Xiong's Acupuncture & Chinese Medicine
8590 Potter Park Dr, Suite C
Sarasota, FL, 34238
941-313-2148
www.XiongsAcupuncture.com

PATIENT GENERAL INFORMATION

Name: _____ 中文名字：_____
(first) (middle) (last)

Date of Birth: ____/____/_____ Age: _____ Gender: □ female □ male □ other _____
(mo) (day) (year)

Height ____ Weight ____ How did you hear about our clinic: _____

Occupation :_____ Place of Employment: _____

Marital Status: □ Married, □ Single, □ Divorced, □ Widowed # of Children_____

Contact Info:	(Write down your address below ▼)	Home Phone #:	
(street, apt)		Business Phone #:	
(city, state, zip)		Cell Phone #:	
(country)		Best # to reach you:	
(email address:)		Be included in our email newsletter?	□ Yes □ No
Emergency Contact Name and relationship:		Emergency contact phone #:	

Reason for visit, in the order of significance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

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TREATMENT CONSENT FORM

I, _____, hereby consent to be treated with acupuncture and herbal medicine by Ying Xiong, A.P. or whomever she designates in her absence in **Xiong's Acupuncture and Chinese Medicine LLC**.

I understand that acupuncture is performed by the insertion of fine needles into specific points of the body with the intent of improving body functions and/or relieving pain.

I understand that only pre-sterilized, disposable needles will be used.

I understand that the needles may cause some temporary localized pain, bruising, or light headaches.

I understand that "Moxibustion" a.k.a. heat therapy may also be used and natural herbal formula may be prescribed.

I am in full compliance with the fact that in the event I decide to seek treatment from a health practitioner outside this clinic and patient records need to be transferred, all herbal prescriptions / acupuncture points in the records are copyrighted, the exclusive property of THIS clinic and may not be used without express written permission from THIS clinic. Any request of patient records by me or any other health practitioner I decide to transfer to for purposes of using copyrighted herbal/acupuncture prescription of THIS clinic without permission is strictly prohibited.

I accept the fact that there is no guarantee concerning the outcome of my acupuncture or herbal treatments and I understand that I may stop treatment at any time. I also accept that there are NO REFUNDS on any services, including herbal formula.

I understand payment must be made in full at the time of treatment.

Signature of Patient or Guardian:_____Date: _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any

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disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that: Protected health information may be disclosed or used for treatment, payment or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Policies. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition treatment upon the execution of this Consent.

I request the following modifications related to communications regarding my health care by Ying Xiong, A.P., or an employee thereof. I may be called with information may be left on answering machine or voice-mail:

at home: □ Yes □ No	Appointment □ Yes □ No	Billing □ Yes □ No	Medical □ Yes □ No
at work: □ Yes □ No	Appointment □ Yes □ No	Billing □ Yes □ No	Medical □ Yes □ No

I give my permission to share information with the following person(s):

Name	Relationship	Permission
		Appointment □ Yes □ No Billing □ Yes □ No Medical □ Yes □ No
		Appointment □ Yes □ No Billing □ Yes □ No Medical □ Yes □ No

I have read and understand the provisions of the Notice of Privacy Practices for Protected Health Information, and understand that a copy is available at my request.

_____

Printed Name – Patient or Guardian if under 18 yrs Signature Date

OFFICE FINANCIAL POLICY

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay (Private Pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**)

_____Insurance Billing (Medical Insurance)

Fees: Our fees are determined by the complexity of each case and different services used.

Missed Appointments: Unless canceled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your health care provider's guidelines and stick to your treatment schedule.

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Please help us to serve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns.

I have read the financial policy and I agree to this financial policy.

_____

PATIENT'S SIGNATURE DATE

_____

Name on Credit Card Credit Card Number Expiration Date CSS#

_____

Credit Card Type Mailing Address with Zip Code associated with Credit Card

AUTHORIATION TO BILL INSURANCE (for insurance billing patients only)

We will verify coverage prior to treatment and we will file all claims as a courtesy to you.
If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR: Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service.

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Xiong's Acupuncture & Chinese Medicine Clinic will submit my claim for me to my insurance company. Although Xiong's Acupuncture & Chinese Medicine Clinic verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month –no exceptions until the outstanding amounts are paid. I further understand that any unpaid balance over 90 days, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to **Xiong's Acupuncture & Chinese Medicine Clinic.** I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

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Signature of Responsible Party Date

PATIENT TESTIMONIAL RELEASE CONSENT

By signing this form, you are consenting to **Xiong's Acupuncture And Chinese Medicine LLC** use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be distributed to the public. You have the right to revoke this Release at any time by giving us written notice of your revocation. Please understand that revocation of this Release will not affect any action **Xiong's Acupuncture And Chinese Medicine LLC** took in reliance on this Release before receiving your revocation.

I hereby authorize **Xiong's Acupuncture And Chinese Medicine LLC** to use my testimonial and any information in the testimonial in its public relations efforts including brochures, pictures, posters, website, video segments. I understand and approve the disclosure by **Xiong's Acupuncture And Chinese Medicine LLC** of testimonial information to the media and other individuals and entities that may be involved in **Xiong's Acupuncture And Chinese Medicine LLC**'s public relations efforts. I acknowledge that the media may be interested in my story, and I am willing to participate in media interviews as they arise.

I understand that I am providing the testimonial information to **Xiong's Acupuncture and Chinese Medicine LLC** and that my treating acupuncture physician will not be providing any information, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including, Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **Xiong's Acupuncture And Chinese Medicine LLC** from all claims for damages of any kind based on the use of my testimonial or information in the testimonial.

I am of legal age and freely sign this release, which I have read and understood.

Print Name Signature Date

PATIENT MEDICAL HISTORY (Please mark "yes" or "no" if you have had any of the following)

AIDS/HIV	□ Yes □ No	Epilepy	□ Yes □ No	Radiation Treatment	□ Yes □ No
Anemia	□ Yes □ No	Fainting or dizziness	□ Yes □ No	Respiratory Disease	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	Glaucoma	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Artificial Joints	□ Yes □ No	Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Asthma	□ Yes □ No	Heart Problems	□ Yes □ No	Seizure	□ Yes □ No

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Auto Accident	□ Yes □ No	Heart Attack	□ Yes □ No	Shortness of Breath	□ Yes □ No
Back Problems	□ Yes □ No	Hepatitis Type_____	□ Yes □ No	Sinus Trouble	□ Yes □ No
Bleeding abnormally	□ Yes □ No	Herpes	□ Yes □ No	Skin Rash	□ Yes □ No
Blood disease	□ Yes □ No	High Blood Pressure	□ Yes □ No	Special Diet	□ Yes □ No
Cancer	□ Yes □ No	Jaundice	□ Yes □ No	Stroke	□ Yes □ No
Chemical Dependency	□ Yes □ No	Jaw Pain	□ Yes □ No	Swollen Ft or Ankles	□ Yes □ No
Chemotherapy	□ Yes □ No	Kidney Disease	□ Yes □ No	Thyroid Problems	□ Yes □ No
Circulatory Problems	□ Yes □ No	Liver Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Tuberculosis	□ Yes □ No
Cortisone Treatments	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Tumor	□ Yes □ No
Cough, persistent or bloody	□ Yes □ No	Nervous Problems	□ Yes □ No	Ulcer	□ Yes □ No
Diabetes	□ Yes □ No	**Pacemaker**	□ Yes □ No	Venereal Disease	□ Yes □ No
Emphysema	□ Yes □ No	Psychiatric Care	□ Yes □ No	Weight Loss, unexplained	□ Yes □ No
Women					
Currently pregnant?	□ Yes □ No	Due date:		Are you nursing?	□ Yes □ No
Birth control pills?	□ Yes □ No	For how long?			

Have you ever had any surgery? □ Yes □ No If yes, please specify:

(Please attach additional paper in case there is not enough space)

Surgery Type	Year	For what purpose:	Recovery Status

Are you taking any medications or pain pills ? □ Yes □ No If yes, please specify:

(Please attach additional paper in case there is not enough space)

Medication Name	Dosage	For what purpose:	For how long:

Are you taking any nutritional supplements ? □ Yes □ No If yes, please specify:

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(Please attach additional paper in case there is not enough space)

Supplements Name	Dosage	For what purpose:	For how long:

Do you have any allergy? □ Yes □ No If yes, please specify:

(Please attach additional paper in case there is not enough space)

PATIENT'S CURRENT HEALTH CONDITIONS (Please check the following conditions that currently pertain to you with X, explicit if necessary.)

Sleep	Appetite	Thirst
___good ___intermittent ___difficult falling asleep ___light sleep ___cannot sleep at all ___lots of dream ___feel rested upon waking up ___feel tired upon waking up	___good; ___excessive ___fair ___poor ___no appetite at all ___picky eater ___comfort eating ____food craving (craving for_____)	___normal ___excessive ___no thirst ___thirsty but don't want to to drink
Preferable temp. of drinks	**Bowel movement**	**Consistency of stool**
___hot ___warm ___room temperature ___cool ___cold ___icy	___time(s)/day ___normal ___constipation ___diarrhea ___urgent ___abdominal cramping	___hard ___soft ___loose ___watery ___small pellets ___bloody ___mucous
Urination	**Urine color**	**Other info about urine**
___time(s)/day ___time(s)/night ___strong ___weak ___incontinent	___light yellow ___medium yellow ___dark yellow ___pink ___red	____clear ___cloudy ___bubbles ___strong odor ___painful

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___no urine desire		___burning
Perspiration	**Hands**	**Feet**
___difficult ___normal ___easy ___spontaneous sweat ___night sweat ___hot flash	___hot ___warm ___cool ___cold ___swollen ___numb ___pain ___tingling ___burning ___discolored	___hot ___warm ___cool ___cold ___swollen ___numb ___pain ___tingling ___burning ___discolored
Body	**Energy**	**Emotion**
• Body: ___hot ___warm ___cool ___cold ___alternately cold and hot	• Energy: ___good ___fair ___poor ___tired in the morning ___tired in the afternoon	• Emotion: ___stressful ___irritable ___anxious ___depressed ___panic ___sorrow ___happy ___worrisome ___sad
Skin	**Other symptoms**	**Other continued**
___itchy ___burning ___flaky ___painful ___inflamed ___acne ___rash ___hives ___ulcer	___acid reflux ___abdominal pain ___abdominal bloating ___chest pain ___chest congestion ___cough ___dizziness ___ear ringing ___heartburn ___headache	___light headed ___nasal congestion ___nausea ___palpitation ___shortness of breath ___stomach pain ___vomiting ___conditions not listed above, please explicit: _____
For Women Only – Gynecological Conditions (Check any following conditions currently applicable to you)	___Endometriosis ___Blocked Fallopian tube ___Infertility ___Menopause ___Ovarian cyst ___PMS ___Peri-Menopause ___Polycystic Ovarian Syndrome ___Pelvic Inflammatory Disease	___Recurrent miscarriages ___STD ___Uterine fibroids ___Yeast infection ___Breast cancer ___Cervical cancer ___Ovarian cancer ___Uterine cancer ___Hysterectomy
Menstruation ___regular ___irregular ___no menses How frequent is your menstrual cycle? Every ____ days. How long does your menstrual	**During ovulation (usually 2 weeks before menstrual cycle)**	___no ovulation ___abdominal pain ___bleeding ___no/little mucus ___moderate mucus ___excessive mucus ___clear mucus

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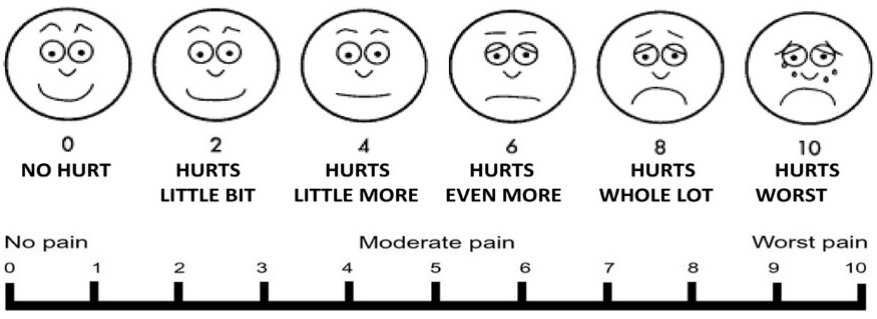
cycle last? ____ days. When was the 1st day of your last menses? _____		___yellow mucus ___green mucus ___brown mucus
Before menstrual cycle ___abdominal bloating ___abdominal cramping ___acne breakout ___breast tenderness ___craving for sweets ___depressed ___diarrhea ___headache ___irritable ___insomnia ___lower back pain ___night sweat	**On menstrual cycle** ___abdominal bloating ___abdominal cramping ___breast tenderness ___diarrhea ___fatigue ___fever ___headache ___moody ___insomnia ___lower back pain ___night sweat ___nosebleed ___swelling ___vomiting	**After menstrual cycle** ___abdominal cramping ___breast tenderness ___dizzy ___fatigue ___headache ___insomnia ___night sweat ___spotting

Pain

Please mark the area that you are experiencing pain, and write down the pain level referring to the pain scale.



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