COMPLETE THIS FORM IF YOU ARE A NEW PATIENT SCHEDULED TO SEE ONE OF OUR LICENSED ACUPUNCTURISTS

YANG INSTITUTE
OF INTEGRATIVE MEDICINE

INSTITUTE OF INTEGRATIVE MEDICINE
CLINIC OF ACUPUNCTURE

General Patient Information

Doctor's Name _____

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Phone _____

Email _____

Date of Birth _____ Age _____ Gender _____

Employed By _____

Occupation _____ Work Telephone _____

Spouse (if married) or Parent (if minor) _____

Address _____

Employed By _____

Occupation _____ Work Telephone _____

Person responsible for payment _____

____ Yes, please add my email address (above) to the Institute Newsletter.

YANG INSTITUTE
OF INTEGRATIVE MEDICINE

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and to provide individuals with the Notice of our legal duties and privacy practices with respect to Protected Health Information.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

By signing this form you are also allowing our office to:

1. Confirm appointments by telephone. Please list the phone number that you prefer us to call: _____;
2. Disclose medical information requested by other treating physicians;
3. Leave messages or discuss medical information with your pharmacist;
4. Disclose medical information to your insurance company;
5. Request medical records and/or medical information when necessary from other physicians or health care facilities

I hereby give permission to disclose health information about me to the following people: (Please print name on the line provided)

Wife/Husband: _____
Daughter/Son: _____
Mother/Father: _____
Other: _____

In the event of a billing issue, do you give permission for us to discuss your bill with someone other than yourself? YES _____ NO_____
If referred, please provide:
Doctor's name_____ Phone #_____

If yes, please list name(s) _____

I have the right to withdraw or revise my permission at any time, in writing.

Print name: _____

Signature: _____ Date: _____

YANG INSTITUTE
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Patient Cancellation and No Show Policy

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require a minimum of 24 hrs. notice. Pleases call the office at 856-802-6888.

"No shows" or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive medical care. For that reason, clients that do not honor their appointments will be charged a cancellation fee as follows:

Cancellations & No Shows

- **If we are given less than 24hours notice there will be a $100 cancellation fee per missed MD appointment, $50 per missed Acupuncturist appointment, or $20 per missed Group Acupuncture appointment**.

- **You will be charged for your session if you are a no show for your scheduled appointment.**

We realize that on a rare occasion, emergencies may arise, and we will address these situations with you at that time.

We thank you for working with us to ensure services are provided to you in the best possible way.

Acknowledgement of Cancellation & No Show Policy

Name: _____

Signature: _____ **Date:** _____

YANG INSTITUTE
OF INTEGRATIVE MEDICINE

Acupuncture Info Sheet

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

Does acupuncture have side effects?

You need to be aware that:

drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive;

minor bleeding or bruising occurs after acupuncture in about 3% of treatments;

pain during treatment occurs in about 1% of treatments;

existing symptoms can get worse after treatment (less than 3% of patients) -- You should tell your acupuncturist about this, but it is usually a good sign;

fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

if you have ever experienced a fit, faint or funny turn;

if you have a pacemaker or any other electrical implants;

if you have a bleeding disorder;

if you are taking anti-coagulants or any other medication;

if you have damaged heart valves or have any other particular risk of infection.

Single-use, sterile, disposable needles are used in the clinic.

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Chinese Herbal Medicine Info Sheet

What is Chinese herbal medicine?

For more than 5,000 years, Chinese herbal medicines have helped people live longer, healthier lives. "Herbal medicine" refers to the use of a plant's seed, berries, roots, leaves, bark or flowers for medicinal purposes. Chinese medicine treats the whole person and not the disease–each prescription will be matched exactly to your condition and needs.

Is Chinese herbal medicine safe?

Chinese herbal medicine is generally very safe.

Does Chinese herbal medicine have side effects?

If Chinese herbs are prescribed by a qualified practitioner and the formula matches the pattern, they are virtually without side effects. Most Chinese medicinal have very low toxicity. Toxic parts of plants are removed or processed to eliminate toxicity. Herbs with potential side effects are combined appropriately and given in small doses only. The most common side effect may be some bloating because of the cloying nature of tonic herbs. This can easily be corrected by adding digestive herbs into the prescription.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Chinese medicine diagnosis is made based on "discrimination of patterns of disharmony". The practitioner will take a thorough health history, ask questions regarding all body functions, feel the wrist pulse, look at the tongue and palpate certain body areas. The various findings are combined into a composite diagnosis regarding which body systems are in disharmony, based on Chinese medical theory. All medicinal substances as well as foods are classified and described according to several categories, e.g. their flavor, their energetic temperature and their therapeutic properties.

CLINIC OF ACUPUNCTURE

Acupuncture Informed Consent

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of:

Electro-acupuncture – Using very small amounts of electricity to stimulate specific acupuncture points.

Cupping – Glass of plastic cups are placed on the skin with a vacuum created by heat or suction.

Moxibustion – The therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations.

Liniments, Essential Oils, Plasters – Herbal or medicinal formulas applied topically to the skin.

Acupressure, Massage and Manual Therapy – The use of Traditional Chinese Medicine massage and therapeutic bodywork

Potential Benefits – Drugless relief of presenting symptoms and improved balance of boy energies that may lead to prevention, improvement or elimination of the presenting problem.

Potential Risks – Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders or pacemakers should inform the acupuncturist PRIOR to receiving treatment.

"With this knowledge, I voluntarily consent to the above procedures"

Printed Name Date

Signature of Patient Date

Referral Source

Please tell us who referred you to Yang Institute? _____

Please list all of your doctors (i.e. Primary Care, Therapist, Chiropractor, etc.)

Name:_____
Specialty: _____
Address: _____
Tele #:_____

Name:_____
Specialty: _____
Address: _____
Tele #:_____

Name:_____
Specialty: _____
Address: _____
Tele #:_____

Name:_____
Specialty: _____
Address: _____
Tele #:_____

*** IF YOU NEED ADDITIONAL SPACE, PLEASE CONTINUE ON THE OTHER SIDE**

NOTE: COMPLETE THIS PAGE ONLY IF YOUR INSURANCE HAS BEEN VERIFIED AND ACUPUNCTURE IS COVERED UNDER YOUR PLAN.

CLINIC OF ACUPUNCTURE

Insurance Release & Responsibility Form

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Phone _____

Responsible Party-If other than Self

Name _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Phone _____

Release of Information / Assignment

I authorize Clinic of Acupuncture, LLC for the use and disclosure of private health information, to bill my insurance company for the purpose of treatment, payment and health care operations.

I instruct and direct my insurance company to pay Yang Clinic of Acupuncture, LLC directly for services provided in this office.

Signature_____ Date _____

Financial Responsibility

I understand that if this office has not received payment from my insurance carrier within 60 days, I will assist in getting my claim paid by contacting my insurance company. I also understand that if this office does not receive payment from my insurance carrier that I am responsible for payment.

Signature_____ Date _____

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Name: _____

Have you ever had acupuncture? Yes No

What is your current complaint? _____

_____ How long? _____

What other treatments have you tried? _____

_____

Medications and Supplements you are currently taking and for what condition:

Medication	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History (check all that apply):

[ ] Aids/HIV	[ ] Alcoholism/Substance Abuse
[ ] Allergies to Latex	[ ] Hepatitis A / B / C
[ ] Cancer	[ ] Herpes
[ ] Emphysema	[ ] Lyme's Disease
[ ] Diabetes	[ ] Multiple Sclerosis
[ ] Heart Disease	[ ] Pacemaker
[ ] Seizures	[ ] Polio
[ ] Tuberculosis	[ ] Varicose Veins

Surgeries: _____
Food Cravings: _____
Food Intolerances: _____
How many 8 oz. glasses do you drink of the following per day?
Water _____ Soda_____ Coffee_____ Tea_____ Alcohol_____

Do you perspire during the day? _____
Do you perspire at night? _____
Are you always thirsty? _____
Do you prefer drinks that are hot or cold? _____
Taste preferences on a scale of 1 to 5 (1 being most liked and 5 disliked):
Salty _____ Sour_____ Bitter_____ Sweet_____ Spicy_____

Name: _____

Gastrointestinal

Do you currently or have you had any major incidences in the past?

[ ] Belching	[ ] Indigestion	[ ] Ulcers
[ ] Hernia	[ ] Nausea	[ ] Vomiting
[ ] Bloating	[ ] Acid Reflux	[ ] Hemorrhoids

Bowel movements - How often? _____ days/week

[ ] Irregularity [ ] Constipation [ ] Diarrhea [ ] Gas

Exercise and Energy

What kind of exercise do you do? _____ How often? _____

How is your general energy level? _____

Are you sedentary or active? _____

Emotional and Sleep

[ ] Panic Attacks [ ] Depression [ ] Anxiety [ ] Poor Memory

[ ] Nervous [ ] Fearful [ ] Difficulty Concentrating

Do you take anti-depressants? _____ What kind? _____

Do you take sleeping pills? _____ What kind? _____

Difficulty falling asleep? _____ Restless?_____ Disturbed Sleep?_____

Dreams? _____ Waking up in the night? _____

Urination

How many times a day?_____ Light/Dark in color_____ Bladder Infections?_____

Frequent Urination? _____ Incontinence? _____ Burning? _____

Do you wake up at night to urinate? _____ Pain during urination? _____

Gynecology (Women Only)

Date of first period _____ Date of last period _____

Are you still menstruating? _____

[ ] Heavy Flow	[ ] Light Flow	[ ] No Flow
[ ] Blood Clots	[ ] PMS	[ ] Painful Periods
[ ] Uterine Fibroids	[ ] Cystic Breasts	

Number of Pregnancies_____ Miscarriages_____

Respiratory

Do you smoke?_____ If yes, _____ times/day for _____ years

[ ] Frequent Colds	[ ] Asthma	[ ] Cough	[ ] Cold Sores
[ ] Bleeding Gums	[ ] Dry Mouth	[ ] Ear Pain	[ ] Migraines
[ ] Ringing in Ears	[ ] Sinusitis	[ ] excessive Phlegm	

Name: _____

Cardiovascular

[ ] Palpitations	[ ] Varicose Veins	[ ] Cold Hands/Feet
[ ] Poor Circulation	[ ] Dizziness	[ ] Chest Pain
[ ] Irregular Heartbeat	[ ] High Blood Pressure	[ ] Low Blood Pressure
[ ] Blood Clots		

Skin and Hair

[ ] Dry Skin	[ ]Skin Rashes	[ ] Itching
[ ] Acne	[ ] Eczema	[ ] Hair Loss

Musculoskeletal

[ ] Joint Pain	[ ] Arthritis	[ ] Muscle Tightness	[ ] Numbness
[ ] Tendonitis	[ ] Osteoporosis	[ ] Swelling	

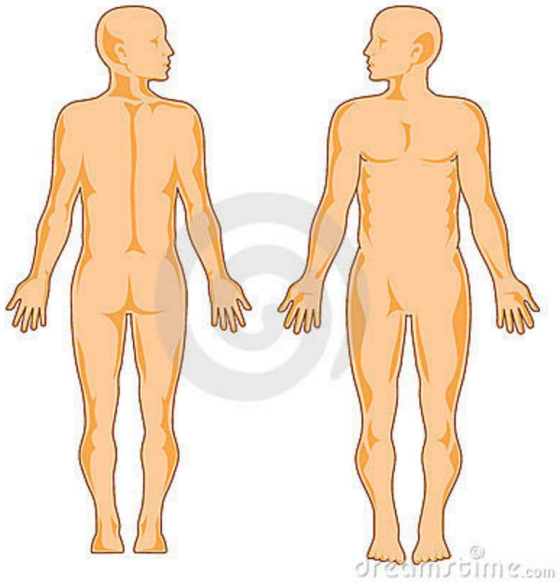
Name: _____

Where is the general area that you are feeling any discomfort? _____

Chronic or Acute? _____

What number best describes your pain now? (Please Circle)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Mark with an (X) on the diagrams below where you are feeling any discomfort or pain.



If pain, please describe (circle): Sharp Dull Stabbing

What makes the pain better? (circle all that apply)

Heat Cold Movement Massage Rest

Do you have any additional health conditions? _____

_____

_____

_____