CONFIDENTIAL PERSONAL INFORMATION

Full Name:___________________________________/_________________________________/___________
(Last Name) (First Name) (Middle Initial)
Preferred Name: _________________ Age: ______ Date of Birth: _____________

Address:____/_____________/____/__________
(street#/PO Box) (city) (state) (Zip code)
Telephone#(____)______________/_(____)___________________/_(____)_____________________
(home) (work) (cell phone or other)
E-mail address: ____
I occasionally send email newsletters. You may opt out at any time by following links in the emails. Please check here if you do NOT want to receive these_____.

Sex/gender identity: female _____ male _____ other/preferred pronoun? ____________________
Are you (check one): Single ____ Partnered ____ Married ____Widowed/widower ____
Partner's Name: ____
Occupation: __________________________(circle) full-time/part-time/student/retired/unemployed
Employer: ____

Do not enter insurance information if we are not billing insurance for you.
Insurance company ____
Insured's Name ______________________________________ Insured's DOB ________________________
Insurance ID No.: __________________________ Group No. _________________________ Plan year dates _____
Acupuncture Benefits: ______________(visits or total amount) Deductible amount: ________ Deductible met? Y or N
Physical/Manual Therapy Benefit: ________(visits or total amount) Deductible amount: _________ Deductible met? Y or N
Co-pay amount ______________ Coinsurance _____________
Please note that payment is due at the time of service. We will bill your insurance company but you will be responsible for payment in full if your insurance company does not pay your claim. Please note that we cannot bill Kaiser/CHP out of network.

Is the reason for your visit due to a motor vehicle or work-related accident? (Circle) Y N
Claim # (MVA or Worker's Comp) __________________
Adjustor: ____ Phone: __________________

Emergency Contact ____ /_______________
(Name) (Relationship)
(_____)____ (_____)________________________________
(Day Phone) (Evening Phone)

What is the best way to communicate with you between office visits?
Circle one: E-mail, Home, Work, Cell Phone
Is there any place you do NOT want me to leave a message? ___________________________

By signing below, I verify that the above information is correct and true to the best of my knowledge. Signature of Patient ____Today's Date______________

200 NE 20th Avenue, Suite 120 • Portland, OR 97232
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INFORMED CONSENT FOR TREATMENT

Please read and initial each statement, indicating that you have read, understood, and agree. Please ask if you have questions. This form must be signed before we can begin treatment. If you prefer to have your practitioner read through this form with you and explain each section, please ask!

____ I hereby request and consent to treatment for myself (or the below-named patient for whom I am legally responsible) by the acupuncturist named below with procedures and techniques including but not limited to: acupuncture, Chinese or western herbal therapy or supplements, moxibustion, cupping, somatic resilience and regulation touch therapy, gua sha (scraping), breathing techniques, exercise therapy, somatic re-education, craniosacral and/or visceral therapy, and/or lifestyle/nutritional counseling.

____ I understand that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks, which the acupuncturist takes careful precautions to avoid, include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. I understand that I should not make significant movements while the needles are being inserted, retained, or removed.

____ I understand that the somatic resilience and regulation touch therapy and craniosacral therapy may be used to address somatic expressions of developmental trauma; I understand these are not a substitute for talk therapy or psychiatry and that they may be used in conjunction with psychiatric or mental health services. I understand that Tracy Andrews, LAc is not a mental health therapist, counselor, or psychologist and that I may request care coordination between Tracy Andrews, LAc and my other providers.

____ I understand that certain craniosacral methods may be contraindicated for concussion, hemorrhage, stroke, or blood clots and state that I am not currently experiencing any of these conditions to the best of my knowledge or I have notified my practitioner of these conditions.

____ I understand that visceral therapy methods may be contraindicated for recent injuries or surgeries to the abdomen or thorax and for tumors in the abdomen or thorax, and state that I am not currently experiencing any of these conditions to the best of my knowledge or I have notified my practitioner of these conditions.

____ Side-effects of cupping, bleeding and gua sha may be bruising or temporary skin discoloration. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that I may opt out of these treatments at any time.

____ The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and in writing and I will immediately notify my practitioner of any effects associated with the consumption of the herbs or other supplements. I will keep the acupuncturist informed of my medications and other supplements to reduce the risk of herb-drug interactions.

____ I have stated all my known medical conditions and take it upon myself to keep my provider updated on my physical health. I will notify my provider if I am or become pregnant, or I have a bleeding disorder. I will notify the acupuncturist of any significant changes in my health, or new diagnoses by my primary medical physician. I understand that my acupuncturist encourages me to see a primary medical physician in conjunction with treatment by the acupuncturist. I release the acupuncturist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

____ I do not expect the acupuncturist to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Printed Name:____
Printed Name of Patient Representative:_______________________________________
Signature of patient or patient representative:_________________________Date:__________

FINANCIAL & CANCELLATION POLICIES

1) Full payment (or co-pay/coinsurance) is due at the time of service. Your payment options are: cash, check, or credit/debit cards. We accept Visa, Master Card, Discover, or American Express. Check or cash is preferred.

2) Insurance Billing: We can bill your insurance whether in or out of network *(we cannot bill Kaiser, CHP, OHP or Medicaid)*. Co-payment or co-insurance due at the time of service; if you have not met your deductible, we ask that you pay some portion of your deductible at your visit. If you have a balance after insurance payment has been received, you will receive a statement of your account balance approximately once a month from Northwest Medical Billing.

3) Deductibles: Many insurance plans have a separate deductible for physical or manual therapy (i.e. hands-on work such as craniosacral therapy and visceral manipulation). You are responsible for payment of the deductible amount for acupuncture and, if you elect to use it, for manual therapy. If you prefer not to use manual therapy benefits, you may pay for manual therapies at the time-of-service rate ($25 per 15 minutes of treatment).

Per your request, a statement can be provided for submitting to your insurance company for reimbursement. You are responsible for full payment on services not paid by your insurance company.

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3) Missed Appointments/Late Cancellations: All appointment cancellations must at least 48 hours before your appointment. You may cancel an appointment by email or phone call. If it is less than 48 hours, you will be charged $85 for the missed appointment. In the event of multiple late cancellations or no-show appointments, a deposit of $85 will be required to schedule future appointments (refundable in the event that a cancellation occurs more than 48 hours in advance of said appointment).

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, I acknowledge that I understand the above **financial, cancellation and HIPAA/privacy** policies and that I have been given the opportunity to review this office's notice of privacy practices.

Printed Name:____

Printed Name of Patient Representative:________________________________

Signature of patient or patient representative:

____Date:__________

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name : ______________________________ DOB: ______________
(Individual whose information is to be disclosed)

I authorize Tracy Andrews, LAc to
_________ exchange information with
_________ release information to the following individual(s) or agenc(ies):

____
(Name of facility or provider) (Address)

____
(Phone) (Fax number)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ General health information including health status and treatment _____ Drug & Alcohol information
_____ Mental health information

Consisting of all health information unless otherwise specified here: ______________________________

Purpose of disclosure: This information will be used for evaluation and to plan for and coordinate services for me, my family or for other purposes specified here: ______________________________

This authorization becomes effective on the date below and will expire 1 year from termination of treatment with Tracy Andrews, LAc unless I indicate otherwise: ☐ Specific expiration date: ______________

I understand that I do not have to sign this authorization. Refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement of services. I have a right to refuse to sign this authorization. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I also understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I have the right to revoke authorization in writing except to the extent that Tracy Andrews, LAc has acted in reliance upon it. My written revocation must by received by Tracy Andrews, LAc.

______________________________ ____________
Client Signature Date

☐ Client (14 and older) ☐ Guardian
☐ Parent ☐ Legal Custodian

______________________________ ____________
Parent or Guardian Signature (if applicable) Date

Rediscl.
Redisclosure: Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of Alcohol/Drug Information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Tracy Andrews
ACUPUNCTURE

RAPID CHECK FORM

Name: ______________________________ Date: ____________

Primary Care Provider (MD/DO/ND): ______________________________ Phone: ____________
Therapist: ______________________________ Phone: ____________
Psychiatric Care: ______________________________ Phone: ____________
Other Care Providers: ______________________________ Phone: ____________

Medication/Supplement	Dosage	Purpose

Office Use Only:

Date	Diagnosis Code(s)	Rx: Formulas/Supplements/Referrals	Pre-Auth Dates/Visits

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