Juliet Kim Acupuncture, PLLC
110 Bedford Ave, Bellmore, NY 11710
Juliet Kim, L.Ac, MSTOM, Dipl. OM

Please complete as accurately as possible. All answers will be held strictly confidential in accordance with our Privacy Policy.

CONTACT INFORMATION

Name: ____ Date: _______________

Street Address: _________________________ City: ____________ State:____ Zip Code:_______

Cell Phone: ____________ Home Phone: ______________ Email Address: ______________

How would you like your appointment reminders? Please circle all that apply: Email / Call / Text

How did you hear about us? Google search / Yelp / Friend / Physician /other: ______________

Primary Health Care Provider/MD Physician:____

Physician Office #: ______________________________

Emergency Information. Please indicate who to notify in case of an emergency.

Name: _____________________________ Relationship:_____________________________

Phone (Home):________________________ Phone (Work/Cell):_________________________

PERSONAL INFORMATION

Date of Birth: _______________ Age:______ Weight:_________ Height:_____ Gender: Female | Male

Marital Status (Please Circle One): Single | Partnered | Married | Divorced | Widowed

Occupation: __________________________________ Please Circle One: Full Time | Part Time

Are you currently under another health care professional's supervision for your current condition? YES | NO

Have you tried acupuncture before? If "YES", when? __________________________________

INSURANCE INFORMATION

Insurance ______________________ ID# _______________ Group# __________________

Address ____________________________________ Phone ____________________

Are you the policy holder? Y / N If not, policy holder's name: _____________________________

Policy holder's date of birth(mm/dd/yyyy):_____________________________

Assignment of Benefits for Insurance: I understand that I am responsible for payment of services rendered and also responsible for paying any co-insurance, co-payment, and deductibles that my insurance does not cover. I authorize payment of benefits to be made directly to this healthcare provider. I also authorize the release of any information, including diagnosis and records of treatment, requested to process this claim.

____

Patient Name (print) Patient Signature Date

Medical History

What is the reason for your visit? Please indicate how long and how frequently you've had the condition(s).

____

What caused this? (accident, lifestyle, drug, unknown, etc.)______________________________

Describe the condition at its worst:______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Have you been given a diagnosis for the problem by a physician? If so, what is it?______________________________

____

What kinds of treatment or therapy have you tried?______________________________

____

List any past or future surgeries:______________________________

List any significant trauma (e.g. auto accident, falls, emotional, sexual, etc) & when it occurred:______________________

____

Are you pregnant? Yes / No　　　　Do you have a pacemaker? Yes / No

Do you have any allergies? (Yes / No) If so, to what?______________________________

Do you take medication? (Yes / No) If so, what types and how often?______________________________

Do you take supplements? (Yes / No) If so, what types and how often? ______________________________

Please indicate if you or any family members have or had any of the following conditions:

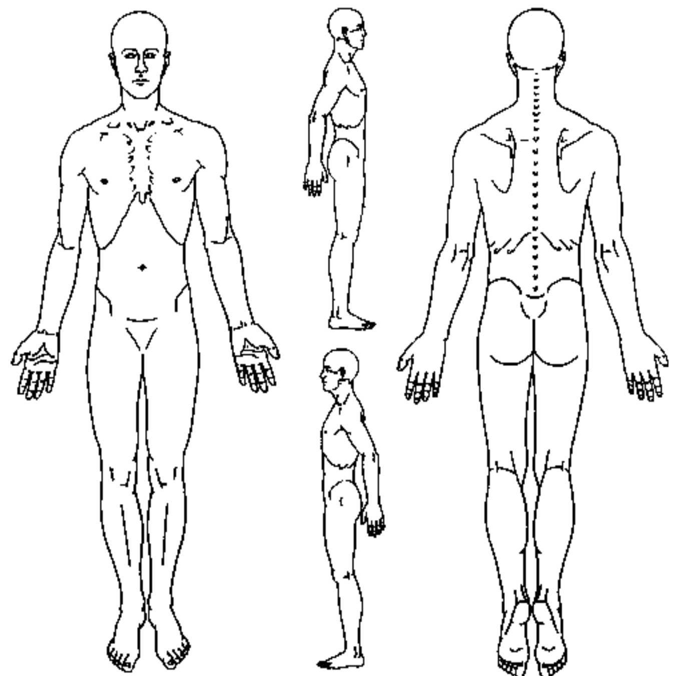
__Pneumonia	__Heart Attack	__Measles	__Gout	__Bone Fracture
__Tuberculosis	__Blood Transfusion	__Mumps	__Mental Illness	__Acute Abdominal Pain
__Hepatitis	__Anemia	__Syphilis	__High/Low BP	__Neurological Changes
__Seizure	__Arthritis	__HIV/AIDS	__Heart Disease	__Hemorrhagic Disorder
__Epilepsy	__Obesity	__Hyperthyroid	__Cancer	__Acute Respiratory Issue
__Kidney Stone	__Jaundice	__Hypothyroid	__Diabetes	__Systemic Infections

Do you exercise regularly? If so, how? ______________________________

Do you sleep well? Yes / No　　How many hours on average per day? ________　　Do you dream? Yes / No

Pain Profile

Please indicate on the diagrams the area where you experience your pain.



How would you characterize your pain (check all that apply):

__sharp	__dull	__fixed
__stabbing	__numbness	__moving
__burning	__achy	__constant
__tingling		__intermittent

Frequency of pain:

__25% of time	__50% of time	__75% of time
__100% of time		

Pain intensity level (circle, 0= no pain; 10=excruciating pain):

0　1　2　3　4　5　6　7　8　9　10

The pain is (check all that apply):

__better / worse with heat	__better / worse with rest
__better / worse with cold	__worse in AM / PM
__better / worse with movement	__better / worse with pressure

Signs and Symptoms

Spleen Function
__weight gain
__weight loss
__low appetite
__abdominal bloating
__gas
__abdominal gurgling
__fatigue after meals
__bruise easily
__hemorrhoids
__previous organ prolapse
__over-thinking
__worry

Stomach Function
__large appetite
__mouth/canker sores
__bad breath
__bleeding gums
__heartburn
__hiccups
__stomach pain / reflux
__vomiting

Energy (Kidney/Lung)
__shortness of breath
__general weakness/fatigue
__get sick easily

Other
__frequent headaches
__easily hot
__easily cold

Heart Function
__chest pain
__palpitations
__anxiety
__restlessness
__frequent dreams
__insomnia
__sores on tip of tongue

Liver Function
__anger
__depression
__irritability
__alternating diarrhea / constipation
__lump in throat
__chest tightness
__bitter taste in mouth
__numbness
__tingling
__muscle spasms or cramps
__seizures
__dizziness/vertigo
__ringing in ears (high pitch)
__itchy eyes
__bloodshot eyes
__dry eyes
__watery eyes
__floaters in vision
__poor night vision
__itching/swelling in genitalia
__brittle nails

Kidney Function
__cold hands / feet
__sweaty hands / feet
__afternoon flushes
__night sweats
__hot flashes
__want to close eyes during day
__sore knees
__weak knees
__low back pain
__poor memory
__frequent cavities
__frequent broken bones
__wake at night to urinate
__ringing in ears (low pitch)
__hair loss
__fear

Lung Function
__cough
__nose bleed
__nasal mucous
__sinus congestion
__dry nose
__alternating fever and chills
__spontaneous sweating
__dry throat
__sore throat
__dry skin
__grief

Dampness
__heavy feeling of head
__heavy feeling of body
__mental fogginess
__swollen joints
__congestion
__nausea
__snoring

Urination
__normal color
__dark yellow
__very light yellow
__cloudy
__bloody
__burning
__painful
__strong odor
__frequent
__dribbling
__incontinence

Bowel movements
__regular (1+/day)
__constipation
__diarrhea
__loose/watery
__incomplete
__bloody
__strong odor

For Women

__Menopausal (If yes, please answer questions below about your past period history.)
Is your cycle regular? Yes / No
Number of pregnancies:_____
Number of live births:____
Do you experience PMS? Yes / No
If yes, please list symptoms:____
____

Is bleeding: __heavy __light __moderate __bright red __dark red __light red __clotted
Do you experience cramping? Yes / No If yes, is cramping worse __ *befor*e or __*during menstruation*

__endometriosis __PCOS __frequent UTI/yeast infections __changes in libido

For Men

Please check any that pertain to you:

__incontinence __impotence __prostate problems

__changes in libido __premature ejaculation __testicular pain

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INFORMED CONSENT AND PRIVACY POLICY

I (or the patient named below, for whom I am legally responsible) hereby request and consent to the performance of Traditional Chinese Medicine treatments including acupuncture and other procedures on me by Juliet Kim, L.Ac, MSTOM, Dipl. OM, associated with Juliet Kim Acupuncture, PLLC. I understand that Traditional Chinese Medicine treatments may include, but are not limited to, acupuncture, electrical stimulation, moxabustion, cupping, Tui-na, Gua Sha, Chinese herbal medicine, and lifestyle/nutritional counseling.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, pain, numbness at the needle site, dizziness or fainting. I understand that I should be well-hydrated and have eaten something before a treatment to minimize the risk of dizziness or fainting. I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burns or scarring. 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, mineral, and animal sources) that have been recommended are traditionally considered safe when practiced by professional practitioners of Oriental Medicine, although some may be toxic in large doses. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that some herbs are inappropriate during pregnancy and along with other herbs or prescription medication. **I will notify the acupuncturist that is caring for me if I am or suspect that I am pregnant**. I will also notify the acupuncturist what drugs (medicinal or recreational) and supplements I take and if there is any change in them.

I do not expect Juliet Kim Acupuncture PLLC and their affiliates to be able to anticipate and explain all possible risks and complications of all modalities, and I wish to rely on Juliet Kim Acupuncture PLLC and their affiliates to exercise judgment during the course of my visits which she thinks, based upon the facts then known is best in my interest. I also understand that results are not guaranteed.

I understand Juliet Kim Acupuncture PLLC's clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent, in full compliance of HIPAA regulations. I also understand Juliet Kim Acupuncture PLLC will from time to time send me information via mail or e-mail including but not limited to receipts, newsletters and office announcements, but that my name and contact information will never be released to any other business or organization. I understand that I may receive a print copy of this INFORMED CONSENT AND PRIVACY POLICY upon request.

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 benefits and risks of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of my treatments for my present condition and for any future condition(s) during my visits to Juliet Kim Acupuncture PLLC. I also understand NY state Law required my acupuncturist to advise me of the importance of consulting a licensed physician regarding my condition.

Patient:____
(or patient representative) Print Signature Date

Relation to patient if not self:____

Office Signature:____ Date:____________

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Authorization to Release Information & Assignment of Benefits

I authorize the release of any information requested to process health insurance claims. I authorize payment to be made directly to Juliet Kim Acupuncture PLLC and their affiliates I understand I am responsible for charges not covered by this assignment.

Patient:____
(or patient representative) Print Signature Date

Payment Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality care. We have developed this payment policy because some of our patients have had questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in some insurance plans. Payment in full is expected at each visit if you are not insured by a plan with which we do business. If you are insured by a plan with which we do business but don't have an up-to-date insurance card, then payment in full for each visit is required until we can verify your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. Non-covered services. Please be aware that some or all of the services you receive might not be covered or not considered reasonable or necessary. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the acupuncturist. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. This is done for your protection. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

____
Signature of patient or responsible party Date

HIPPA

Notice Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

· Limited access to facilities where information is stored.
· Policies and procedures for handling information.
· Requirements for third parties to contractually comply with privacy laws.
· All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

· From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
· From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Juliet Kim Acupuncture, PLLC maintain my records confidentially in accordance with the law. I agree to inform Juliet Kim Acupuncture, PLLC if I need any special arrangements pertaining to this issue.

Signature:	**Date:**
Print Name:	