RADIANCE
acupuncture

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New Patient Demographic Information

Name:_____ Today's Date:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____Emergency Contact Name + Number:_____

Sex:_____ Date of Birth:_____ Age:_____ Marital Status:_____Language Preference:_____

Insurance Company:_____ ID #:_____ Group #::_____

Height:_____ Weight:_____ Have you tried acupuncture before? ☐ YES ☐ NO Do you have a pacemaker? ☐ YES ☐ NO

Current Complaints

Primary Reason(s) for Visit:_____

How did it start?_____ When? _____

Other Complaints: 1._ _____ How did it start?_____ When?_____

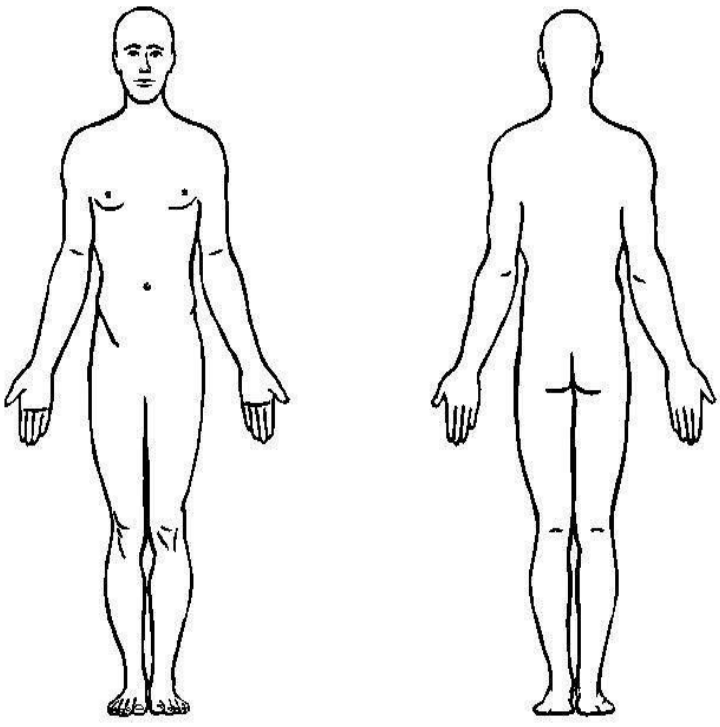
2._____ How did it start?_____ When?_____

List of medications, supplements, vitamins:_____

_____

_____

Indicate areas of pain:



Medical History

Family History

☐ Alcoholism	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Epilepsy	☐ Hepatitis	☐ Mental Illness	☐ Asthma

Skin + Hair

☐ Hives	☐ Eczema	☐ Acne	☐ Hair loss	☐ Easy sweating
☐ Itching	☐ Psoriasis	☐ Dry scalp	☐Bruise Easily	☐ Night sweats

Head, Eyes, Ears, Nose Throat

☐ Dizziness	☐ Cataracts	☐ Sore throat	☐ Bleeding gums	☐ Loss of smell
☐ Migraines/Headaches	☐Glasses/contacts	☐ Nose bleeds	☐ TMJ	☐ Sinus infection
☐ Spots/floaters in eyes	☐Poor hearing	☐ Sores on lips or tongue	☐ Lymph node swelling	☐ Tinnitus (ear ring)

Cardiovascular/Respiratory

☐ Dizziness	☐ High blood pressure	☐ Cold hands or feet	☐ Pacemaker	☐ Fainting
☐ Low blood pressure	☐Irregular heartbeat	☐ Swelling of hands/feet	☐ Chest pain/angina	☐ Cough
☐Asthma	☐Shortness of breath	☐ Pneumonia	☐ Coughing up blood	☐ Bronchitis

Gastrointestinal

☐ Nausea	☐ Constipation	☐ Black stool	☐ Acid regurgitation	☐ Celiac Disease
☐ Vomiting	☐ Gas	☐ Indigestion	☐ Chrohn's Disease	☐ Ulcers
☐ Diarrhea	☐ Blood in stool	☐Abdominal pain/ cramps	☐ Collitis	☐ Bad breath

Musculoskeletal

☐ Neck pain	☐ Back pain	☐ Hand wrist pain	☐ Muscle spasm	☐ Knee pain
☐ Muscle pains	☐ Muscle weakness	☐ Shoulder pain	☐ Foot/ankle pain	☐ Hip pain

Neuropsychological

☐ Seizures	☐ Area of numbness	☐ Concussion	☐ Anxiety	☐ Panic attacks
☐ Loss of balance	☐ Poor memory	☐ Depression	☐ Bipolar disorder	☐ Obsessive/compulsive

Urinary

☐ Frequent urination	☐ Frequent UTIs	☐ Kidney stones	☐ Dark urine	☐ Edema

Viral/Autoimmune/Infection/Miscellaneous

☐ Epstein Barr	☐ Diabetes Mellitus	☐ Thyroid Disorder	☐ Multiple Sclerosis	☐ Shingles
☐ Lupus Erythematosus	☐ HIV/AIDS	☐ TB	☐ Hepatitis or at risk	☐ Herpes (oral/genital)
☐ ADD/ADHD	☐ Amenia	☐ Fatigue	☐ Hernia	☐ Surgical implants

Emotions

☐ Anger	☐ Anxiety	☐ Fear	☐ Sadness	☐ Worry

Reproductive + Gynecologic

Menarche:_____ Last Period: ____ /____ /____ Length of Cycle: _____ Days of Menstrual Flow: _____

Pregnancies: _____ Births _____ Miscarriages: _____ Abortions:_____ Age of Menopause: _____

Please list any surgeries, traumas, accidents, etc...____

_____

_____

Informed Consent to Treatment + Cancellation Policy

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now, or in the future treat me while employed by, working or associated with, or serving as a back-up for the treating acupuncturist named below, including those working at the clinic or office listed or any other office or clinic, whether signatories to this form or not.

I understand that treatments may include acupuncture, diagnostic techniques (questioning, pulse evaluation, palpation, observation, active and passive range of motion, muscle and orthopedic testing), massage techniques, joint and/or visceral manipulation, heat and/or cold therapy, electrical stimulation (e-stim), instrument assisted soft tissue manipulation (cupping, gua sha), moxibustion, recommendation of herbal and homeopathic preparations for ingestion and/or external application, dietary recommendations, and healthy lifestyle counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand and am informed that acupuncture is a safe method of treatment, however, as in allopathic medicine, there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to bleeding, bruising, nerve pain, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. I do not expect the practitioner to be able to anticipate and explain all risks and complications and wish to rely on the practitioner to exercise such judgement to be in my best interest based on the known facts at the time. I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that treatment from the acupuncturist named below does not substitute for appropriate medical evaluation and treatment by a licensed physician. I have been advised to consult with a licensed physician if there is worsening of my ailment/condition, if it does not improve within an estimated timeframe or if a new ailment/condition arises. If I am presently under the care of a physician, I have been advised to continue all treatments and medications as prescribed.

We request/prefer at least a 48 hour notice for all rescheduled appointments and cancellations. Due to the nature and size of our business, we REQUIRE a proper 24 hour notice before incurring a “no show” or late cancellation fee. This policy enables us to better utilize available appointments for our patients needing immediate care. While we understand that situations come up and emergencies happen, we do not double-book the schedule and late cancellations and missed appointments *greatly* impact our business.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call or text at least **24 hours in advance**. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care. To cancel appointments, please call, text, or email Mariel (858.263.6088 mariel@radianceacupuncture.com). If you do not reach her, you may leave a detailed message at either number. If you would like to reschedule your appointment, please be sure to leave us your name and phone number and we will return your call within the business day.

A "no-show” is someone who misses an appointment without calling in advance to cancel.. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the provider. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". A **"no- show" will result in an automatic fee of $25.00**. If a patient accumulates 3 “no-shows”, he/she may be asked to leave the practice. Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of the scheduled appointment will never be assessed a cancellation fee.

I have read, or have had read to me this informed consent form and cancellation policy. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend that this consent form covers the entire course of treatment for my present and any future conditions for which I seek treatment with this practitioner.

_____ _____ _____ /_____ / _____

Patient Name (Please print) Patient Signature Date

HIPAA Compliance: Authorization to Release Information Financial Policy Assignment of Benefits

Patient consent to the use and disclosure of private health information for the treatment, payment and/or healthcare operations.

I, _____ , understand that as part of my healthcare, Dr. Mariel Gallet, DACM, L.Ac. originates and maintains paper, and/or electronic records describing my health history, symptoms,examination, and test results, diagnosis, treatment and any plans for future care or treatment. that this information serves as:
I understand

- A basis for planning my care and treatment.
- A means of communication among the 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 services billed were provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, in disclosure, via electronic fax.

It is our office policy that the patient is responsible for the total fees for medical services at the time of the visit. We accept cash, check, money order and credit card. Visa, MasterCard, American Express and Discover are allowable forms of credit card payment. As a condition of our contract with the insurance companies, we will do the insurance billing for you and will accept assignment on the claim. It is your responsibility to provide us with a copy of your insurance coverage in order for us to determine if your coverage is through one of our contracted carriers. If not, then we will provide you with a Superbill (itemized billing statement) in order for you to seek reimbursement from your insurance company. In either event, you are ultimately responsible for the resolution of your account.

I understand that it is my responsibility to notify Dr. Mariel Gallet, DACM, L.Ac. of any changes in my health care coverage and that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

I hereby authorize to verify eligibility for services rendered by them. I request that payment from my insurance company be made directly to the treating provider(s). I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____ _____/_____/_____

Patient Name (Please print) Patient (or Patient's Representative) Signature Date