



Central Oregon Acupuncture

How to prepare for your appointment:

- * Wear loose clothing that can be rolled up on the legs and arms
- * Because many of our patients are sensitive to perfumes, lotions and scented beauty products, please refrain from using these products on the day of your appointment.
- * Please have your paperwork filled out and ready by the time of your appointment or come in 10-15 minutes before your appointment to fill it out.
- * Please make sure that you bring in all of your insurance information:
 - Current Insurance card
 - For accident claims (workers compensation/auto accident):
 - Prescription from you primary doctor for acupuncture
 - Claim #
 - Date of injury
 - Insurance company and contact information
 - Adjuster's name and contact information

**If you can not make it to your appointment,
we ask that you please give 24 hours notice.
(541) 330-8298**

HIPAA Privacy Authorization Form

(Authorization for Use or Disclosure of Protected Health Information)

1. Authorization:

I authorize Central Oregon Acupuncture, LLC to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period:

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. all past, present, and future periods.

3. Extent of Authorization:

a. I authorize the release of my complete health record (including records relation to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment and consultation, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure and the information may not be protected by federal confidentiality rules. My treatment, payment, enrollment, or eligibility for benefits will NOT be conditioned on whether I sign this authorization.

Signature of Patient or Personal Representative

Date

Printed name of Patient or Personal Representative

Date

Health History Questionnaire

Information for your acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosing and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ___/___/___ Name: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Age: _____ Date of Birth: ___/___/___ Place of Birth: _____

Guardian (If under 18): _____

Gender: M F Height: ___' ___" Weight: _____ lbs.

Occupation: _____ Employer: _____

How did you hear about us? Walk By Website Insurance Company Phonebook

Referral Please tell us who referred you, so that we may thank them: _____

Other physicians/therapists seen for this condition: _____

Medications (if any): _____

Prescribed by: _____

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

Major Complaint(s) (why you are seeking acupuncture), in order of significance to you:

- | | Severe | Moderate | Slight | Normal | |
|----|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent Tests: (Please indicate test results and date below)

- Physical Cholesterol Prostate Blood (which?)
- HIV/STD Pap Smear Mammography Other

Test results and date: _____

Check any you have had in the past:

- Diabetes Allergies Glaucoma Rheumatic Fever
- Heart Attack CVA (Stroke) Vein Condition Thyroid disorder
- Asthma Pneumonia Tuberculosis Emphysema
- Jaundice Gonorrhea Mumps Bleeding tendency
- Syphilis Measles Chicken Pox Nervous disorder
- Meningitis HIV Polio Mononucleosis
- Epilepsy High Fever Hepatitis Multiple Sclerosis
- Paralysis Cancer Migraines High blood Pressure
- Other lung illness Other Liver Illness Other heart illness
- Other spleen illness Other stomach illness Other kidney illness
- Other: _____

Immunizations: _____

Surgeries: _____

III. Family History

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
Children	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	

Please check the following that pertain to you:

Overall Temperature (Kidney Function):

- Cold Hands Hot Body Temperature Cold Feet Cold Body Temperature
- Sweaty Hands Sweaty Feet Thirsty Heat in hands, feet, chest
- Night Sweats Afternoon Flushes Perspire Easily Lack of Perspiration
- Take water to bed Hot Flashes any time of day
- Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney Function):

- Shortness of breath General weakness Easily catch colds Low energy
- Feel worse after exercise Difficulty keeping eyes open in the daytime

Blood (Liver, Spleen, Heart Function):

- Dizziness See floating black spots

Heart Function:

- Palpitations Anxiety Frequent dreams Mental Confusion
- Restlessness Chest pain traveling to shoulder Wake unrefreshed
- Drink coffee (# of cups per week: _____)

Lung Function:

- Cough Nose bleeds Sinus congestion Dry Mouth Stiff neck
- Dry throat Dry nose Dry skin Sneezing Sore throat
- Difficulty breathing Stiff shoulders Melancholy Sadness
- Alternating fever and chills Overall achy feeling in body
- Nasal Discharge (Color: _____)
- Headache (Location: _____)
- Smoke cigarettes (# of cigarettes per day: _____)
- Allergies (To what? _____)

Spleen Function:

- Low appetite Abrupt weight gain Abrupt weight loss Abdominal bloating
- Abdominal gas Fatigue after eating Easily bruise Hemorrhoids
- Pensive Over-thinking Gurgling stomach Worry
- Prolapsed organs(Previously diagnosed, which organ? _____)

Spleen, Stomach, Large Intestine, Small Intestine Function:

- Loose Constipated Incomplete Diarrhea Blood in stools
- Mucous in stools Undigested food in stools

Dampness trapped in the body:

- Mental Heaviness Mental sluggishness Mental fogginess Swollen hands
- Swollen feet Swollen joints Chest congestion Nausea
- Snoring General sensation of heaviness in body

Do you experience any of the following pre-menstrual syndromes?

- | | | | |
|---|--|--|------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Depression | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Water retention | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Breast tenderness | |
| <input type="checkbox"/> Other emotions: _____ | <input type="checkbox"/> Dull pain, where? _____ | | |
| <input type="checkbox"/> Sharp pain, where? _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (Normal, bright red, pale, brown, dark, purple)							
Amount of flow (Normal, heavy, Light)							
Pain/Cramps (Location, dull, sharp)							
Clots (Large, small, black, purple, red)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men Only:

- | | | | | |
|--|---------------------------------|-----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Swollen testes | Severe <input type="checkbox"/> | Moderate <input type="checkbox"/> | Slight <input type="checkbox"/> | Normal <input type="checkbox"/> |
| <input type="checkbox"/> Testicular pain | Severe <input type="checkbox"/> | Moderate <input type="checkbox"/> | Slight <input type="checkbox"/> | Normal <input type="checkbox"/> |
| <input type="checkbox"/> Premature ejaculation | Severe <input type="checkbox"/> | Moderate <input type="checkbox"/> | Slight <input type="checkbox"/> | Normal <input type="checkbox"/> |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia | Severe <input type="checkbox"/> | Moderate <input type="checkbox"/> | Slight <input type="checkbox"/> | Normal <input type="checkbox"/> |
| <input type="checkbox"/> Other: _____ | | | | |

Other Comments: _____

Informed Consent to Treatment

Oriental Medicine is an ancient form of healing that began in China over 3,000 years ago and is now utilized throughout the world. Diagnosis and treatment are based on the premise that our bodies run on bioelectrical energy called Qi (“chee”) that runs through our systems in organized energy flows called meridians. This energy can be affected by both internal and external factors, such as extreme emotions, seasonal and environmental changes, trauma, and can create imbalances in the system that can lead to physical and psychological manifestations. Oriental Medicine takes into account the incredible complexity of each individual’s mind, body, and spirit. The goal of treatment is to rebalance the energetic systems, optimizing a person’s function on all levels.

Oriental medicine is a proven, safe, and effective form of treatment for a wide variety of conditions and can work well in conjunction with any other medical treatment with no side effects. The primary modality used in Oriental Medicine is acupuncture, the insertion of thin, sterile, single-use disposable needles in the body. Various sensations are experienced during treatment including a distended feeling around the needle site, itching, tingling, a dull ache, or energy moving. Some patients feel nothing until after the treatment. If at any time you experience a stinging, burning or any uncomfortable feeling please let your practitioner know so the needle may be adjusted or removed. After the needles are in place you will be given time to rest, usually 20-45 minutes. During this time many experience a floating or heavy sensation, but typically feel comfortable, relaxed and sometimes fall asleep. It is advisable to avoid heavy exercise, eating, alcohol, or stimulants just before or after treatments. Please inform your acupuncturist if you have any food or drug allergies, if you are pregnant, or wearing a pacemaker.

Inherent risks of acupuncture treatment include and are not limited to slight bruising and dizziness. It is possible to experience changes in emotions, appetite, sleep, energy levels, and bowel or urinary patterns. If you have any concerns, do not hesitate to call in a medical emergency contact your physician or nearest medical facility.

Cancellation policy: Please give at least 24 hours notice if you need to reschedule so that the time may be used for someone else. If notice is not given, you may be charged a cancellation fee for the missed appointment.

I, (patient/guardian) _____ do hereby request and consent to the performance of procedures that are within the scope of Acupuncture and Oriental Medicine as recognized by the state of Oregon, including but not limited to: acupuncture, moxibustion, cupping, electro-acupuncture, herbal therapy, nutritional consultation, and infra-red heat therapy on me (or the patient for whom I’m legally responsible), by the licensed acupuncturists who now or in the future work with me. I have the choice at any time to accept or reject any procedure being offered, and understand that the results are not guaranteed.

This consent is intended to cover the entire course of treatment for any present conditions and for any future conditions for which I seek treatment. I am responsible for all payments of my treatments at the time of service. My signature below signifies that I have read and understand all of the above, all privacy practices and cancellation policies, and I give my consent to treatment.

Signature of Patient or Legal Guardian

Date

*Please print the patient’s name here
(If you are not the patient)*

Jennifer L. Cochrane, L.Ac.
State License # AC00648
P. (541) 330-8298 F. (541) 317-9569

INSURANCE INFORMATION

Patient Name: _____ Patient's Date of Birth: _____

Patient Social Security #: _____

Name of Insurance Company: _____

Policy/ ID# : _____ Group #: _____

Do you have an open accident claim? Yes NO

Accident Information:

Date of accident: _____ Claim #: _____

Insurance company: _____ Phone: _____

Your primary/referring doctor: _____

Accident claims: You must have a prescription for acupuncture from your primary doctor prior to your first appointment.

PAYMENT

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, and any services rejected by my insurance company. I understand that benefits quoted to Central Oregon Acupuncture by my insurance company are not a guarantee of payment and that I am ultimately responsible for all charges incurred.

RELEASE OF INFORMATION

I also authorize this office to release any information that is required or necessary for my claim to an insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequences thereof.

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this office, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for service rendered by this office. I give this office power of attorney to endorse checks made out to me, to be credited to my account.

Signature of Patient or Legal Guardian

Date

OFFICE USE ONLY

Today's Date: _____ **Time:** _____

Insurance Co. Rep. Talked to: _____

Co-pay: _____ **Paid at (%):** _____

Deductible: _____ **Met:** _____ **Max:** _____ **Used:** _____

Notes: _____