PHILIP KELLEY, LICENSED ACUPUNCTURIST

2120 SW 152ND ST, BURIEN WA 98166 • (206) 244-7973 CLINIC • (206) 241-8677 FAX

Health History Questionnaire

Date: _____ / _____ / _____

- Please help me evaluate your health by filling out this form. Be brief; we will talk in some detail at your first visit.
- All information will be held confidential. Be aware that if an insurance claim is being filed on your behalf, that your insurance company has the right to view your records. Feel free to discuss any other concerns privately.
- If there is anything you wish to bring to my attention that is not asked on this form, additional space is provided for comments at the end.
- Thank you for your trust. I look forward to helping you work toward better health.

Name: _____ Insurance ID Number:_____
Address:_____ City: _____State: ___
Zip Code: _____ Place of Birth: _____ Date of Birth: ____ / ____ / ____
Home Phone: _____ Work Phone: _____
Sex: ___ Marital Status: ___ Occupation: _____ email: _____
Employer: _____ Insurance Plan: _____
Name of Insured, if other than you: _____ Relationship to Insured: _____
Insured's Date of Birth: ____ / ____ / ____ Auto Accident? Y ❑ N ❑
Your Primary Healthcare Provider _____ Phone: _____
Emergency Contact: _____ Phone: _____
How did you find out about me? _____
Have you ever been treated by Acupuncture or Oriental Medicine Before? Y ❑ N ❑

MAIN COMPLAINT

What is/are the problems you would like help with? _____

_____

_____

When did this problem begin? Be specific if possible. _____

_____

What do you think caused it? Is the cause still present? _____

_____

To what extent/how does this problem interfere with your daily activities? _____

_____

_____

Have you been given a diagnosis for this Problem? If so, what? _____

_____

What kinds of treatments have you tried? _____

_____

How severe is your problem right now? (Please mark the scale below):

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below):

No problem Moderate Worst Imaginable

MEDICAL HISTORY Name: _____ Date: ____/ ____/ ____

Surgeries (type and date): _____

_____

_____

Significant Trauma, auto accidents, falls etc. Include approximate date: _____

_____

_____

Allergies; drugs, chemicals, foods, etc. What reaction do you have? _____

_____

_____

Medicines taken within the past six months, include vitamins, supplements, etc: _____

_____

_____

Occupational stress; chemical, physical, psychological, etc: _____

_____

_____

Lifestyle/emotional stress: _____

_____

_____

Do you have a regular exercise program? Y ❑ N ❑ Please describe. _____

_____

_____

Have you ever been on a restricted diet? Y ❑ N ❑ Please describe. _____

_____

_____

Please give a general description of the food you eat during a "typical" day.

Morning: _____

Afternoon: _____

Evening: _____

Before Bed/Between Meals: _____

Habits, how would you describe your average intake of:

	None	Low	Moderate	High
Caffeinated drinks, coffee, tea, etc	❑	❑	❑	❑
Tobacco products:	❑	❑	❑	❑
Non-prescription (recreational) drugs:	❑	❑	❑	❑

Is there anything else you would like to discuss or bring to my attention? _____

_____

_____

_____

Philip Kelley, Licensed Acupuncturist

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Welcome!

I want to reassure you that acupuncture is safe and, by and large, painless. Most people experience a sense of relaxation and well-being. My goal is to support your body's natural healing process and assist you in improving your overall health and vitality.

Please do not skip a meal before your appointment. If possible, wear loose fitting clothes that easily roll up over the elbows and slide up over your knees.

Financial Policies

As a courtesy, I will directly bill your insurance claim. Be aware that insurance coverage is an agreement between you and your insurance carrier, and that you are personally responsible for any reasonable charges. I work with a medical billing service which processes claims and invoices clients for me. If have questions about, or feel there is an error on a statement that you receive, please contact them or myself, and we will address your concerns.

Even if you are sure you are eligible for insurance coverage, please call your insurance company customer service to verify your benefits. I have included an insurance verification form for your convenience. Using this form will help answer important questions regarding your coverage. If you wish, I may help verify your benefits for you, but this does not guarantee payment.

Co-payments and unmet deductibles are due at the time of the visit. If you are waiting for a referral that has not yet been confirmed, you may need to pay out of pocket until the referral is finalized. If your insurance coverage is declined due to ineligibility or other reasons, you must pay for services rendered. Balances, (deductibles plus coinsurances), are due upon receipt of statement. A rebilling fee of $3 will be added to each additional bill that we need to send.

If your insurance will not cover treatment, your payment is due at the time of your visit. We accept cash and personal checks, Mastercard and Visa. For any returned checks, a $10 fee will be charged to you. A billing statement is available upon request.

I ask 24-hour notice for any appointments that you are unable to keep. I understand that missed appointments can happen for a variety of reasons and am generally forgiving of mistakes. However, when necessary I may assess a charge of $35 for missed appointments. Unavoidable emergencies will be considered reasonable exceptions. Missed appointments are absolutely not billable to your insurance company.

I have read and authorize this disclosure. I understand the above financial policies and agree to adhere to them in all respects. I also authorize Philip Kelley, LAc. to release to my insurance company or companies any and all information necessary to process any claim. I further authorize that payment(s) be made directly to Philip Kelley, LAc. PLLC

_____ _____

Signature of Patient (or Parent or Guardian) *Date*

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Disclosure and Consent for Acupuncture Treatment

- Practitioner has been licensed the State of Washington to practice Acupuncture and Oriental Medicine since 12/19/2000. Washington State Acupuncture license # AC 711.

- Acupuncture is a health care service based on the principles of Traditional Chinese Medicine (TCM). Diagnosis and treatment is based on these principles, and is intended to resolve a variety of conditions including relief of symptoms and improved general health. As with any medical treatment, no guarantee can be made regarding the outcomes of treatment.

- Under State Law, Acupuncturists are licensed to perform the following procedures: Use of acupuncture needles to stimulate acupuncture points and meridians, Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians; Moxibustion (burning a warming medicinal herb), acupressure, dermal friction, cupping, infra-red, sound or laser stimulation, therapeutic exercises, dietary advice based on the principles of TCM.

- Acupuncture has consistently been shown to be very safe. Serious side effects are quite uncommon, however there are some potential risks. These may include but are not limited to:

    - Discomfort or pain during or after insertion of needles
    - Localized minor bruising or swelling
    - "Needle sickness"- dizziness, fainting or nausea
    - Minor burns with the use of moxa
    - Infection (rare with the use of sterile disposable needles
    - Broken needle (rare with the use of disposable needles)

These problems are less likely if you are not overly anxious, tired, hungry, or dehydrated before treatment. Please let me know if I should be concerned about any of the above. Please inform me if these or any other adverse effects occur during or after treatment.

- To reduce the risk of infection, all needles are pre-sterilized, single use needles made of surgical steel. After use, needles are disposed of as medical waste, never reused.

- Patients with severe bleeding disorders, pacemakers or other electronic medical devices, compromised immune function, or who may be pregnant should inform me prior to treatment.

- Acupuncture does not take the place of general medical care from a Primary Care Provider (PCP). State Law does not permit acupuncturists to treat potentially serious conditions without the consultation of or referral to a PCP. These include but are not limited to:

    - Acute abdominal symptoms
    - Acute undiagnosed neurological changes
    - Unexplained weight change ≥15% of bodyweight within a three month period
    - Suspected fracture or dislocation
    - Suspected systemic infection
    - Any serious undiagnosed hemorrhagic disorder
    - Acute respiratory distress without previous history or diagnosis

- No practitioner is able to anticipate or explain all risks and complications that may occur during or after treatment. You are encouraged to ask questions at any time, and have the right to refuse any treatment of revoke this consent at any time.

_____ _____

Signature of Patient (or Parent or Guardian) *Date*

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program which requires that all medical records and other health information are kept confidential. This Act gives you, the patient, rights to understand and control how your health information is used. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Use and Disclosure With Consent

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review. Healthcare operations include the business aspects of running our practice. For example, using your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization.

Use and Disclosure without Consent

In some limited situations, the law requires us to use and disclose your health information without your permission. Examples are: for public health purposes; Medicare audits; law enforcement; orders of the court; and worker's compensation programs.

Your Rights Regarding Your Health Information

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request.

- The right to request restrictions on certain uses and disclosures of protected health information.
- The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address.
- The right to ask to see or to get photocopies of your health information. Photocopy and mailing expense is charged to patient.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice or full HIPPA disclosure statement upon request.

Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices for the practice of Philip Kelley, LAc. PLLC. The notice describes the types of uses and disclosures of my health care information that may occur during treatment, payment for service, and in the performance of office operations. It also describes my rights and responsibilities as well as that of the practice of Philip Kelley with respect to the protected health care information. You have the right to file a formal, written complaint with us or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated.

_____ _____

Signature of Patient (or Parent or Guardian) *Date*