All and One Acupuncture and Wellness
New Patient Appointment Information

Thank you for scheduling an appointment with us! Please review the below information regarding your first acupuncture appointment with us.

Where we are:

2906 NE Glisan St
Portland, OR 97232

What to expect:

- Your new patient appointment may range from 30, 60, 90 to 120 minutes – depending on which service you booked
- The first portion of your appointment is a health and wellness review and second portion is your treatment

Appointment Checklist:

- ✓ Eat something before your appointment and avoid caffeine and smoking.
- ✓ Wear or bring loose clothing.
- ✓ Cosmetic & Facial Patients should arrive with a clean & make-up free face
- ✓ Compile a list of current medications and bring relevant medical records, labs, and reports.
- ✓ Bring your completed paperwork (below).

Payment & Insurance

- **Some services such as Cosmetic, Facial & Cupping only appointments may not be billed to Insurance**
- Co-pay's, payment for services, tools, products & supplements are required at the time of service.
- Payment for co-insurance's & deductibles will be billed to your insurance first and then a balance later collected from the insured.
- Missed New Patient Appointments may be subject to a $120 non-refundable deposit to reschedule. Appt. cancellations or changes under 24-hours from the scheduled time is considered a missed appointment.
- If you have Medical Insurance* and would like us to bill them, please provide the following information prior to your appointment so we may verify your benefits:
  - Full Name
  - DOB
  - Insurance Company
  - Insurance Company Phone Number (usually on the back of the card)
  - Member ID#
- Motor Vehicle Accidents please provide the following information:
  - Date and State of Accident
  - Claim #
  - Claim Adjuster Contact Information

Please feel free to contact us with any questions!

~ All and One Acupuncture and Wellness

* Please note that if you do not provide your insurance information prior to your appointment you will be responsible for the "time of service rate" should your insurance not cover acupuncture benefits or if the provider you booked with is not in-network with your insurance company. We accept cash, check, Visa, MasterCard, and American Express.

All and One Acupuncture and Wellness
New Patient Health History Form

Name ______________________________ Today's Date______________

Date of Birth: ______________ Age: ________ Legal Sex: ☐ M ☐ F | Gender:________

Marital Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed

Address:______________________ City/State/Zip:______________________

Email: ____

Phone Number(s) (cell)__________________(home)____________________

Do we have your permission to leave a message concerning your care at the above numbers?

☐ Yes ☐ Only at: ____________________ ☐ No

Who lives at home with you, including pets (example: John (husband), Ruth (housemate), Isis (cat)):

____

____

Emergency contact: ____
(Name) (Relationship) (Phone Number)

How did you hear about us? ______________________________________

Have you had acupuncture before? ☐ Yes ☐ No, If yes, where? ____________________

Name of primary care provider______________________________________

Reason and date of last care received______________________________________

Please identify the health concerns that have brought you to All and One Acupuncture in order of importance:

Condition **Past Treatment**

1.____

How does this condition affect you? ______________________________

2. ____

How does this condition affect you? ______________________________

3. ____

How does this condition affect you? ______________________________

Height: ________ **Weight:** Currently: ________Past Maximum: ________ When?____________

What is your most recent blood pressure reading?__________ When was this reading taken?__________

Please mark an "√ " next to any conditions you currently have and underline conditions you had in the past.

MENTAL/EMOTIONAL

____ Mood swings
____ Depression
____ Seasonal depression
____ Considered suicide
____ Attempted suicide
____ Eating disorder
____ Panic attacks
____ Tension
____ Anxiety
____ Other: ___________________

NEUROLOGIC

____ Seizures
____ Vertigo or dizziness
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of balance
____ Loss of memory
____ Fainting
____ Tremor
____ Other: ____________________

RESPIRATORY/NOSE/SINUSES

____ Cough
____ Pain on breathing
____ Wheezing or asthma
____ Shortness of breath
____ Bronchitis
____ Spitting up blood
____ Stuffiness
____ Nose Bleeds
____ Hay fever
____ Sinus problems
____ Loss of smell
____ Sinus headaches
____ Other: ____________________

HEAD

____ Headaches
____ Migraines
____ Head Injury
____ Jaw/TMJ problems
____ Other: ____________________

MOUTH AND THROAT

____ Teeth grinding
____ Hoarseness
____ Copious Saliva
____ Dry mouth
____ Gum problems
____ Sore tongue or lips
____ Frequent sore throat
____ Other: ____________________

EARS

____ Impaired hearing
____ Earaches
____ Ringing
____ Chronic ear infections
____ Other: ____________________

EYES

____ Floaters or 'spots'
____ Cataracts
____ Blurriness
____ Double Vision
____ Glaucoma
____ Near/Far sightedness
____ Tearing or dryness
____ Other: ___________________

SKIN

____ Rashes
____ Color change
____ Eczema
____ Fungus
____ Itching
____ Acne or boils
____ Hair loss
____ Other: ____________________

URINARY/KIDNEY

____ Pain on urination
____ Increased frequency
____ Nighttime urination
____ Kidney stones
____ Infections
____ Urine leakage
____ Urgency
____ Other: ___________________

MUSCULOSKELETAL

____ Osteoporosis
____ Joint pain
____ Joint stiffness
____ Arthritis
____ Weakness
____ Sciatica
____ Broken bones
____ Muscle pain
____ Muscle spasms
____ Degenerative Disc Disease
____ Other: ____________________

ENDOCRINE IMMUNE

____ Thyroid problems
____ Heat intolerance
____ Cold intolerance
____ Fatigue
____ Hypoglycemia
____ Excess thirst or hunger
____ Diabetes
____ Chronic fatigue syndrome
____ Chronically swollen glands
____ Chronic infections
____ Frequent colds
____ Autoimmune disease
____ Allergies or hay fever
____ Other: ____________________

CARDIOVASCULAR

____ Heart disease
____ Murmurs
____ Chest pain
____ Poor circulation
____ Blood clots
____ Deep leg pain
____ Valvular problems
____ High Blood Pressure
____ Easy bruising
____ Anemia
____ Varicose veins
____ Fainting
____ Swelling in ankles
____ Palpitations
____ Other: ___________________

Please mark an "√ " next to any conditions you currently have and underline conditions you had in the past.

GASTROINTESTINAL

____Change in appetite
____ Trouble swallowing
____ Nausea
____ Vomiting
____ Diarrhea
____ Belching
____ Passing gas
____ Change in thirst
____ Heartburn
____ Ulcers
____Irritable bowel syndrome
____ Crohn's/Ulcerative Colitis
____ Constipation
____ Pain or cramps
____ Black stool
____ Hemorrhoids
____ Other: ____________________

REPRODUCTIVE/SEXUAL

____ Pain with intercourse
____ Genital warts/ HPV
____ Herpes
____ Other STDs
____ Discharge or sores
____ Sexual difficulties
____ Trouble conceiving
____ Change in libido
____ Other: ____________________

MALE ONLY

____ Hair loss
____ Lower libido
____ Hernias
____ Testicular swelling/mass
____ Testicular pain
____ Prostate disease
____ Impotence
____ Premature ejaculation
____ Penile discharge
____ Urinary hesitancy
____ Other: ____________________

FEMALE ONLY

____ Menstrual cramps
____ Irregular cycles
____ PMS
____ Change in length of cycle
____ Bleeding between cycles
____ Abnormal discharge
____ Frequent yeast infections
____ Endometriosis
____ Menopause symptoms
____ Breast lumps or pain
____ Nipple discharge
____ Heavy cycles
____ Ovarian cysts
____ Clotting
____ Loss of menses
____ Abnormal paps
____ Age of first menses
____ # of pregnancies
____ # of miscarriages
____ # of live births
____ # of abortions
____ Other: ____________________

Do you have: ☐ Pacemaker ☐ Electric Implants ☐ Metal Implants ☐ Bleeding Disorder ☐ HIV/AIDS ☐ Hepatitis A/B/C ☐ Tuberculosis ☐ Other infectious disease

Do you have any reason to believe you may be pregnant? ☐Yes ☐ No

Please list any hypersensitivities or allergies (including foods, drugs, and medications, and your reaction):

____

____

Please list all prescription and over the counter medications, vitamins, and supplements you are currently taking, including dosage and frequency:

____

____

____

Please list all major accidents, illnesses, hospitalizations and surgeries:

Reason	**When**	**Reason**	**When**

Please list any chronic illnesses/conditions: ____

____

____

	Health Status/Diseases	Age	If deceased, cause of death
Mother			
Father			
Brothers			
Sisters			
Maternal Grandparents			
Paternal Grandparents			

If you consume caffeine, please indicate type (coffee, tea, etc) and amount/day____________________

____

Do you consume alcohol? Y N If yes, please give average number/week for each type:

beer________________ wine ________________ liquor________________

Have you ever smoked or chewed tobacco ☐Yes ☐No If yes, type and start date: ________________

Average packs/day__________________________ If applicable, quit date: ________________

Do you use recreational drugs? ☐Yes ☐No

Occupation: ____________________________________**Employer**: __________________________

Hours/Week: ____________**Do you enjoy work?** ☐Yes ☐No **Why/Why not?**__________________

____

Interests/Hobbies: ____

____

All and One Acupuncture and Wellness
HIPAA Privacy & Financial Policy Acknowledgement and Consent Form

I understand that All and One Acupuncture and Wellness ('All and One') may use and disclose health information about me.

I understand that my health information may include information both created and received by All and One, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that All and One may use and disclose my health information within the practice of All and One:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers within All and One for my care and treatments;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support my provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how All and One will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of All and One, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of All and One's Notice of Privacy Practices in effect will be available in the waiting area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that All and One is not required by law to agree to such requests.

_______ I understand that All and One will provide billing services to my insurance company and that co-pays, co-insurances, & deductible amounts will be collected at the time of service or billed afterwards. Any amount not covered by my insurance company for any reason will be my responsibility. I also understand that products, tools, and supplements are additional costs, and **missed appointments (change/cancellation under 24 hours of scheduled appointment time) fees may be charged a fee of $55.**

INSURANCE CLIENTS PLEASE INTIAL ONE OPTION BELOW

______ I understand that some services such as, but not limited to, cupping, massage, tui na, and shiatsu billed under CPT code 97140, Manual Therapy and the use of infrared heating elements (TDP Lamps) billed under CPT code 97026 may not be included under my acupuncture benefit. Other CPT codes which may apply are 97110 & 97124. Any amount applying to my deductible or not covered by my insurance company for any reason will be my responsibility.

______ I decline to receive these services.

All and One Acupuncture and Wellness
HIPAA Privacy & Financial Policy Acknowledgement and Consent Form

By signing below, I agree that I have reviewed and understand the information about and that a copy of the Notice of Privacy Practices and fee schedule is available to me should I request it.

INSURANCE BILLING RATES

97810, Acupuncture, Initial 15 Minutes $70

97811, Acupuncture, Additional 15 Minutes $50

97813, Electro-Acupuncture, Initial 15 Minutes $75

97814, Electro-Acupuncture, Additional 15 Minutes $55

97124, Massage Therapy, 15 Minutes $50

97140, Manual Therapy, 15 Minutes $50

97110, Therapeutic Exercises $25

97026, Infrared Heat / Light $10

99201, New Patient, Limited $80

99203, New Patient, Expanded $100

99212, Existing Patient, Limited $80

99213, Existing Patient, Expanded $90

Signature: ______________________ **Date:** ______________

Patient's Printed Name: ______________________ **Date of Birth:** ______________

Authorized Representative's Name & Relationship (if applicable): ______________________

All and One Acupuncture and Wellness
Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and other procedures within the scope of the practice of acupuncture by any practitioners employed at All and One Acupuncture and Wellness. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed M.D. is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, numbness or tingling near the needling sites that may last a few days, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Rare but serious risks of acupuncture including lung puncture (pneumothorax), nerve damage, infection, and spontaneous miscarriage. I understand that there are no guarantees concerning its use and effects, and that I am free to stop acupuncture at any time.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. Adverse effects may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Cupping/Gua Sha Bruising and muscle soreness are common side effects of cupping and gua sha, and burns, blisters, cuts and scarring are potential risks of moxibustion and cupping. I understand that I may refuse or stop the treatment.

Herbal Therapy I understand that I may be given Chinese herbs as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I will immediately notify a clinic staff member of any unanticipated or unpleasant effects associated with the herbal therapy. Some possible side effects of herbal therapy include nausea, gas, stomachache, vomiting, headache, change in bowel movements, rash, hives, and tingling of the tongue.

Acupressure/Tui-Na/Shiatsu and other forms of Massage I understand that I may also be given acupressure, tui-na, shiatsu and other forms massage as part of my treatment. Adverse effects could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the therapy at any time.

Thai Steamed Herbal Compress Massage carries the risk of possible overheating or burning of the skin. The herbal components could cause a dermatological irritation if the patient has an allergy or sensitivity to the ingredients.

I do not expect my practitioner to be able to anticipate and explain all risks and complications. By voluntarily signing below, I show that I have carefully read and understood all of the above information, and I am fully aware of what I am signing. I give my permission and consent to treatment.

Signature: ______________________________ **Date:** ____________________

Patient's Printed Name: ______________________________ **Date of Birth:** ____________________

Authorized Representative's Name (if applicable): ______________________________

All and One Acupuncture and Wellness
Patient Request for Email Communications

I understand that as a patient at All and One Acupuncture and Wellness (the "Clinic") may request that the Clinic communicate with me via email. I understand that the Clinic provides this service as a courtesy to me only after I have carefully reviewed and completed this form.

I understand that email presents inherent privacy risks. Email is typically sent without encryption, and unencrypted emails can be viewed and read by others while the email is in transit or when the email is stored on my computer or other electronic device. I also understand that errors can occur in transmission, despite the reasonable caution of the sender. As a result, I understand that there is no assurance of confidentiality when information is communicated via email.

I also understand that any emails I send to the Clinic may be forwarded for the purposes of providing me treatment or securing payment for my care, and that these emails may become part of my medical record.

I understand that I can request that the Clinic stop communicating with me via email at any time.

I request that the Clinic communicate with me at the following email address:

Email Address: ____

I understand that the Clinic may communicate with me at this email address about the following topics:

- Scheduling and Appointments
- Billing and Payment
- Symptoms, Diagnoses, and Treatment

By signing below, I show that I understand that there are inherent risks associated with email communication, and I authorize All and One Acupuncture and Wellness to communicate with me regarding my health care and protected health information via email. I agree to hold the Clinic and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request.

Signature: ______________________________________ **Date:** ____________________

Patient's Printed Name: ______________________________ **Date of Birth:** ________________

Authorized Representative's Name & Relationship (if applicable): ______________________________