McMinnville Community Acupuncture
117 NE 5th Street, Suite E 503-437-3391

Birthday: _____

Name: _____
First Middle Last

Phone #: (best) _____ cell home (second best) _____

E-mail:_____ Gender: Male Female

Mailing Address:_____

City:_____ State:_____ Zip:_____- _____
2013 regulation requires claims to be filed using a home address NOT a PO Box

Bring your insurance card (so that we can make a copy) and SKIP filling out this section

Insurance Company:_____
Name of Policy Holder:_____DOB: ____/_____/_____
Subscriber ID#:_____
Policy Holder Relationship to Patient:_____ (Self / Spouse / Child)
Do you have secondary insurance? YES NO

Occupation:_____ Employer:_____

MOTOR VEHICLE CLAIMS ONLY
Auto Insurance Company:_____ Date of Accident: _____
Claim #:_____
Ins. Adjuster Name: _____ Adjuster Phone #: _____
Address of Policy Holder (If different from you): _____
Insurance Claim Address: _____

Emergency Contact Name:_____Phone #:_____
Relationship to you: _____

How did you hear about our clinic? _____
May we thank them? YES NO

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under the title XIX of the Social Security Act, by Insurers, or by any other third party is correct. I assign payment to the provider(s) rendering medical service to the patient. I understand that I am responsible for payment of any health insurance deductible(s), co-insurance, or any other charges incurred which are not paid by any insurance or third party payors.

RELEASE OF INFORMATION: I hereby authorize my health care providers, hospital, pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, or benefits payable for this claim to any organization responsible for payment of this claim or to any health service provider who will render care to the patient after discharge:
I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party agency for collection. I agree to pay all reasonable arbitration, court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

*** TURN PAGE OVER!!! ***

Primary Care Physician Name: _____ City:_____

Please list all current medications (with dose), vitamins, and supplements:

What are your main reasons for seeking treatment today?

Please briefly list your major medical history (illnesses, injuries, traumas, hospitalizations, surjeries, chronic conditions, etc):

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Office Policies

Billing:
We require payment for services rendered and materials prescribed at the time of service unless other arrangements are made in advance. We accept cash, check and credit cards. As a courtesy we will bill your insurance and will provide you with a billing statement upon request. Courtesy billing and billing statements are currently transmitted through the office, but we may elect to use a billing service in the future. This may change at any time without notice.

Cancellations and Missed appointments
In the event you are unable to make your scheduled appointment time, please call with as much notice as possible. If less than 24 hour notice is given and we are unable to fill your appointment time, you will be charged a **$20 fee.** Missed appointments are not reimbursed by insurance companies. Exceptions to this rule may be made for inclement weather, unsafe travel conditions and some emergencies.

Supervision
Children must be supervised at all times in both the waiting room and parking lot.

Mandated Reporter
I am a mandated reporter of child abuse, elder abuse, homicide and suicide. If I assess at anytime you are at risk of hurting yourself or others the law requires me to break confidentiality and secure peoples safety.

Emergencies
I am generally not available for emergencies, after business hours, or on weekends. I check my messages daily and return calls promptly. If you have an emergency call 911 or go to the nearest hospital emergency room. If your call is urgent, please say so on my voice mail so that I can prioritize my schedule to fit your needs.

Private and Separate Businesses
Each clinician in the building is a private business entity. Each business is completely separate and shares no responsibility or liability for the delivery of service of the other practitioners.

I have read and understand the above office policies.

_____ _____
Signature of Patient or Guardian Date

_____
Printed Name

McMinnville Community Acupuncture

Authorization to Disclose Protected Health Information

If you would like McMinnville Community Acupuncture to discuss your case with any other health practitioners or family members, please list their names here (if not, skip this section)

I hereby authorize McMinnville Community Acupuncture to disclose my protected health information and patient file to the following people/practitioners and discuss my case as medically necessary:

Name of Practitioner or Family: _____
Name of Practitioner or Family:_____

By authorizing the above people/practitioners, they will have access to the information in your file.

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

Patient Signature: _____

Acknowledgement of receipt of Notice of Privacy Practices

By signing this, you acknowledge access and receipt of the *Notice of Privacy Practice* available on our website www.mcaclinic.com. Our *Notice of Privacy Practices* is subject to change; if changes occur, you may obtain a copy of the revised notice by contacting at 503-437-3391.

Patient Signature: _____

OFFICE USE ONLY

I made good faith attempts to provide the patient with our *Notice of Privacy Practices*. However, I was unable to obtain the patient's written acknowledgment of receipt of the notice.

Signature of Provider:_____

INFORMED CONSENT TO TREAT

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

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Shiatsu (Japanese massage), Tuina (Chinese Massage), Chinese herbal medicine, and nutritional counseling.

Acupuncture: Acupuncture is a way of directing the human body's own mechanisms of self-healing to promote wellness and treat disease. Most people experience a deep sense of relaxation during and after an acupuncture treatment; many even fall asleep. It is commonly used for relaxation, internal medicine, stress reduction and pain symptoms. Possible side effects include bruising or tingling near the needling site. Unusual risks of acupuncture include spontaneous miscarriage, organ puncture such as lung puncture (pneumothorax). Though infection is another possible risk, our clinic uses sterile disposable needles and maintains a clean and safe environment.

Moxibustion/Cupping/Gua Sha: Moxibustion (moxa) is a technique that involves burning mugwort above the skin to strengthen the immune system and stimulate blood flow to initiate healing and maintain general health. Burns and/or scarring are a potential risk of moxa. Cupping is a technique that involves glass cups placed on the skin and gua sha, a gentle skin scraping technique.

Herbs: Chinese herbal medicine takes a gentle, holistic approach to healing. Using the signs and symptoms of the body, feeling the patient's pulse and asking the right questions, we write a personalized herbal formula for the body- a poem that shows it the direction back to exuberant health and wellness. Herbs are given in a powder form to be mixed with hot water to make a tea. Our clinic staff will provide specific intake directions for each patient and will do their best to answer any questions. Some possible side effects of taking herbs are nausea and gas due to the nature of some herbs cleaning out the gut flora, however the immediate effects of most herbs are relatively calm.

Electro-Acupuncture: Electro-acupuncture may be administered with the acupuncture based on the patient's preference and treatment plan. Electro- Acupuncture is restful and relaxing. Possible side effects are pain or discomfort, and the possible aggravation of symptoms.

Acupressure-Massage: Acupressure-massage is used to modify or prevent pain perception and to normalize the body's physiological functions. Muscles may feel sore after treating.

Group Treatment: In some situations, treatment will be administered in a group setting in a large room. It is possible that other individuals in the room may hear treatment information. We request confidentiality.

I understand that while this document describes the major risks of treatment, other side effect and risks may occur. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Patient Signature:_____ **Date**:_____

(Or Patient Representative) (Indicate relationship if signing for patient)