Acupuncture ~ Health History

Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ Date of last physical exam: _____

What is your primary reason for this visit? _____

SYMPTOMS: place a check mark by all symptoms you have today, or have had in the last year.

GENERAL

__Chills
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Sleeplessness
__Weight loss
__Nervousness
__Numbness
__Sweating

MUSCLE/JOINT/BONE
Pain/Weak/Numb in:
__Neck __Shoulders
__Arms __Hands
__Back __Hips
__Legs __Knees
__Feet __Other

GENITO-URINARY
__Blood in urine
pregnant? _____
__Frequent urination
__Bladder control
__Painful urination

GASTROINTESTINAL

__Poor appetite
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Excessive hunger
__Excessive thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal bleeding
__Stomach pain
__Vomiting
__Vomiting blood

CARDIOVASCULAR
__Chest pain
__High blood pressure
__Irregular heart beat
__Low blood pressure
__Poor circulation
__Rapid heartbeat
__Swollen ankles
__Varicose veins

EYE/EAR/NOSE/THROAT

__Bleeding gums
__Blurred vision
__Crossed eyes
__Difficulty swallowing
__Double vision
__Earache
__Ear discharge
__Hay fever
__Hoarseness
__Hearing loss
__Nose bleeds
__Persistent cough
__Ringing in ears
__Sinus problems
__Visual flashes of light
__Visual halos

SKIN
__Bruise easily
__Hives
__Itching
__Change in moles
__Rash
__Scars
__Sores that won't heal

MEN ONLY

__Breast lump
__Erection difficulties
__Lump in testicles
__Penis discharge
__Sore on penis
__Other _____

WOMEN ONLY
__Abnormal pap smear
__Bleeding between periods
__Breast lump
__Extreme menstrual pain
__Hot flashes
__Nipple discharge
__Painful intercourse
__Vaginal discharge
__Other _____
Date of last menstrual period
_____
Date of last pap smear
_____
Date of last mammogram
_____
Are you

Number of children _____

CONDITIONS: place a check mark next to all conditions you have now or have had in the past

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding disorder
__Breast lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV positive
__Kidney disease
__Liver disease
__Measles
__Migraine headache
__Miscarriage
__Mononucleosis
__Multiple sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate problems
__Psychiatric care
__Rheumatic fever
__Scarlet fever
__Stroke
__Suicide attempt
__Thyroid problems
__Tonsillitis
__Tuberculosis
__Typhoid fever
__Ulcers
__Vaginal infections
__Venereal disease

MEDICATIONS AND ALLERGIES: list all below or attach a separate list

Current Medications:

Allergies:

FAMILY HISTORY: Fill in health information about family members related by blood line

Relation	Age	Healthy?	Age at Death	Cause of Death	Check each condition a relative has experienced:	
					Disease	Relationship to you
Father					Arthritis/Gout	
Mother					Asthma/Hay fever	
Brothers					Cancer	
					Chemical dependence	
					Diabetes	
					Heart disease/Stroke	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS:

Year	Hospital	Reason for treatment and outcome	Pregnancy History: Year	Gender	Complications

Have you ever had a blood transfusion? __No __Yes (if yes, please provide approximate dates)

Serious Illness/Injury	Date	Outcome

HEALTH HABITS: place a check mark next to any that apply and describe how much you use

__Caffeine _____ __Tobacco

_____

__Street drugs _____ __Other

_____

OCCUPATIONAL CONCERNS: place a check mark if you are exposed to the following

__ Stress __Hazardous materials/waste __Heavy lifting __Other

What is your occupation?

_____

_____ _____

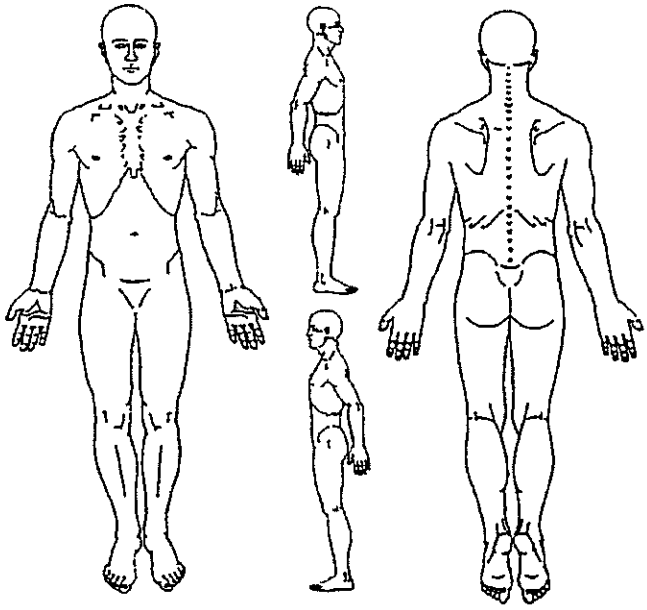
Signature of Patient Date

If you are having pain, please describe the date and the event or events which led to your present pain:

Date		Description
_____	Accident	_____
_____	Injury	_____
_____	Following surgery	_____
_____	Cancer	_____
_____	Other disease	_____
_____	No obvious cause	_____

Using the figure provided, please indicate the location and type of pain you experience:

AAA = Ache NNN = Numb OOO = Pins/Needles XXX = burning /// = stabbing



What makes your pain better?

What makes your pain worse?

Does the pain interrupt your sleep?

Applied Pain Institute LLC
1015 S. Mercer Avenue
Bloomington, IL 61701

Patient Registration Information:

Patient Name: _____ Date: _____

Address:

_____

City: _____ State/Zip: _____

Birth date: _____ Age: _____ Gender: M F (circle)

Married _____ Single _____ Widowed _____

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

NOTICE REGARDING INSURANCE COVERAGE FOR ACUPUNCTURE

Effective January 1, 2011

Payment is due in full at the time of service.

In order for our billing staff to submit your claim to insurance, you must contact your insurance company to request a statement of coverage specific to the conditions for which you receive acupuncture.

If your policy does not cover acupuncture for your condition, we cannot submit your bills.

If we are not in network with your insurance, regardless of whether acupuncture is covered, we cannot submit your bills. Any discounts or write-offs are the patient's expense in out of network scenarios.

If you have a Medical Expense Reimbursement plan, please pay *BEFORE* your treatment and we will have a paid receipt ready for you when your treatment is complete.

If you have a CIGNA plan that allows acupuncture you are responsible for having your primary care obtain preauthorization for your treatment. If your primary has question he or she is welcome to call for information, but we cannot act on his or her behalf.

Billing Exceptions:

- Blue Cross Blue Shield – due to contractual obligations
- Worker's Compensation – due to required pre-authorizations
- Medicare as primary insurance ONLY when the denial is needed for secondary insurance to pay.

Primary Insurance:

Insured's Name:

_____

(last) (first) (middle initial)

Relationship to patient _____ Insured's Birth date:

_____

Address (if different from patient):

_____(phone)_____

City:_____ State/Zip: _____

Insured's Employer: _____Occupation:

_____

Business Address:

_____(Phone)_____

Insurance Company:

_____

Secondary Insurance:

Insured's Name:

_____

(last) (first) (middle initial)

Relationship to Patient: _____(Birth date)_____

Address (if different from patient)

_____

City: _____ State/Zip: _____

Insured's Employer: _____Occupation:

_____

Business Address:

_____(Phone)_____

Insurance Company:

_____

Please provide your photo identification.

We will only need copies of your insurance cards if you qualify for insurance billing (see above).

Worker's Compensation:

Please ask the front desk staff for our Worker's Compensation form. Complete all sections.

You must provide all claim information before being seen.

We must receive written authorization before providing treatment. We may require your help or the help of your attorney to obtain this authorization.

Auto Accidents and Personal Liability Claims:

All Auto Accident and Personal Liability Claims are subject to Lien for Payment.

You must provide all claim information before being seen.

Date of accident/injury _____

Select type of claim:

___ Non-auto (personal liability) claim ___ Auto (At-Fault Driver) ___ Auto (Other driver At-Fault)

For Auto Claims:

Your Auto Insurance Company _____

Your Claim number _____

Name of Your Insurance Company's Claim Adjustor_____

Other Driver's Name _____

Other Driver's Auto Insurance Company_____

Name of Other Driver's Claim Adjustor_____

Name of Attorney _____ Attorney ph # _____

For Non-auto Claims:

Name of Insurance Company _____

Name/ph # of Responsible Party _____

Name of Attorney _____ Attorney ph # _____

For all Worker's Compensation, Auto Accident and Personal Liability Claims:

You are required to provide:

1. Regular (commercial, group or individual) health insurance cards
2. photo identification

Applied Pain Institute, LLC
1015 S. Mercer Avenue
Bloomington, IL 61701

Financial Agreement / Assignment of Benefits / Release of Records

Forms: There is a $25.00 fee for completing each of the following forms This fee is due when the form is submitted – forms are not completed until payment is received.

Disability Insurance ~ Leave of Absence ~ Family Medical Leave Act (FMLA)

This office does not complete Certification for Permanent Disability or Financial Hardship forms. Please direct these forms to your primary care physician.

Late Cancellation/Missed Appointments: Because late cancellations and missed appointments impact everyone a $25.00 fee will be charged for appointments that are missed without 24 hours notice. This fee cannot be billed to insurance and therefore, is the responsibility of the patient. This fee is subject to collections if not paid within 60 days.

Non-sufficient funds/Returned Checks: Checks returned for insufficient funds will result in a $25.00 service fee in addition to the original billed amount. Please make payment arrangements with our billing staff to prevent incurring additional fees.

Collections and Interest Owed: If your outstanding balance is more than you can afford within the first 60 days please make payment arrangements with our billing staff before you incur additional fees and interest owed, as well as risking damage to your credit record. A Collections Fee of $100 will be added to any account turned over.

Every effort is made to bill insurance accurately and in accordance with insurance timely filing rules; however, it is ultimately the patient's responsibility to pay for services rendered. Additionally, it is the patient's responsibility to notify this office of any change in insurance coverage. I understand that this office bills for reimbursement from my insurer or other third party payer as a courtesy. Failure on the part of the insurer to make payment shall not relieve me of my obligation to pay for services rendered. Once insurance makes a determination, all outstanding balances are patient responsibility to the extent allowed by law and by contractual agreements with the insuring entity. This balance is due within 60 days. Account balances that are 60 days past due may bear interest on the unpaid amount up to the maximum allowed by law and will be sent to collections. Collection fees and attorney fees are in addition to the outstanding balance and are the responsibility of the patient. I hereby waive all claims of exemption. Should the account be referred to an attorney, I shall pay reasonable attorney and associated collection expenses regardless of whether suit is filed.

Insurance Assignment of Benefits and Release of Medical Information: I assign all insurance benefits (Medicare, Medicaid, group or private commercial insurance, Worker's Compensation) to be paid directly to Applied Pain Institute, LLC for services rendered. A photocopy of this agreement shall be valid as the original.

I authorize the use of my signature below for all insurance submissions. I authorize Applied Pain Institute, LLC (physicians, staff, other HIPAA authorized agents) to disclose my protected health information (medical and financial records) for the purposes of determining insurance benefit eligibility and preauthorization/ predetermination, obtaining benefit payment, and/or discussing disputed payments related to services rendered. I further agree to allow my protected health information to be released to (a) any affiliate and its employees and agents for continuation of care; (b) any person or entity responsible for all or part of continuation of care rendered at a hospital or ambulatory surgical center; (c) any person or entity to whom I have been referred for continuing care; (d) any physician treating, consulting, or otherwise performing services for me, including his or her employees or agents; (e) the Health Care Financing Administration, any government or accrediting agency, or their agents or employees.

I understand I am financially responsible for all charges regardless of insurance payment (co-pay, deductible, excluded for any reason, or otherwise denied to the extent not expressly prohibited by law or by the contract between the provider and my third party payer).

Your signature below indicates that you have read and understand these policies.

Signature of patient/authorized representative Date

FINANCIAL AGREEMENT – READ BEFORE SIGNING

Applied Pain Institute, LLC
1015 S Mercer Avenue
Bloomington, IL 61701

Phone: 309-662-0088 Fax: 309-662-0089

2020 HIPAA Acknowledgement and Message Permission

I acknowledge I have been offered a copy of the HIPPA Privacy Notice from Applied Pain Institute, LLC.

I understand my personal health information may be exchanged between Applied Pain Institute, LLC and my primary care physician, as well as other physicians involved in my care, and insurance companies involved in payments for my care for the full calendar year. I understand I may stop the release of my information at any time by notifying Applied Pain Institute, LLC in writing as outlined in the Notice of Privacy Practice.

Our staff will attempt to speak directly with you about your healthcare needs; however, if we are unable to reach you, your signature below indicates you understand and agree that we may leave a general voice message for you at the phone numbers which you have provided to us. Additionally, with your signed permission below, we may communicate with your family members or other designated persons about your appointments and your health care issues.

Initial here to grant permission for messages: Yes _____ No _____

Initial here to grant permission for communication with others: Yes _____ No _____

Please list the contact information for any designated persons

Name	Relationship	Phone number
Name	Relationship	Phone number

Print name of patient/authorized representative Date of Birth

Signature of patient/authorized representative Date

If Personal Representative's signature appears above for either of these designations, please indicate relationship to patient and provide a copy of legal authority to act on patient's behalf.

Relationship (POAH, Guardian, Custodian, etc.)

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Bloomington, IL 61701

Phone: 309-662-0088

Fax: 309-662-0089

Self-Referral Information

Effective August 23, 2004, a law (SB 2254) was signed into effect modifying the *Acupuncture Practice Act*. The law states a physician's referral is no longer necessary in order to receive acupuncture treatment. This law can be found in *Public Act 93-999*.

Acupuncture is an alternative treatment that should be used in conjunction with the care, diagnosis, and treatment of a primary care physician or specialist. As a self-referring patient you are responsible for seeking and maintaining proper care from a primary care physician.

If at any time Jiong Gu, licensed acupuncturist feels it is necessary for you to see your primary care physician or a specialist he will advise you. At his discretion, he may choose to discontinue treatment until you have sought the recommended care and have been advised to resume acupuncture.

Your signature below indicates you have read and understand the above information.

_____

Print name of patient/authorized representative

_____ _____

Signature of patient/authorized representative Date

If Personal Representative's signature appears above, please indicate relationship to patient and provide a copy of legal authority to act on patient's behalf.

_____

Relationship (POAH, Guardian, Custodian, etc.)