American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002 Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture

For questions, please call ASH Plans at 888.226.8879

Patient Name _____ Birthdate _____ Sex M / F
(Last) (First)

Address _____ City _____ State _____ Zip _____

Subscriber Name:_____ Subscriber ID #: _____Group #:_____

Phone # (Home):_____Work #: _____Employer _____Occupation_____

Primary Health Plan: _____ Patient/Member ID #: _____

2nd Health Plan:_____ Primary Care Physician: _____ PCP phone #: _____
(Required) (Required)

Patient's Primary Language: _____

Please describe your current health problem(s):_____

How and When it began:_____

If you are undergoing acupuncture treatments, describe your progress: _____

☐ Worsened ☐ No change ☐ 25% improved ☐ 50% improved ☐ 75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? ☐Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

Are you currently under the care of a physician? ☐ No ☐ Yes, please explain _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

Please check all of the following that apply to you:

- ☐ Alcohol/tobacco/drug dependence
- ☐ Abnormal menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/rheumatoid arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disorder
- ☐ Breast lumps
- ☐ Cancer/tumor
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Diarrhea/constipation
- ☐ Excessive thirst
- ☐ Fainting or dizziness
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headache
- ☐ Heart attack
- ☐ Heartburn or indigestion
- ☐ Hypertension
- ☐ Hospitalizations/surgical procedures_____
- ☐ Kidney disease
- ☐ Liver problems
- ☐ Pacemaker
- ☐ Painful menstruation
- ☐ Palpitation/arrhythmia
- ☐ Peptic ulcer
- ☐ PMS
- ☐ Pregnancy, months _____
- ☐ Prostate problems
- ☐ Rapid weight gain/loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ **Medications** _____
- ☐ Other:_____

If a family member has had any of the following, please mark the appropriate box and explain:

- ☐ Lupus
- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Other: _____

Comments:_____

I certify the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my ASH Plans Acupuncture Provider or an ASH Plans Clinical Services Manager may need to contact my PCP or treating physician if my condition needs to be co-managed. Therefore, I give my authorization to ASH Plans to contact my medical doctor if necessary.

Patient signature: _____ **Date:** _____

KASTNER ACUPUNCTURE GROUP, INC.
4638 PARK BOULEVARD
SAN DIEGO, CA 92116

TEL. (619)220-0878
FAX (619)220-8147

OFFICE POLICY

INSURANCE ACCEPTANCE

Should we agree to bill your insurance for you, please understand that this is done as a courtesy and it is not our responsibility to pursue payment of your account. You hold the contract with your insurance company and it is your responsibility to collect and/or negotiate settlement of your claims. We will be happy to furnish information and answer all inquiries directed to us from your insurance company.

PLEASE NOTE: American Specialty Health only covers acupuncture. We provide therapeutic massage in addition to acupuncture which is not reimbursed by your insurance. On your initial visit we will offer a complimentary massage so you may experience this service. Should you wish to continue receiving massage with your treatment there is a $15 fee that will apply in addition to your copay. If you do not wish to continue receiving massage please let us know before receiving your treatment, otherwise it will be considered that you consent to this service and be billed accordingly. **INITIALS** _____

We will be happy to assist you in billing your insurance and will accept payment directly to Circle of Living. It's the patient's responsibility to understand their policy and benefits pertaining to their acupuncture treatment. If for any reason the claims are denied, the patient or responsible party will satisfy the account in full within 10 days. If there is a deductible or co-payment, that portion will be due at the time of each service. It is the patient's responsibility to notify us with any changes in coverage.

We reserve the right to make the financial charge at an interest rate of 1.5% per month for every month that the account remains overdue, after 10 days. **INITIALS** _____

FLEXPAY/HSA ACCOUNT CARD POLICY

Payments may be made with FlexPay/HSA cards, but it should be understood that **we cannot guarantee that your card will be accepted**, and unfortunately this is out of our control. Should your card be declined, you will need to use another form of payment at the time of each service, and we will provide you an itemized receipt so that you may be reimbursed by your insurance company. **INITIALS** _____

RETURNED CHECK POLICY

Payments made by check to Circle of Living and/or Kastner Acupuncture Group that are not honored by the bank will incur a returned check fee of $30 or five percent (5%) of the check amount, whichever is greater. The payment will be reversed from the appropriate account when a check is returned by the bank. Any account not paid in full by the due date is subject to interest, penalties, and additional fees may be added if not paid within 10 days.

A collection letter is sent to inform the account holder of the returned check and consequences if not paid within 10 days. Returned check reimbursement payments must be in the form of cash, cashier's check, certified check or money order. Circle of Living will not accept checks as payment if two checks have been returned for insufficient funds. **INITIALS** _____

APPOINTMENT CANCELLATION

If you're unable to keep your scheduled appointment time, please notify our office within 24 hours. You will be charged a $35 fee for a missed appointment not canceled. **INITIALS** _____

I understand and accept the above information

_____ _____

Signature of Patient (or Guardian) Date

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Fax: 877.248.2746

INFORMED CONSENT AND DISCLOSURE

For questions, please call ASH Plans at 888.226.8879

INFORMED CONSENT:

_____
Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgment during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow *direct* moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child's medical doctor if/when necessary.

_____
Patient Name (please print)

_____
Patient ID Number

_____
Primary Care Physician (or specialist) Name

_____
Patient Signature

_____
Primary Care Physician (or specialist) Telephone

_____
Date