___________ Weight: ___________ Blood Type: __________ BP: ____________

Occupation: __________________________________ Employer: ____________________________________

Guardian & Phone Number (under 18): ____

Emergency Contact: ____

Relationship: ____

Emergency Contact Phone Number: ____

Primary Insurance & ID No.: ____

Secondary Insurance & ID No.: ____

Motor Vehicle Ins., Claim No. & Date of Accident: ____

Worker Comp Ins. Claim No. & Date of Injury: ____

Primary Care Doctor & Phone No.: ____

Date & Reason of last Dr. Appointment:____

Permission to contact Primary Care Doctor (Signature) ____

How did you hear about us? ____

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Name - ______________________________

Date of Birth - ___________________________

Past Acupuncture Experience

Have you ever received professional acupuncture? ☐ Yes ☐ No

If **Yes**:

Date of last session: ________________ How often did you go?: _________________

Type of Acupuncture (if known): ____

How was your experience?: ____

____

Past Massage Experience

Have you ever received professional massage? ☐ Yes ☐ No

If **Yes**:

Date of last session: ________________ How often did you go?: _________________

Type of Massage (if known): ____

How was your experience?: ____

____

Outcome Expectations

What results do you want from you session?:____

____

____

____

____

____

____

EARTH MOON ACUPUNCTURE
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Name - ______________________________

Date of Birth - ___________________________

What brings you in today? Area(s) of Complaint(s) or Concern(s) :

____

____

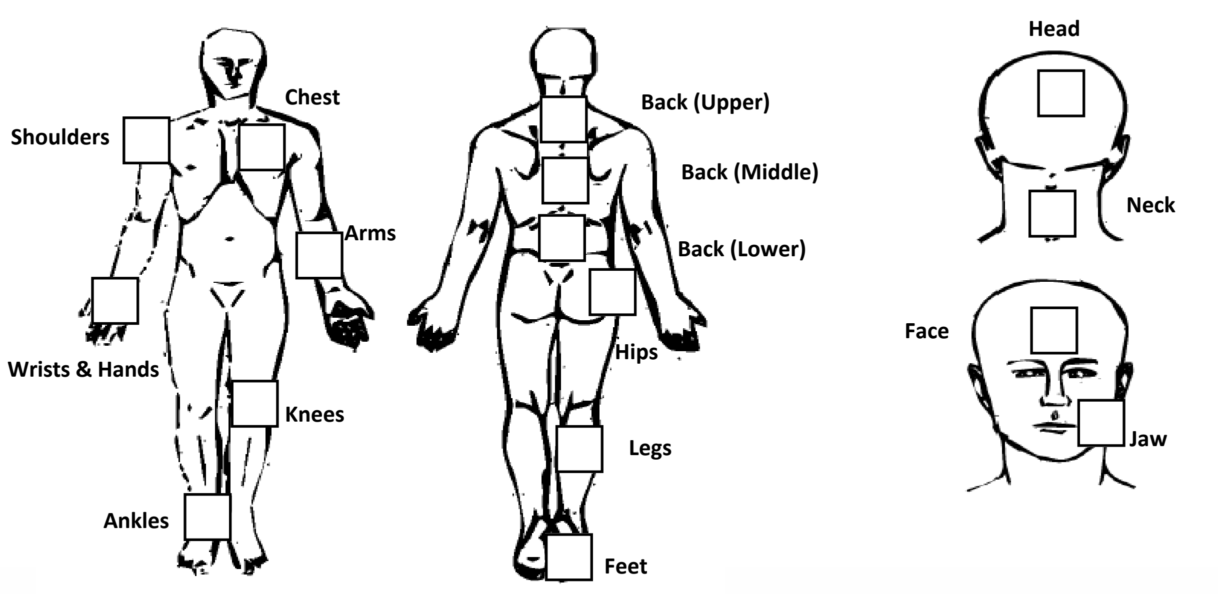
____

When did it start?: __________________________

What makes it better?:____

What makes it worse?: ____

Mark Affected Areas:



Describe the Nature of the Pain/Complaint:
(please circle/check all that apply)

Location: deep ☐ superficial ☐ local ☐ global ☐ radiating ☐

Quality: stiff ☐ achy ☐ tight ☐ spasms ☐ cramping ☐ ripping ☐

burning ☐ dull ☐ sharp ☐ numb ☐ pins &needles ☐

shooting ☐ tingling ☐ stabbing ☐ throbbing ☐

Describe How Often the Pain/Complaint Occurs
(please circle/check all that apply)

How Often:
constant ☐ periodic ☐ cyclical ☐ recurring ☐

For How Long: acute ☐ chronic ☐

When:
AM ☐ AFT ☐ PM ☐

____x per ☐ day ☐ week ☐ month

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Name - ______________________________

Date of Birth - ___________________________

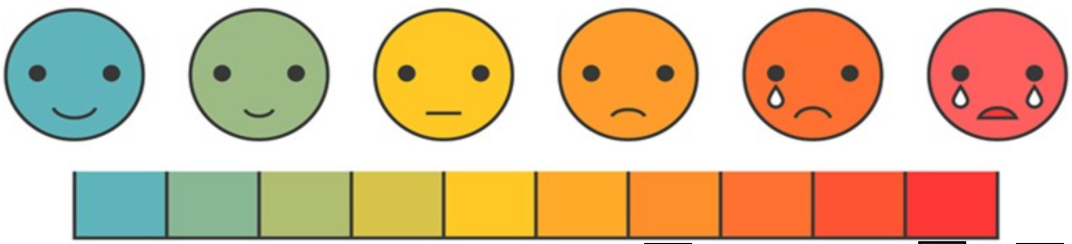
Are there any areas that need to be avoided/to be cautious around due to injury/disease? Area(s) of Caution/Contraindication

____

____

____

No Pain/ Not Affected	Mild Pain/ Mildly Affected	Moderate Pain/ Moderately Affected	Severe Pain/ Severely Affected	Very Severe Pain/ Very Severely Affected	Worst Pain Imaginable/ Extremely Affected



0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Please write in your pain scale/degree of activity affected, 1=low, 10=high or 0% = low, 100% = high

General Pain __________________ Walking Affected ______________ Traveling Affected ______________

Sleep Affected _________________ Sitting Affected ________________ Social Life Affected ______________

Lifting Affected ________________ Standing Affected ______________ Other __________________________

Massage Areas of Consent:
Please **circle/highlight** the area(s) of your body that you give permission to receive massage:

Head Face Neck Back Arms Hands Chest Buttocks/Glutes Hips Abdomen Legs Feet Other: _______________

Wendy Childs, LAc • Serena Bordes, LAc • Michelle Denker, LAc • Bryon Leverman, LAc • Dianne Weaver, LAc • Alice Sherard, LMT # 22885 • LMT # • Suzanne Vorachek, LMT #19619

Earth-Moon Acupuncture • 2365 Grear St NE • Salem, OR 97301
Phone – 971.273.7177 • Fax – 971.273.6658

EARTH MOON ACUPUNCTURE
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Name - ______________________________

Date of Birth - ______________________________

PERSONAL HEALTH HISTORY

Health Habits – Please write in how often

☐ Caffeine: ____________ ☐ Tobacco: ____________ ☐ Drug: ______________ ☐ Alcohol: ______________
☐ Exercise: ____________ ☐ Other: ______________

Work Concerns

☐ Heavy Lifting ☐ Stress ☐ Hazardous Exposure ☐ Other: ____________

Medications/Supplements

____
____
____
____
____

Accidents, injuries, hospitalizations?

____
____
____
____
____

General Information

☐ Anorexia/Bulimia	☐ Disease: ____________	☐ Herpes/ Cold Sores	☐ Polio
☐ Cancer: ______________	☐ Fever	☐ Measles	☐ Tuberculosis
☐ Chronic Fatigue	☐ Fibromyalgia	☐ Mononucleosis	☐ Weight Gain
☐ Chicken Pox	☐ HIV/AIDS	☐ Multiple Sclerosis	☐ Weight Loss
☐ Diabetes	☐ Hepatitis: __________	☐ Mumps	☐ Other: ______________

Cardiovascular

☐ Anemia	☐ Fainting	☐ Irregular Heart Beat	☐ Swelling
☐ Chest Pain	☐ Heart Disease: _________	☐ Pacemaker	☐ Varicose Veins
☐ Bleeding Disorder	☐ High Cholesterol	☐ Palpitations	☐ Other: ______________
☐ Easily Bruised	☐ High/Low Blood Pressure	☐ Stroke	

Endocrine

☐ Thyroid Disease ☐ Overactive ☐ Underactive ☐ Other: ______________

Eyes, Ears, Nose (Head) and Throat

☐ Bitter Taste	☐ Dizziness/Vertigo	☐ Goiter	☐ TMJ
☐ Blurred Vision	☐ Double Vision	☐ Gum Problems/Bleeding	☐ Traumatic Head Injury
☐ Cataracts	☐ Dry Mouth/Nose	☐ Headaches	☐ Vision Flashes/Halos
☐ Concussion	☐ Earaches	☐ Hearing aids/poor hearing	☐ Other: ______________
☐ Cross eyed	☐ Eye/Facial Pain	☐ Itchy/Watery Eyes	☐ Ringing in ears
☐ Difficulty Swallowing	☐ Glaucoma	☐ Migraines	☐ High Pitch ☐ Low Pitch

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Name - ______________________________

Date of Birth - ______________________________

Gastrointestinal/Digestion

- [ ] Abdominal Pain
- [ ] Appetite Loss/Gain
- [ ] Appendicitis
- [ ] Bloating
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Diverticulitis
- [ ] Hernia
- [ ] Indigestion/IBS
- [ ] Nausea/Vomiting
- [ ] Rectal Pain/Itching/Bleeding
- [ ] Ulcer
- [ ] Vomiting Blood
- [ ] Other: ________________________

Genito-Urinary

- [ ] Bloody Urine
- [ ] Frequent Urination
- [ ] Painful Urination
- [ ] Incontinence
- [ ] Kidney Disease
- [ ] Other: __________________

Musculoskeletal

- [ ] Arthritis
- [ ] Bone or Joint Disease
- [ ] Broken/fractured Bone(s)
- [ ] Bursitis
- [ ] Chronic Pain
- [ ] Joint Pain
- [ ] Loss of Range of Motion
- [ ] Muscle Tension/Stiffness
- [ ] Muscle Spasm(s)/Cramp(s)
- [ ] Numbness/Tingling
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Sprain/Strain
- [ ] Tendonitis/Tenosynovitis
- [ ] Other: ___________________________

Neuro-Psychological

- [ ] Addiction: ______________
- [ ] Chemical Dependency
- [ ] Depression / Anxiety
- [ ] Epilepsy
- [ ] Numbness
- [ ] Poor Memory
- [ ] Psychiatric Care
- [ ] Suicide Attempt
- [ ] Other - ________________

Reproductive

- [ ] Abnormal PAP
- [ ] Breast lump
- [ ] Cysts
- [ ] Endometriosis
- [ ] Erectile dysfunction
- [ ] Genital discharge/burning/ itching
- [ ] Genital sores
- [ ] Hot flashes
- [ ] Lump in testicles
- [ ] Menopause
- [ ] Nipple discharge
- [ ] Prostate Disorders
- [ ] STI: _________________

Date Of Last Mammogram: ______________________

Date of Last PAP: ______________________

Date of Last Prostate Exam: ______________________

Pregnancies: __________

Currently Pregnant? [ ] Yes [ ] No

Miscarriages: __________

Children: ______________

- [ ] Other: _________________________

Respiratory

- [ ] Asthma/Wheezing
- [ ] Allergies: ____
- [ ] Bronchitis
- [ ] Cough
- [ ] Emphysema
- [ ] COPD
- [ ] Other: _______________

Skin and Hair

- [ ] Acne
- [ ] Athletes Foot
- [ ] Changes in mole(s)
- [ ] Chills
- [ ] Hives
- [ ] Heavy Sweating
- [ ] Itchy/dry Skin
- [ ] Psoriasis/Rashes
- [ ] Scars
- [ ] Sore(s) that won't heal
- [ ] Wart(s)
- [ ] Other: __________________

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

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 healthcare needs.

24-hour Cancellation Policy: Missed appointments, including No-Shows/No-Calls and cancellations without 24-hour prior notification, prevent 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 us at 971-273-7177 or email the office at info.earthmoon@gmail.com 24 hours in advance if you are unable to show up for your appointment. This time will be reallocated to someone who is in need of treatment. **Failure to do so will result in a $50 charge, being required to call in and schedule for day-of appointment availability only, or, if problem persists, dismissal from Earth-Moon Acupuncture. This charge is <u>not</u> covered by your insurance company.**

Late Arrival Policy: Arriving more than <u>10 minutes late will result in the need to reschedule your appointment</u> or a <u>reduction of the allotted time</u> for your services.

Insurance Policy

Copayments, Coinsurance and Deductibles: A ***Copayment*** *(or* ***Copay***) is a fixed amount for a covered service that is paid by the patient each time a medical service is accessed and is due at the time of service. ***Coinsurance*** is the patient responsibility amount for any billed service. It is a percentage of what is owed for the appointment and is due at the time of service. A ***Deductible*** is a specified amount of money a patient must pay before insurance will cover a claim. It must be paid as contracted with your insurance company. **PAYMENTS ARE DUE AT TIME OF SERVICE.**

PLEASE NOTE

Your insurance will be billed for the covered services performed. All copayments and coinsurances are due at the time of service. However, it may be the case that **<u>you could owe more than what has already been paid</u>.** Insurances can take between **<u>45-60 days to process a claim</u>.** After a claim has been processed, it is possible **YOU MAY OWE MORE** than what was paid at time of service. **All Balances Will Be Billed To You. <u>YOU ARE RESPONSIBLE for any balance not paid for by your insurance.</u>**

THE FINAL BALANCE DETERMINED BY YOUR INSURANCE WILL BE COLLECTED. WE ARE CONTRACTUALLY OBLIGATED TO COLLECT WHAT IS REFLECTED ON THE EOB from your insurance plan.

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 Plans: 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.

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Self-Pay Policy

For those who do not have insurance, whose insurance does not cover either acupuncture or massage, or for those who prefer to pay in full at the time of service, Earth-Moon offers discounted Self-Pay rates and packages.

Acupuncture Self-Pay & Package Information: Acupuncture treatment packages for those without Acupuncture Insurance Coverage or for those to choose to Self-Pay at time of service
(*Self-pay and package prices are subject to change without notice*)

Acupuncture Prices
Initial Consult w/ Treatment: **$199**
Reassessment w/ Treatment: **$156**
Follow-Up Treatment: **$99**

Acupuncture Package Prices
3-Pack of Acupuncture Treatments: **$293**
6-Pack of Acupuncture Treatments: **$579**
9-Pack of Acupuncture Treatments: **$856**
12-Pack of Acupuncture Treatments: **$1,125**

Cupping Add-On:
15 Min Add-On: **$26**
30 Min Add-On**: $48**

Cupping Insurance Policy
Based on each insurance benefit plan or type, cupping therapy may be a combined benefit with physical therapy, and count towards your physical therapy benefit limit. By agreeing to receive cupping as part of your treatment, you are agreeing for us to bill your insurance company for these services.

Massage Self-Pay & Package Information: Massage treatment packages for those without Massage Insurance Coverage or for those to choose to Self-Pay at time of service
(*Self-pay and package prices are subject to change without notice*)

Massage Prices
60-Minute Massage: **$96**
90 Minute Massage: **$133**

Massage Package Prices

3-Pack
60-Min Massages: **$271**
90-Min Massages: **$386**

6-Pack
60-Min Massages: **$533**
90-Min Massages: **$759**

9-Pack
60-Min Massages: **$773**
90-Min Massages: **$1099**

12-Pack
60-Min Massages: **$995**
90-Min Massages: **$1412**

Chair Massage Prices
15-Min Chair Massage: **$30**
30-Min Chair Massage: **$60**

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

Print:____ Date: ______________

Signature: ____

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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: 1) that Protected Health Information may be disclosed or used for treatment, payment, or health care operations; 2) that the Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice; 3) that the Practice reserves the right to change the Notice of Privacy Practices; 4) that the patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions; 5) that the patient may revoke this Consent in writing at any time and all future disclosures will then cease; 6) that 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: ____________________

EARTH-MOON ACUPUNCTURE & WELLNESS

ACUPUNCTURE/MASSAGE INFORMED CONSENT TO TREAT

Wendy Childs, L.Ac. • Serena Bordes, L.Ac. • Michelle Denker, L.Ac., • Bryon Leverman, L.Ac. • Dianne Weaver, L.Ac.,
Alice Sherard LMT #22885 • LMT #00000 • Suzanne Vorachek, LMT #19619
2365 Grear St NE Salem, OR 97301 Phone: 971-273-7177 Fax: 971-273-6658

Acupuncture

I hereby request and consent to the performance, treatments, and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for, the acupuncturist, including all those working at the clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling site that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name - ______________________________ DOB- ______________________________

Patient Signature - ______________________________ Date - ______________________________

Massage

It is my choice to receive massage therapy which may include the use of hot stones and/or cupping, and I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Patient Name - ______________________________ DOB- ______________________________

Patient Signature - ______________________________ Date - ______________________________