ShoshanaSadow
ACUPUNCTURE FOR PAIN FREE HEALTH

Shoshana Sadow M.Ac., L.Ac., Dipl.Ac.
Acupuncture Sports Medicine & Orthopedics
Licensed Acupuncturist / Alaska + Arizona

(907) 399-5655
info@ShoshanaSadow.com
ShoshanaSadow.com

Patient Intake

NAME	**EMAIL**	**DATE OF BIRTH**

MAILING ADDRESS	City	State	Zip

PHONE Home	**PHONE** Business	**PHONE** Cell

EMERGENCY Contact Name	**EMERGENCY** Contact Phone

PRIMARY PHYSICIAN	**REFERRED BY**

Primary Reason(s) for Your Visit

DATE OF ONSET	**CONDITION / INJURY / PAINFUL AREA**	**LEFT/RIGHT** Or both

Check all that apply to your symptoms:

☐ Work Related Injury ☐ Recurrence of Previous Injury ☐ Motor Vehicle Accident

☐ Injury Related to Lifting ☐ Athletic or Recreational Injury ☐ Cause Unknown

☐ Other (describe)

Please list all accidents or injuries starting with the most recent.

DATE	ACCIDENT, INJURY OR TRAUMA

Please list all hospitalizations, surgeries or serious illness starting with the most recent.

DATE	SURGERY OR SERIOUS ILLNESS

What other therapies have you tried for pain?

DATE	TREATMENT

What evaluations, scans or blood tests have been done? (X-Rays, MRI's, CT Scans, etc.)

DATE	TREATMENT

Please describe your pain.

How would you describe your pain?	
What increases your pain?	**What relieves your pain?**
Does your pain occur with certain movements or positions? Please explain.	
Do you have limited range of motion or loss of function? Please explain.	
Does your pain have associated symptoms such as numbness, tingling, swelling or weakness? Please explain.	
Is the pain worse at night or in the morning?	**Is your pain better or worse at rest?**
Does your pain improve with stretching or movement?	**Is your pain worse or better while sitting, standing or walking?**
Does your pain change with the weather?	**Does your pain have chronic and acute cycles?**
Do you do repetitive strain activities at work or leisure? Please explain.	**Does the pain limit your activities?** Please explain.
Do you have metal implants or prosthesis? If yes, please explain.	
Do you have osteoarthritis, osteoporosis, fibromyalgia or other systemic musculoskeletal disorder?	

What is the intensity of your pain on a scale of 1 to 10? (0 being no pain and 10 being the worst.)

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

What medications are you taking?

DATE	MEDICATIONS

What supplements/herbs are you taking?

DATE	SUPPLEMENTS/HERBS

Do you have any of the following conditions? (Please put an X in the appropriate box.)

Head, Eyes, Ears, Nose & Throat

- ☐ Headache
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Blurry Vision
- ☐ Sinus Problems
- ☐ Seasonal Allergies
- ☐ Nose Bleeds
- ☐ Ear Aches
- ☐ Ear Ringing
- ☐ Sore Throat
- ☐ TMJ/Teeth Grinding
- ☐ Dental Problems

Cardiovascular

- ☐ Heart Disease
- ☐ Palpitations
- ☐ Dizziness/Fainting
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Rapid Pulse
- ☐ Varicose Veins
- ☐ Swelling of Ankles
- ☐ Cold Hands/Feet
- ☐ Blood Thinner
- ☐ Pacemaker
- ☐ Stroke
- ☐ Other (Please describe.)

Respiratory

- ☐ Chronic Cough
- ☐ Frequent Respiratory Infections
- ☐ Asthma
- ☐ Rescue Inhaler
- ☐ Smoker
- ☐ Pneumonia/Bronchitis
- ☐ Airborne Allergies

Gastrointestinal

- ☐ Epigastric Pain
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Changes in Appetite
- ☐ Gas/Bloating
- ☐ Liver/Gall Bladder Problems
- ☐ Hepatitis B or C
- ☐ Abdominal Pain
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood or Mucus in Stool
- ☐ Abdominal Surgery
- ☐ Food Allergies
- ☐ Special Diet

Urinary Tract

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Frequent Infection
- ☐ Nighttime Urination
- ☐ Impaired Urination
- ☐ Kidney Stones

Hormonal/Menstrual

- ☐ Breast Lumps and/or Tenderness
- ☐ Irregular Mammogram
- ☐ Breast Cancer/Surgery
- ☐ Premenstrual Syndrome
- ☐ Irregular Cycles
- ☐ Heavy/Painful Periods
- ☐ Vaginal Infections
- ☐ Irregular PAP
- ☐ Menopausal Symptoms
- ☐ Pregnant
- ☐ History of C-Section

Males

- ☐ Prostrate Problems
- ☐ Erectile Dysfunction
- ☐ Testicular Pain

Endocrine

- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other Endocrine Disorders

Neurological System

- ☐ Poor Balance
- ☐ Dizziness/Vertigo
- ☐ Numbness
- ☐ Tingling
- ☐ Epilepsy
- ☐ Seizures

Other

- ☐ Low Energy/Fatigue
- ☐ Mood swings
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress/Tension
- ☐ Rashes/Skin Disorders
- ☐ Chronic Infections
- ☐ Sensitivity to Hot/Cold
- ☐ Chills/Fever
- ☐ Chronic Illness
- ☐ Cancer

SIGNATURE OF PATIENT	DATE

ShoshanaSadow
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Financial Information & Cancellation Policy

Shoshana Sadow M.Ac., L.Ac., Dipl.Ac.
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Please read and acknowledge your acceptance of the financial policy for acupuncture treatment.

Payment

Payment may be done with cash, check or credit card and is due at the time of service. Payment is accepted from HSA (Health Savings Accounts) and MSA (Medical Savings Accounts). There is an additional cost for any herbal medicine, nutritional supplement or adjunctive home therapy product that is prescribed.

Insurance

Many insurance companies now reimburse for acupuncture. It is important to know your coverage before coming in for your first appointment. Contact your insurance company directly to verify your specific policy benefits.

You will be provided with an itemized medical bill that can be submitted to your insurance company for reimbursement. Please come to your first appointment with your insurance card along with your completed Insurance Form for your records.

Cancellation Policy

We ask that you give at least 24 hours notice for cancellation of your scheduled appointment.
Except for emergencies, you will be billed for the missed appointment.

This policy provides guidelines that we have found applicable to the majority of our clients.
If you have any additional questions, please contact the office at (907) 399-5655.

SIGNATURE OF PATIENT	**DATE**
SIGNATURE OF AUTHORIZED PARENT/GUARDIAN	**DATE**

ShoshanaSadow
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Acupuncture & Insurance

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Many inurance companies now reimburse for acupuncture. You will be provided with an itemized medical bill that can be submitted to your insurance company for reimbursement.

It is important to know your coverage before coming to your first appointment. Contact your insurance company directly to verify benefits. Please fill out the Acupuncture & Insurance form for your records.

Contact Information

NAME OF INSURED	EMPLOYER	
PHONE	DATE OF BIRTH	MARTIAL STATUS
SEX ☐ Male ☐ Female		

Insurance Information

INSURANCE COMPANY	COMPANY PHONE #
INSURANCE PLAN #	GROUP POLICY #

SIGNATURE	DATE

Insurance Questions

Below are questions to ask your insurance company prior to acupuncture.
1. Do I need prior authorization or pre-approval for acupuncture?
2. Do I need a doctor's referral?
3. What is my annual benefit for acupuncture? (number of treatments per year or annual monetary cap)
4. Do I need to meet my deductible before receiving reimbursement for acupuncture?
5. Is there a co-pay for acupuncture?
6. What conditions are covered for acupuncture?

Payment

Payment may be done with cash, check or credit card and is due at time of service. Payment is accepted from HSA (Health Savings Accounts) and MSA (Medical Savings Accounts). There is an additional cost for any herbal medicine, nutritional supplement or adjunctive home therapy product that is prescribed.

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Consent for Acupuncture

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I, the undersigned, hereby voluntarily authorize Shoshana Sadow, M.Ac., L.Ac., Dipl.Ac. of Acupuncture Sports Medicine & Orthopedics, a licensed acupuncturist in the State of Alaska and Arizona to perform the following procedures related to my health care:

Acupuncture procedures involving the insertion of single-use sterilized acupuncture needles into specific points on the body along with adjunctive therapies in the scope of practice for licensed acupuncturists, which includes but is not limited to: acupressure, moxibustion, dermal friction technique, cupping, mechanical, thermal, electrical, and/or electromagnetic treatments, dietary guidelines, therapeutic exercises and lifestyle counseling based on Asian medical theory.

I understand that acupuncture is a safe and effective treatment, but I do recognize the potential risks regarding the procedure of acupuncture and its adjunctive therapies which are listed below, but not limited to: temporary discomfort at the site of the insertion of needles, swelling, bruising, bleeding, tingling, and/or pain. Unusual systematic responses such as nausea, fainting, dizziness or weakness can occur in rare cases. There may be a temporary aggravation of the signs and symptoms that existed before the acupuncture treatment.

I understand that if I am pregnant, have a severe bleeding disorder or a pacemaker, I must inform my practitioner before treatment.

I understand that the use of Acupuncture and Traditional Chinese Medicine does not exclude the administration of primary medical care by a licensed physician and that I am free to consult a licensed medical doctor regarding any of my health care concerns or changes in my current signs and symptoms.

I understand that the privacy of my Protected Health Information will be maintained and will be kept confidential according to the HIPAA privacy policy regulations. No records will be released without my consent. If it becomes necessary to share my health information, this will be done according to my Notice of Privacy Policies document that has been provided to me by Acupuncture Sports Medicine & Orthopedics.

With this understanding, I recognize that no guarantees of success or claims are being made as to the improvement of my presenting condition and that I am giving my consent voluntarily to the above-mentioned acupuncture procedures. I hereby release Shoshana Sadow, M.Ac., L.Ac., Dipl.Ac. of Acupuncture Sports Medicine & Orthopedics from any liability which may occur in connection with such procedures.

I understand that I am free to withdraw my consent and discontinue acupuncture treatment sessions at any time.

SIGNATURE OF PATIENT	DATE
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HIPPA Consent Agreement

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Shoshana Sadow M.Ac., L.Ac., Dipl.Ac. of Acupuncture Sports Medicine & Orthopedics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of health-care professionals.

If desired, I can request a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Shoshana Sadow M.Ac., L.Ac., Dipl.Ac. of Acupuncture Sports Medicine & Orthopedics is not required to agree to the restrictions requested if required by law.

I understand that I may revoke this consent in writing, except to the extent that Shoshana Sadow M.Ac., L.Ac., Dipl.Ac. of Acupuncture Sports Medicine & Orthopedics has already take action in reliance thereon, and acknowledge that I have been provided with a HIPAA Compliance Assurance Notification to review if desired on the reverse of this form.

At this time, I request the following restrictions to the use or disclosure of my health information.

Restrictions

Write your request here

Please read the attached **Notice of HIPPA Privacy Policy** and check here that you have read it: ☐
(There is no need to print off the Privacy Policy and bring it to your office visit.)

SIGNATURE OF PATIENT	**DATE**
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Notice of HIPPA Privacy Policy

HIPPA Compliance Assurance Notification

Required by law for us—opitional reading for you.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to review our privacy notice upon request, and to request restriction, and to revoke consent in writing after you have reviewed our privacy notice.

Compliance Assurance Notification for Our Patients

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI. We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.