Goji Acupuncture & Wellness Clinic
(209) 597-3886

1770 N Tracy Blvd., Suite A
Tracy, CA 95376

Cindy Tsui, L.Ac

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Website: www.gojiacupuncture.com

Patient Form

This is a confidential questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible. Thank you!

Contact Information Today's Date: _____ /_____ /_____

Name:_____ Sex: F ☐ M ☐ DOB: ____ /____ / ____ Age:_____

Street:_____Email Address:_____

City:_____State:_____Zip:_____ Martial Status: M ☐ S ☐ D ☐ W ☐

Preferred Spoken Language:_____ Preferred Written Language:_____

Phone Number:_____Alternative Phone Number:_____

Occupation:_____Employer:_____

Emergency Contact:_____Phone:_____

How did you find out about us? _____

Have you had acupuncture before? Y ☐ N ☐ Allow email/mail/phone contact by us? Y ☐ N ☐

Chief complaint/ reason for your visit:_____

What diagnosis, if any, have you received for this problem?_____

How long have you had this condition?_____

What was the initial cause?_____

Have you ever experienced this before?____N ____Y (If Y, When?_____)

What makes this problem worse?_____Better?_____

Is there anybody in your family with the same problem?_____

What other treatments have you tried?_____How long?_____
Were they effective?_____

Please list your other health concerns, if any, in order of importance

1. _____3. _____

2. _____4. _____

Are there any spiritual beliefs or practices we should be mindful of?_____

NOW: ___ Pregnant ___ Pacemaker ___HIV Disease ___Hepatitis A/B/C ___Bleeding Disorder ___Blood transfusion ___ Implants (metal, electronic, silicone, etc)

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐		Other:_____			

Known allergies (food, medications, or other):_____

Significant trauma (car accident, sports injuries etc.):_____

Hospitalizations/Surgeries (procedures and dates):_____

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):_____

_____

Family Medical History (please specify family member)

☐ Alcoholism/Drug Abuse_____
☐ Asthma/Allergies_____
☐ Cancer_____
☐ Depression/Mental Illness_____
☐ Diabetes_____
☐ Other_____
☐ Heart Disease_____
☐ Hypertension_____
☐ Miscarriage_____
☐ Osteoporosis_____
☐ Stroke_____

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day?_____ For how long?_____

Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____

Do you sit in traffic/commute as a daily routine? Y ☐ N ☐

How many hours do you sleep in general?_____ What time do you usually go to bed?_____

What time do you usually get up?_____

Diet

Soft drinks per day_____ Cups of tea per day_____ Cups of coffee per day_____Glasses of water per day_____

Alcoholic beverages per week_____ Are you a vegetarian? Y ☐ N ☐

Please describe your average daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Foods you tend to crave:_____

Medications and Supplements: Please list all the prescriptions, over-the-counter medicines, vitamins and supplements you are currently using.

Name	Purpose	How Often	Dose	Start Date	Date of Last Dose

Please check any of the following symptoms that **currently** pertain to you.

General
___Insomnia
___Dreams/ nightmares
___Irritability
___Depression
___Mood swings
___Fatigue
___Poor memory
___Strongly like cold drinks
___Strongly like hot drinks
___Recent weight loss/gain
___Cold hands & feet
___Chills
___Fever

Head & Neck
___Headaches
___Migraines
___Stiff neck
___Dizziness
___Fainting
___Swollen glands

Ears
___Ringing
___Hearing loss
___Infections
___Earache
___Hearing aids
___Vertigo

Eyes
___Glasses/ contact lenses
___Blurred vision
___Poor night vision
___Spots or floaters
___Eye inflammation
___Double vision
___Glaucoma
___Cataracts

Skin
___Hives
___Rashes
___Eczema/ psoriasis
___Night sweating
___Excess sweating
___Dry skin
___Easy bruising
___Changes in moles, lumps
___Itching

Respiratory
___Difficulty breathing
___Difficulty breathing when lying down
___Wheezing
___Asthma
___Chronic cough
___Wet cough
___Dry cough
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Tight chest
___Pneumonia

Cardiovascular
___High blood pressure
___Low blood pressure
___Chest pain or tightness
___Palpitation
___Rapid heart beat
___Irregular heart beat
___Poor circulation
___Swollen ankles
___Phlebitis
___Anemia
___History of heart attack

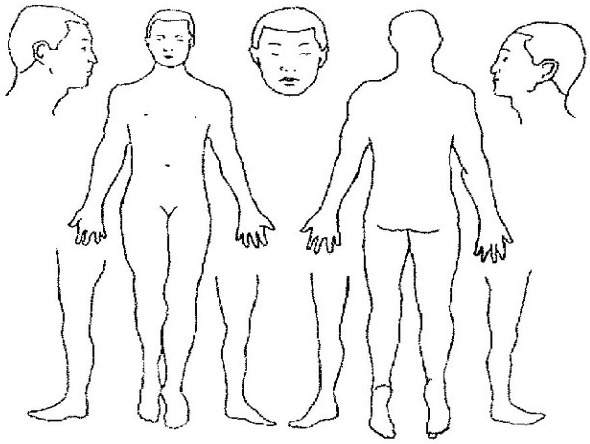
Musculoskeletal
___Joint pain/disorder
___Sore muscles
___Weak muscles
___Difficulty walking
___Neck/shoulder pain
___Upper back pain
___Lower back pain
___Rib pain
___Limited range of motion
___Other (describe)

Neurological
___Seizures
___Tremors
___Numbness or tingling
___Pain
___Paralysis
___Poor coordination
___Other (describe)

Genito-urinary
___Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Unable to hold urine
___Incomplete urination
___Bedwetting
___Wake to urinate
___Increased libido
___Decreased libido
___Kidney stones
___Impotence
___Premature ejaculation
___Nocturnal emission
___Pain/itching of genitalia
___Lumps in testicles

Nose, Throat & Mouth	**Gastrointestinal**	**Infection Screening**
___Sinus infection	___Nausea	___HIV risks: self or partner
___Hay fever/ allergies	___Indigestion	___TB: self or household
___Frequent sore throat	___Stomach pain	___Hepatitis risk: self or partner
___Difficulty swallowing	___Diarrhea	___History of sexually transmitted
___Mouth & tongue ulcers	___Constipation	disease: self or partner
___Frequent colds	___Poor appetite	___Gonorrhea
___Excessive phlegm	___Excessive hunger	___Chlamydia
___Dry nose ___Facial pain	___Vomiting	___Syphilis
___Nasal congestion	___Gas	___Genital warts
___Loss of voice	___Hiccups	___Herpes: oral/ genital
___Thirst ___Dry mouth	___Acid regurgitation	
___Nosebleed	___Bloating ___Mucus in stool	**Other:**_____
___TMJ ___Gum problems	___Bad breath ___Hemorrhoids	_____
	___Laxative use ___Gall Bladder	_____
	___Bloody stool disorder	

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:

XXX	**Sharp / Stabbing**
PPP	**Pins and Needles**
DDD	**Dull / Aching**
NNN	**Numbness**

Please circle your **current** level of pain: **Very mild 1 2 3 4 5 6 7 8 9 10 Very severe**

Thank you for taking the time to answer these questions, we appreciate your time and effort!

Goji Acupuncture & Wellness Clinic

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for and under my legal guardianship) by Cindy Tsui, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists who now or in the future treat me while employed by, working for, associated with, or serving as back-up for Cindy Tsui, 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, gua sha (scraping), electrical stimulation, Tui-Na (Chinese bodywork), acupressure, Chinese herbal medicine, application of liniments, oils and plasters, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some potential risks that may include, but are not limited to, discomfort, pain, bruising or tingling near the needling sites that last a few days to a few weeks, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment, dizziness, nausea, fainting, scarring, stuck or broken needle. There may be some bruising after cupping and gua sha (scraping). I understand that although it is rare, acupuncture during pregnancy can result in spontaneous miscarriage, induction of premature labor and pneumothorax.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the Cindy Tsui, L.Ac.

Cindy Tsui, L.Ac. does not provide Western medical care, and asks that you see your medical doctor for routine check-ups. If you are pregnant, have a pacemaker, high blood pressure, have a bleeding disorder, local infection, or if you have been prescribed anticoagulant medications such as Coumadin, she can still treat you but needs to be informed of your condition. I have informed Cindy Tsui. L.Ac. of such conditions above and voluntarily consent to the above procedures.

With this knowledge, I voluntarily consent to the procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I hereby release the practitioner, Cindy Tsui, l.Ac., from any and all liability, which occur in connection with the above-mentioned treatments. I understand that I may choose to stop the treatment at any time at my discretion. I will immediately notify the practitioner of any unpleasant or unanticipated effects of my treatment.
I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

To ensure patient privacy, please no photos may be taken by patients or visitors inside the clinic

By signing below, I agree to the above- named procedures. 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.

_____ X_____
Patient's name (PLEASE PRINT) Signature / Date

_____ X_____
Name of Legal Guardian (PLEASE PRINT) Signature / Date

Goji Acupuncture & Wellness Clinic
Cindy Tsui, L.Ac.

HiPAA Notice of Privacy Policies

We are required by law to:

- Maintain the privacy of protected health information.
- Give you notice of legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information:

- We will use and disclose health information only with your written permission
- You may revoke such permissions at any time by writing to our practice's privacy officer
- I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and medical treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations — and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

_____ X_____ _____

Patient's name (PLEASE PRINT) Signature / Date

_____ X_____

Name of Legal Guardian (PLEASE PRINT) Signature / Date

Goji Acupuncture & Wellness Clinic

Office Policies and Financial Agreement (part1)

The office has a **24-hour cancellation policy** — if you do not cancel your appointment with a minimum of 24 hours notice and no-show for your appointment, there is a charge of **$40.00**. Please be on time for your appointments — a specific amount of time has been set aside for your treatment. **Arriving late means that your treatment will be adjusted to fit into the scheduled time allotted.** Please note the $40 fee cannot be billed to your insurance**.**

Payment in full of time-of-service fees (discounted rates for non-insured), deductibles, co-pays, and coinsurance is always due at each appointment. I accept cash, checks, and credit cards (Visa, Mastercard, American Express and Discover). There is a $35 fee for any returned checks. Information about insurance billing is detailed below.

Explanation of Insurance Coverage:

Many insurance policies do cover acupuncture but please be informed that insurance policies do vary greatly in terms of deductibles, co-pays, and percentage of coverage. This office makes no representation that your policy does provide for acupuncture treatments.

I can assist you in the verification of your insurance coverage, but this service is offered as a COURTESY. Obtaining accurate information regarding your particular insurance plan's coverage is ultimately your responsibility. I am also happy to assist you in understanding your insurance benefits based upon the information provided by your insurance company, but I take no responsibility for the accuracy of the information provided.

Upon verification of your insurance benefits, we can discuss your billing options. I am an in-network provider with Blue Shield of California, United Healthcare, Sutter Select, Sutter Select Plus, MultiPlan and TriWest (Choice) plans; and an out-of-network service provider with all other insurance companies..

In most situations, it will be possible for my office to bill your insurance directly — you will be responsible for paying any co-pay/co-insurance amounts at the time of service. If you have not met your deductible, you will be responsible for paying out-of-pocket until you meet your deductible, and my office can submit claims towards your deductible.

For in-network claims, payment in full for any modalities or diagnoses that your insurance does not cover is your responsibility as determined by your insurance carrier.

For out-of-network claims, payment in full for insurance denials for any reason is your responsibility. If I have not received reimbursement from your insurance within 90-days of the treatment date, you will be responsible for any unpaid balances within 14 days of my notice to you. .

In some situations, it will not be possible for my office to bill your insurance directly. In such cases, payment in full will be due at each office visit; however, I can provide you with a Superbill that you may submit to your insurance company for reimbursement. Any reimbursements that you may be entitled to are determined by the rules of your particular insurance plan, and are a contract between you and your insurance provider. Your insurance company will reimburse you directly for your Superbill submission. Superbill is not a guarantee for reimbursement, and I reserve the right to not be involved in any claim disputes.

Goji Acupuncture & Wellness Clinic

Office Policies and Financial Agreement (part2)

Assignment of Benefits

I hereby authorize insurance benefits to be assigned to the above listed health care provider, for health care services provided to me.

_____Please initial here.

If I am billing your insurance directly, and if for any reason your insurance company sends payments directly to you for services performed in this office, you agree to inform the office of any payments received and pay forward these amounts to the office immediately upon receipt. If the office has been informed that you received payment for services performed in this office, and you have not notified the office or paid forward the amounts paid by your insurance to the office within 30 days of the payment's issue date, lack of communication on your part will result in the claims being turned over to collections.

Release of Information

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

HIPAA Compliant Email Communication

Your privacy is important to us — email communication between our office and you may include your protected health information — please be aware that our office does not use a specialized HIPAA compliant email service. Your signature below acknowledges this fact, and consents to our office communicating with you via email using a standard email service (e.g., Gmail, Yahoo, Webmail). You may revoke this consent at any time, in writing.

I have read, or have had read to me, the cancellation policy and financial agreement of Cindy Tsui, L.Ac.
By signing below, I agree to all policies as set forth in the entirety of this document.

_____ X_____ _____

Patient's name (PLEASE PRINT) Signature / Date

_____ X_____

Name of Legal Guardian (PLEASE PRINT) Signature / Date