PATIENT INFORMATION

Patient First Name: ______________________ M.I. ________ Last Name: ____________________________

Address: ______________________________ City: ____________________ State: _____ Zip: __________

Home Phone: (   )____________ Work Phone: (   )____________ Cell Phone: (   )____________

Email Appt Reminders : YES ☐ NO ☐ Email: ____

Circle One: MALE or FEMALE Date of Birth: ____________ SS#: ____________________________

Marital Status: S M D W Work Status (circle one): Unemployed Full-Time Part-Time Self-Employed Retired

Employer Name: ____ Occupation: __________________

Employer Address: ______________________________ City: ______________ State: _____ Zip: __________

Emergency Contact: ______________________ Relation: ________________ Contact #: (   )__________

Referred to this office by : ____

INSURANCE INFORMATION

Insurance Company: ____ Phone#: (   ) __________

Insurance Address: ______________________________ City: ______________ State: _____ Zip: __________

Name of Policyholder: ____ Date of Birth: __________

Insurance Member ID#: ____ Group#: ____________________

Relationship to Policyholder: Self Spouse Child Other: ____

Is this a (circle one): PPO HMO Workers Compensation Ins. Referral Other: ________________

Assignment of Benefits and Eligibility Guarantee

I request that payment of insurance benefits be made on my behalf to Circle of Living for any services rendered. I authorize the release to my insurance plan and its agents any information requested to process claims. I understand that I am liable for all charges not covered by this assignment. I agree to pay in full for all non-covered services within 10 days of notification of non-coverage.

____ ____________________

Signature of Patient/Legal Guardian Date

CONTINUED →

CASE HISTORY

Name: ______________________________ Date: ________________

Is your present condition caused by?

☐ Work Injury ☐ Auto Accident ☐ Fall ☐ Illness ☐ Other: ____________

Date of Injury/First Symptom: ____________ ☐ Gradual Onset ☐ Recurring

List present complaints:

____

____

____

Rate the severity of your pain (circle a number) 1 = least pain 10 = severe pain

NO PAIN **SEVERE PAIN**

0 1 2 3 4 5 6 7 8 9 10

List all medications/herbal supplements you are presently taking for your condition:

____

____

____

What treatment have you had for this condition in the past? (surgery, therapy, chiropractic, etc.)

____

____

(PLEASE COMPLETE THE BACK PAGE)

FOR OFFICE USE ONLY: ______________________________

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HEALTH HISTORY

Please check all boxes that apply to PAST or PRESENT health conditions.

Past	Present	Condition	Past	Present	Condition
☐	☐	Swelling/Stiffness of Joint(s)	☐	☐	Constipation
☐	☐	Arthritis/Rheumatism	☐	☐	Prostate Problems
☐	☐	Fainting or Dizziness	☐	☐	Kidney/Bladder Problems
☐	☐	Heart Disease	☐	☐	Liver/Gallbladder Problems
☐	☐	High Blood Pressure	☐	☐	Hepatitis
☐	☐	High Blood Cholesterol	☐	☐	Chronic Sinusitis
☐	☐	Aortic Aneurism	☐	☐	Chronic Cough
☐	☐	Diabetes	☐	☐	Asthma
☐	☐	Nausea or Vomiting	☐	☐	Headache
☐	☐	Heartburn or Indigestion	☐	☐	Fatigue
☐	☐	Peptic Ulcer	☐	☐	Abnormal WeightGain/Loss
☐	☐	Diarrhea	☐	☐	Thyroid Disease

Past	Present	Condition
☐	☐	Allergies (specify) ____________
☐	☐	Blood Disorder (specify) ____________
☐	☐	Cancer (explain) ____________
☐	☐	Tumor (explain) ____________
☐	☐	Stroke (date) ____________
☐	☐	Heart Attack (date) ____________
☐	☐	HIV/AIDS ____________
☐	☐	Other (explain) ____________

Do you: Smoke cigarettes? ☐ Yes ☐ No packs/week __________

Drink alcohol? ☐ Yes ☐ No drinks/week __________

Women only: ☐ Menstrual cramping ☐ PMS ☐ Irregularity Date of last period? ________

Breast: ☐ Tenderness ☐ Lumps Do you use birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes How long?__________ ☐ No

I certify that the above information is correct to the best of my knowledge.

Patient/Guardian 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.

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 $45 fee for a missed appointment not canceled. **INITIALS** _________

I understand and accept the above information

_______________________________ _______________

Signature of Patient (or Guardian) Date

Kastner Acupuncture Group
4638 Park Blvd., San Diego, CA 92116

Tel. (619) 220-0878
Fax (619) 220-8147

Acupuncture Informed Consent Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, 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 the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothoax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are form plant, animal and mineral 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 will notify staff member who is caring for me if I am or become pregnant.

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 further condition(s) for which I seek treatment.

Patient
Signature____Date_____________
(Or Patient Representative)

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PRACTICE'S REQUIREMENTS

THE PRACTICE:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a compliant.

I understand and accept the above information

______________________________ ________________

Signature of Patient (or Guardian) Date