VIRGINIA ACUPUNCTURE center

44330 PREMIER PLAZA | SUITE 110 | ASHBURN VA 20147 | TEL: (703) 723-9355 | FAX: (703) 723-6647

ACUPUNCTURE & ORIENTAL MEDICINE

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire as thoroughly as possible. Your answers will be held strictly confidential. If you have any questions, please do not hesitate to ask. Thank you!

PATIENT INFORMATION

PATIENT NAME:_____ SEX: □ MALE □ FEMALE EMAIL:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PHONE (H):_____ (W):_____ (C):_____ SS#:_____

DOES YOUR INSURANCE POLICY OFFER REIMBERSEMENT FOR ACUPUNCTURE SERVICES? □ YES □ NO □ UNSURE

WOULD YOU LIKE TO RECEIVE A SUPERBILL TO SUBMIT TO YOUR INSURANCE COMPANY? □ YES □ NO □ UNSURE

HEIGHT:_____ft._____ in. WEIGHT:_____lbs. DOB:____/____/____ AGE:_____ BIRTH PLACE:_____

MARITAL STATUS:_____ OCCUPATION:_____ □ RETIRED

GUARDIAN NAME/SIGNATURE (IF UNDER 18 YEARS OLD): _____

IN CASE OF EMERGENCY CONTACT:_____ PHONE:_____

PHYSICIAN'S NAME:_____ PHONE:_____

□ REFERRED BY:_____ □ GOOGLE □ YELP □ ACUFINDER □ FACEBOOK □ OTHER:_____

REASON FOR VISIT

_____

REASON FOR YOUR VISIT TODAY (MAIN COMPLAINT)? HAVE YOU BEEN GIVEN A DIAGNOSIS BY YOUR PHYSICIAN? □ YES □ NO IF SO, WHAT IS IT?

_____

WHEN DID IT BEGIN? HAVE YOU EXPERIENCED THIS BEFORE? □ YES □ NO

_____

HOW DID IT BEGIN? THE ONSET WAS: □ SUDDEN □ GRADUAL

_____

WHAT SEEMS TO MAKE IT BETTER? WHAT SEEMS TO MAKE IT WORSE?

_____

OTHER CONCERNS?

HOW DOES THIS PROBLEM INTERFERE WITH YOUR DAILY ACTIVITIES?

□Eating	□Sleeping	□Movement	□Sitting	□Standing
□Work	□Emotional	□Relationships	□Sexually	□Other_____

WHAT KINDS OF TREATMENT OR THERAPIES HAVE YOU TRIED? _____

OTHER CONCURRENT THERAPIES?_____

ARE YOU INTERESTED IN: □Acupuncture □ Herbal Medicine □ Nutrition □ Cupping □Asian Body Work

PLEASE LIST ALL SURGERIES, MAJOR ILLNESSES, OR TRAUMAS YOU HAVE HAD: (physical, viral, emotional, sexual etc.)

Surgery/Illness/Trauma	Date	Surgery/Illness/Trauma	Date

***PLEASE LIST ANY MEDICATIONS/ SUPPLEMENTS YOU ARE CURRENTLY TAKING**

MEDICATION/DOSAGE	WHAT IS IT FOR?	FOR HOW LONG?	SUPPLEMENTS	WHAT IS IT FOR?	FOR HOW LONG?

MEDICAL HISTORY – Complete for each family member. Place an "X" in the appropriate box to indicate any illnesses current or past.

	SELF	MOTHER	FATHER	SIBLING
ALLERGIES (LIST):				
ARTERIOSCLEROSIS				
ASTHMA				
ALCOHOLISM				
BLOOD OR BLEEDING DISORDER				
CANCER (TYPE):				
DEPRESSION OR MENTAL ILLNESS				
DIABETES (TYPE):				
HEART DISEASE OR PACEMAKER				
HEPATITIS				
HERPES (TYPE):				
HIGH BLOOD PRESSURE				
SEIZURES				
SEXUALLY TRANSMITTED DISEASE (TYPE):				
STROKE				

Rev: 11/06 (LAC)

Recommendation for Examination by a Physician

I, _____(licensed acupuncturist), recommend to you_____(patient), that you be examined by a physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

Patient Signature_____ Date_____

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathic medicine, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia, Section 54.1-2956.9, 18VAC85-110-10)

Acupuncturist Signature_____ Date_____

***PLEASE CHECK ALL CURRENTLY PRESENTING SYMPTOMS**

GENERAL SYMPTOMS

□ Poor appetite	□ Difficulty falling asleep	□ Fatigue	□ Leg cramps at night	□ Bleed or bruise easily
□ Strong appetite	□ Difficulty staying asleep	□ Lack of strength	□ Fever	□ Muzzy head
□ Strongly like cold drinks	□ Dream disturbed sleep	□ Bodily heaviness	□ Chills	Other_____
□ Strongly like hot drinks	□ Waking startled	□ Cold hands or feet	□ Night sweats	_____
□ Recent weight gain/loss	□ Sleep apnea	□ Edema or water retention	□ Sweat easily	_____

HEAD, EYES, EARS, NOSE, THROAT

□ Eye pressure or pain	□ Grinding teeth	□ Excessive saliva	□ Difficulty swallowing	□ Headaches
□ Dry eyes	□ TMJ	□ Sinus problems	□ Enlarged thyroid	□ Migraines
□ Spots or floaters in vision	□ Facial pain	□ Excessive phlegm	□ Nosebleeds	□ Concussions
□ Blurred vision	□ Gum problems	□ Recurrent sore throat	□ Ringing in the ears	Other_____
□ Poor night vision	□ Sores on lips or tongue	□ Swollen glands	□ Poor hearing	_____
□ Teeth problems	□ Dry mouth	□ Lumps in throat	□ Earaches	_____

RESPIRATORY

□ Shortness of breath	□ Difficulty with inhalation	□ Chest tightness	□ Cough: ○Wet ○Dry	□ Coughing up blood
□ Wheezing	□ Difficulty with exhalation	□ Catch colds frequently	□ Phlegm: ○Thick ○Thin	Other_____

CARDIOVASCULAR

□ High blood pressure	□ Low blood pressure	□ Chest pain	□ Palpitations	□ Dizziness upon standing
□ Blood clots	□ Fainting	□ Difficulty breathing	□ Irregular heartbeat	Other_____

GASTROINTESTINAL

□ Nausea/Vomiting	□ Bloating	□ Black stools	□ Intestinal pain or cramping	Bowel movements:
□ Acid reflux	□ Fatigue after meals	□ Bloody stools	□ Hemorrhoids	Frequency_____x day
□ Bitter taste upon waking	□ Bad breath	□ Mucous in stools	□ Rectal pain	Color_____
□ Gas	□ Diarrhea	□ Itchy anus	□ Anal fissures	Texture/ Form_____
□ Hiccup	□ Constipation	□ Burning anus	Other_____	Odor_____

MUSCULOSKELETAL

□ Neck/Shoulder pain	□ Low back pain	□ Joint pain	□ Limited range of motion	Other _____
□ Upper back pain	□ Muscle pain	□ Rib pain	□ Limited use	_____

SKIN & HAIR

□ Rashes	□ Psoriasis	□ Dandruff	□ Change in hair/skin texture	Other _____
□ Hives	□ Ulcerations	□ Dry skin	□ Cherry hemangiomas	_____
□ Eczema	□ Acne	□ Hair loss	□ Fungal infections	_____

NEUROPSYCHOLOGICAL

□ Seizures	□ Numbness	□ Irritability/ easily stressed	□ Abuse survivor	Other _____
□ Loss of consciousness	□ Poor memory	□ Depression/ loss of interest	□ Suicidal thoughts	_____
□ Tremors or tics	□ Mood swings	□ Anxiety/ difficulty relaxing	□ Seeing a therapist	_____

GENITOURINARY

□ Pain on urination	□ Incomplete urination	□ Bedwetting	□ Increased libido	□ Premature ejaculation
□ Frequent urination	□ Blood in urine	□ Kidney stone	□ Decreased libido	□ Nocturnal emission
□ Urgent urination	□ Wake to urinate	□ Venereal disease	□ Impotence	Other _____

GYNECOLOGY

□ Currently pregnant	□ Irregular periods	□ PMS	□ Vaginal sores	# Pregnancies _____
Age menses began_____	□ Painful periods	□ Breast tenderness	□ Vaginal itching	# Live births _____
Length of cycle (day 1- day 1)	□ Heavy periods	□ Breast lumps	□ Vaginal odor	# Miscarriages _____
_____	□ Clots in menstrual blood	□ Fibrocystic breasts	□ Vaginal discharge	Other_____
Duration of flow _____	□ No periods	□ Breast	(color) _____	_____

ADDITIONAL NOTES:

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other 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 named below, including those working at the clinic or office listed below or any other office or 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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant 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 sites 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 sterile 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 written 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 SIGNATURE **X** DATE:

(Or Patient Representative) (Indicate relationship if signing for patient)

Newton Lee, D.O.M., Dipl.Ac. (NCCAOM), L.Ac.
44330 Premier Plaza, Suite 110, Ashburn, VA 20147
Clinic: 703-723-9355 Direct: 703-283-8717

NOTICE OF HIPAA PRIVACY PRACTICES

Virginia Acupuncture Center, LLC

Beyond Wellness, LLC
44330 Premier Plaza, Suite 110 • Ashburn, VA 20147

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementing regulations (HIPAA). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

I. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

1. We may provide your Health Information to health care professionals including doctors, nurses and technicians -- for purposes of providing you with care.
2. Our billing department may access your information and send relevant parts to other insurance companies to allow us to be paid for the services we render to you.
3. We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions.

II. We May Also Use or Disclose Your Health Information Under the Following Circumstances without Obtaining Your Prior Authorization:

1. To Notify and/or Communicate with your Family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.
2. As Required by Law.

- For Public Health Purposes: We may use or disclose your health information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.
- For Health Oversight Activities: We may use or disclose your health information to health agencies during the course of audits, investigations, certification and other proceedings.
- In Response to Subpoenas or for Judicial and Administrative Proceedings. We may use or disclose your health information in the course of any administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your health information prior to providing it to another person.
- To Law Enforcement Personnel. We may use or disclose your health information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or subpoena and other law enforcement purposes.
- To Coroners or Funeral Directors. We may use or disclose your health information for purposes of communicating with coroners, medical examiners and funeral directors.
- For Purposes of Organ Donation. We may use or disclose your health information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
- For Public Safety. We may use or disclose your health information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
- To Aid Specialized Government Functions. If necessary, we may use or disclose your health information for military or national security purposes.
- For Worker's Compensation. We may use or disclose your health information as necessary to comply with worker's compensation laws.
- To Correctional Institutions or Law Enforcement Officials, if you are an inmate.

III. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an **Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.**

IV. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

1. Appointment Reminders. We may use your health information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.
2. Change of Ownership. In the event that our entity is sold or merged with another organization, your health information/record will become the property of the new owner.
3. Providing Information to Our Plan Sponsor [If a Health Plan]. We may disclose your health information to our plan sponsor.

V. Your Rights

1. You have the right to request restrictions on the uses and disclosures of your health information. However, we are not required to comply with your request.
2. You have the right to receive your health information through confidential means through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your health information. We may charge you a reasonable cost-based fee to cover copying, postage and/or preparation of a summary.
4. You have a right to request that we amend your health information that is incorrect or incomplete. We are not required to change your health information and will provide you with information about our denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your health information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.
6. You have a right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact us.

Our Duties.

7. We are required by law to maintain the privacy of your health information [and to provide you with a copy of this Notice.]
8. We are also required to abide by the terms of this Notice.
9. We reserve the right to amend this notice at any time in the future and to make the new notice provisions applicable to all your health information even if it was created prior to the change in the notice. If such amendment is made, we will immediately display the revised notice at our office and provide you with a copy of the amended notice. We will also provide you with a copy, at any time, upon request.

VI. Complaints to the Government.

You may make complaints to the Secretary of the Department of Health and Human Services (DHHS) if you believe your rights have been violated.

We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

VII. Contact Information.

You may contact us about our privacy practices by calling the Privacy Officer,

LucilleWalke, Office Manager
Beyond Wellness, LLC
44330 Premier Plaza, Suite 110 • Ashburn, VA 20147
Phone No. (703) 723-9355 • Fax No. (703) 723-6647 •Website: www.mybwdoc.com

You may contact the DHHS at:

U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

I have received a copy of this Health Insurance Portability and Accessibility Act (HIPAA) NOTICE OF PRIVACY PRACTICES. I have been informed whom to contact if I need more information.

Patient Name (print) _____

Patient Signature _____ Date _____

24 Hour
Cancellation Policy

In order to avoid a late cancellation charge, please call the clinic at 703-723-9355 and give at least 24-hours notice before your scheduled appointment.

We appreciate your cooperation in helping to serve our community by allowing your practitioner to be available to all those in need.