WELCOME TO LING'S ACUPUNCTURE

Thank you for choosing Ling's Acupuncture for your healthcare needs. We would like to implement a few office policies that are fair and simple which revolve around the care of our patients.

Please read each section, indicate your acceptance with a check mark and sign at the bottom of the page.

CANCELLATION POLICY:

Cancellations 24 hours **before** an appointment are accepted without charge. Cancellations **on the day of the appointment** are billed a cancellation fee of $20.00. When a patient makes an appointment and fails to show up or call us 24 hours before the appointed time, we have to bill them. This policy is considered fair trade policy throughout the medical profession. For some time we have posted such policy in all treatment rooms at our facility and have included it in all new patient forms signed by the patient.

☐ I acknowledge and accept the cancellation policy.

INSURANCE POLICY COVERAGE:

We accept most insurance policies when individual policies provide coverage for acupuncture procedures and related treatments. We are a Cigna in-network provider Patients are responsible for payment if their policies do not cover treatment. Patients will be billed accordingly. Prompt payment is expected and appreciated. Medicare does not presently cover acupuncture procedures, however, secondary insurance policies might provide coverage of acupuncture treatments.

PAYMENT POLICY:

Payment for services is due in full at the tie services are rendered. We accept cash, check, Visa and Mastercard only. Please note that if you wish to file a claim with your health insurance provider this is the patient's responsibility. (Filing a claim does not guarantee that you will be compensated.) We will provide any necessary paperwork to enable you to file a claim. However, you are still responsible to Ling's Acupuncture for the full payment of services provided.

☐ I have read and understand the insurance and payment policy.

RETURNED CHECK POLICY:

When a check is returned by the bank for insufficient funds we are charged $35 by the bank. We will contact you by mail to alert you to this problem for payment due plus the bank charge. Payment must be made to us within 20 days from date of the letter. At that time we will file a written complaint with the Edgewood Police Department who will proceed with prosecution in a Court of Law. Patient needs to pay balance BEFORE any more services are rendered and must pay BEFORE they are seen by the doctor. No write-offs accepted.

☐ I have read and understand the returned check policy.

Signed _____ Print Name _____ Date _____

LING'S ACUPUNCTURE

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a significant role in your diagnosis and treatment.

General Patient Information

Name_____ Date_____

Street Address_____

City_____ State_____ Zip_____

Social Security #_____ Date of Birth_____

Age_____ Gender: Male_____ Female_____ Married_____ Single_____

Home/Cell Phone_____E-Mail address:_____

Place of Employment_____

Emergency Contact/Relation_____Phone_____

How did you hear about us? Referred by_____

Yellow pages_____ Web-site_____ Drive-by_____ Other_____

Medications (if any):_____

_____

Supplements (if any vitamins, herbs, etc.):_____

_____

Major Complaint(s), in order of significance to you:

1. Major Complaint:_____
2. Secondary Complaint:_____
3. Other Complaint:_____
4. Other Complaint:_____

How do these conditions impair your daily activities?_____

_____

Patient Medical History

How was your childhood health?_____

Hospital visits/stays:_____

Recent tests: (please indicate test results and date on following page)

○Physical ○Cholesterol ○Blood ○Prostate ○HIV ○STD ○Pap Smear

○Mammography ○Other_____

Test Results and Date:_____

Check any you have had in the past:

○Diabetes	○Allergies	○Rheumatic Fever	○Bleeding tendency
○Heart Disease	○Thyroid Disorder	○Asthma	○Multiple Sclerosis
○CVA (stroke)	○Tuberculosis	○Jaundice	○High Blood Pressure
○Vein Condition	○Gonorrhea	○Mumps	○Cancer
○Measles	○Chicken Pox	○Nervous Disorder	○Migraines
○HIV	○Hepatitis	○Epilepsy	

Other:_____

Surgeries:_____

Family Medical History

Check the following that have occurred in your blood relatives:

○Diabetes	○Cancer	○Heart Disease	○High Blood Pressure
○Allergies	○Tuberculosis	○Obesity	○Bleeding Tendency
○Kidney Disease	○Alcoholism	○Nervous Illness	○Mental Illness
○Stroke	○Other_____		

Patient Profile

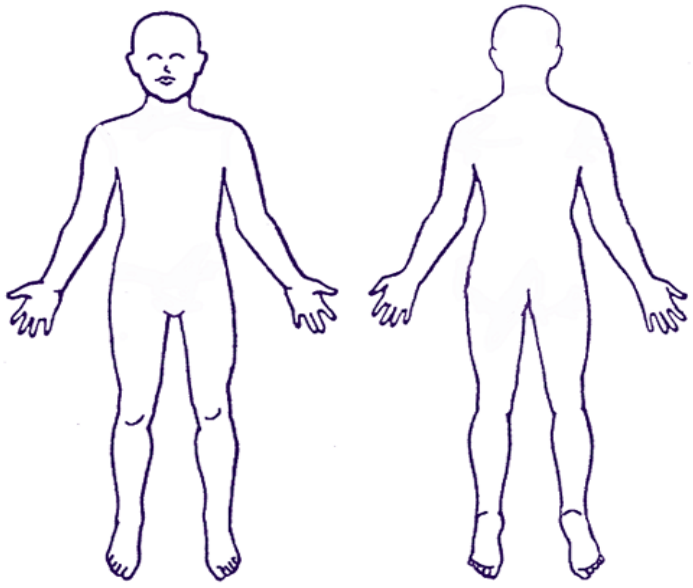
Please clearly mark any areas of pain on the diagram below:

Is the pain:

○Sharp ○Burning ○Aching ○Cramping ○Dull ○Moving ○Fixed ○Other:_____

Do the following lessen the pain:

○Pressure ○Cold ○Heat ○Exercise ○Other:_____



Do the following worsen the pain:

○Pressure ○Cold ○Heat ○Exercise
○Other:_____

Overall Temperature (Kidney function):

○cold hands & feet ○sweaty hands & feet ○night sweats ○hot sensation
○afternoon flushes ○hot flushes ○lack of perspiration ○vaginal dryness
○cold sensation ○perspire easily ○thirsty ○low energy

Heart function:
○palpitations ○anxiety ○restlessness ○memory problem
○mental confusion ○vivid dreams ○chest pain ○insomnia
○mental fogginess ○mental sluggishness ○wake unrefreshed

Lung function:
○cough ○sinus congestion ○nose bleeds ○dry mouth
○dry throat ○dry nose ○dry skin ○sneezing
○difficult breathing ○chills & fever ○stiff neck ○sore throat
○nasal discharge /color:_____ ○cough with sputum/color:_____
○allergies/to what:_____

Spleen function:
○low appetite ○bloating ○abrupt weight change ○mucous in stools
○gurgling stomach ○gas ○fatigue after eating ○blood in stools
○diarrhea ○constipation ○undigested food in stools ○incomplete stools
○loose stools ○hemorrhoids ○alternating diarrhea & constipation
○swollen hands ○swollen feet ○heavy body sensation ○nausea

Stomach function:
○burning ○bad breath ○very large appetite ○canker sores
○acid reflux ○belching ○stomach pain ○vomiting
○bleeding or swollen gums

Liver/Gallbladder function:
○over thinking ○anger easily ○tightness in chest ○bitter taste
○frustration ○depression ○frequent headaches ○irritability
○tingling ○numbness ○muscles spasms ○ringing in ears
○drink alcohol ○lump in throat ○muscle tension

Kidney/Bladder function:
○sore/weak knees ○low back pain ○high libido ○normal libido
○excessive hair loss ○fearful ○low libido ○lack of bladder control

Urination:
○frequent ○urgent ○dark yellow color ○strong odor ○cloudy
○scanty ○burning ○painful ○difficult

Men only:

○testicular pain ○swollen testes ○premature ejaculation ○impotence
○coldness or numbness in genitalia
○other:_____

Women only:

Age of first menses:_____ Number of children:_____
Are you pregnant now?_____ Age of menopause:_____
Vaginal discharge: color:_____ thin/thick:_____ strong odor:_____

Do you experience any of the following pre-menstrual symptoms:

○nausea ○food cravings ○depression ○vomiting
○headaches ○irritability ○water retention ○migraines
○anxiety ○cramps ○breast tenderness ○emotional

Days in menstrual cycle:_____ Average number days of flow:_____

Menstrual Chart

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	
Color (bright red, pale, dark)								
Amount of flow(heavy, light)								
Cramps (dull, sharp)								
Clots (large, small, purple, red)								
Nause or vomiting								
Mood								
Breast soreness								

Ling's Acupuncture and Chinese Medicine

120 Gatlin Ave. Orlando, FL 32806 407-851-2533

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 affect any disclosure 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.

_____

Patient or Representative Signature: _____Date:_____

Relationship to Patient (if other than patient):_____Date:_____
Witness_____Date:_____
(Printed Name Ling's Acupuncture Representative)

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Patient Consent to Treatment

I hereby consent to the following:

Patient's Name (Please Print): _____

A. Treatment: Any and all health care treatment, which may include acupuncture, herbal formulas, TuiNa, cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.

B. Financial Information: All professional fees are due in full at the time services are rendered, unless prior arrangements have been made with the patient's health insurance company. I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to LING'S ACUPUNCTURE for the amount due after services have been rendered. Payment can be made by major credit cards, cash, or check.

C. Authorization to Use and Disclose Health Information: I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care. Patient or Representative

Patient or Representative Signature: _____ Date: _____

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

   _____

2. Please list the family members or significant others, if any, whom we may inform about your Medical condition ONLY IN AN EMERGENCY_____

3. Please print the **telephone number(s) where you want to receive calls** about your appointments, lab and x-ray results, or other information:_____
(Check one)
_____Okay to leave message with detailed information_____Leave message with callback number only

It is the responsibility of the patient to notify Ling's Acupuncture if this information should change