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? _____

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?:_____

_____

_____

_____

_____

_____

_____

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Name - _____

Date of Birth - _____

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

_____

_____

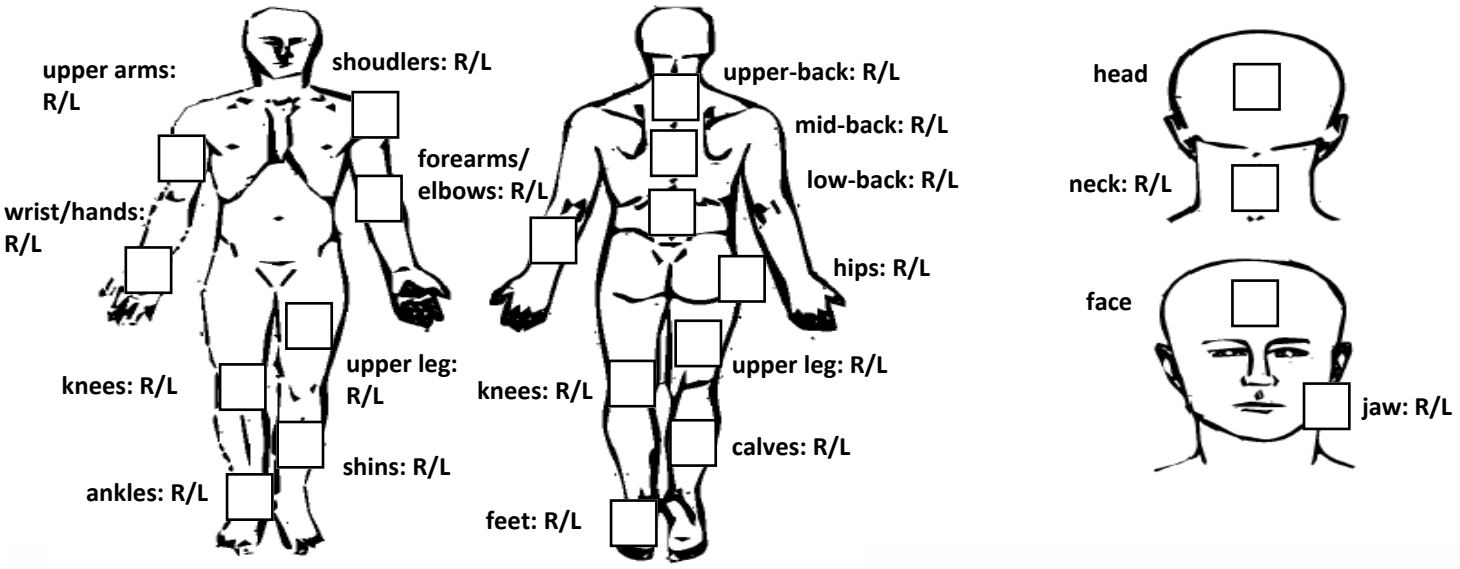
_____

When did it start?: _____

What makes it better?:_____

What makes it worse?: _____

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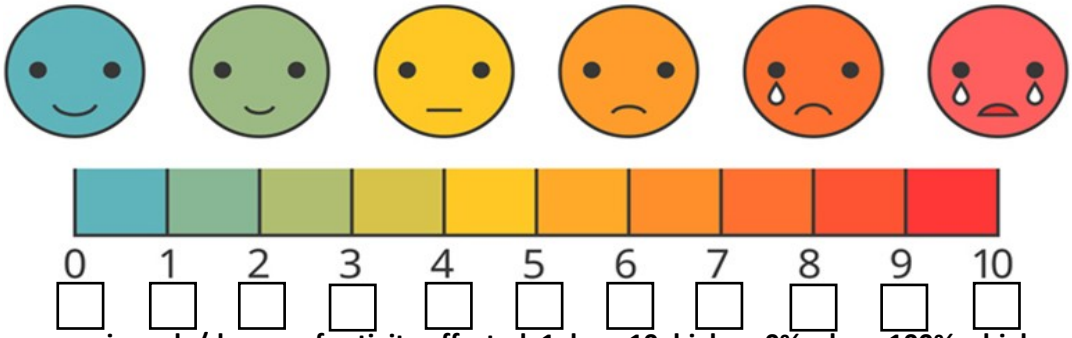
Are there any areas that need to be avoided/to be cautious around due to injury/disease? Area(s) of Caution/Contraindication

_____

_____

_____

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 ☐



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 **check** 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: _____

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

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

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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: _____

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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 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 (which is NOT be covered by insurance), being required to call in and schedule for day-of appointments only, or, if problem persists, dismissal from Earth-Moon Acupuncture.**

Late Arrival Policy: Arriving more than 10 minutes late will result in the need to reschedule your appointment or a reduction of the allotted time 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 **you could owe more than what has already been paid.** Insurances can take between **45-60 days to process a claim.** 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. YOU ARE RESPONSIBLE for any balance not paid for by your insurance.**

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: _____

Updated 9/5/24

EARTH MOON ACUPUNCTURE

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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.,
Alyssia Silagyi LMT #28237 • Dustin Talbott LMT #16301 • 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 - _____