NEW PATIENT REGISTRATION FORM

ACUPUNCTURE
OF TCM CLINIC, LLC.

Patient Information

First Name _____ Middle Init _____ Last Name _____

MM / DD / YYYY
Date Of Birth _____ / _____ / _____

☐ Male
☐ Female

Address _____ City _____ State _____ Zip Code _____

Height _____ Weight _____

Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other _____ ☐ Divorced

Home Phone ( ) _____

Occupation _____

Cell Phone ( ) _____

E-mail Address _____

Number of Children _____

Spouse's Name _____

Emergency Contact Information

Name	Relationship	Phone Number
_____	_____	( ) _____
_____	_____	( ) _____

Previous Health History *(select all that apply)*

☐ AIDS / HIV	☐ Drug / Alcohol Abuse	☐ High Cholesterol	☐ Respiratory Problems
☐ Anemia	☐ Epilepsy / Seizures	☐ Hyper Thyroid	☐ Rheumatism
☐ Arthritis	☐ Excessive Bleeding	☐ Hypo Thyroid	☐ Sinus Problems
☐ Artificial Joints	☐ Fainting	☐ Jaundice	☐ Sleep Apnea
☐ Asthma	☐ Glaucoma	☐ Kidney Disease	☐ Stomach Problems
☐ Blood Transfusion	☐ Hay Fever	☐ Liver Disease	☐ Tuberculosis
☐ Cancer	☐ Head Injury	☐ Low Blood Pressure	☐ Tumors
☐ Cardiovascular Disease	☐ Heart Disease	☐ Mental Disorders	☐ Ulcers
☐ Diabetes	☐ Hepatitus	☐ Nervous Disorders	☐ Venereal Disease
☐ Dizziness	☐ High Blood Pressure	☐ Pacemaker	☐ Other _____

Medications, Herbs and Vitamins currently taking *(List Name, Dose and Reason for taking)*

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Previous Surgeries

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

List Allergies

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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Current Health Conditions *(select all that apply)*

- ☐ Anxiety / Depression
- ☐ Day / Night Sweating
- ☐ Chest Tightness / Pain
- ☐ Abdominal distention / Cramps
- ☐ Urgent / Pain Urination
- ☐ Irritability
- ☐ Insomnia
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath
- ☐ Palpitation
- ☐ Constipation
- ☐ Cough
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Other _____
- ☐ Vertigo
- ☐ Chill / Fever
- ☐ Nausea / Vomit
- ☐ Blood in Urine
- ☐ Blurred Vision
- ☐ Dry Mouth
- ☐ Food Craving
- ☐ Ear Ringing

_____ Energy Level (scale 0 to 10)

_____ Stress Level (scale 0 to 10)

Bowel Movements: _____ ☐ Per Day ☐ Per Week

No. of Urinations: _____ Times per Day _____ Times per Night

Appetite: ☐ Good ☐ Poor

_____ Water Intake *(mugs per day)*

For Females

Age of First Menses: _____
Age of Menopause: _____
Length of Cycle: _____ *(days)*
Duration of Flow: _____ *(days of bleeding)*
Last Mammogram: ___ /___ /_____
Last Pap Smear: ___ /___ /_____

- ☐ Heavy Period
- ☐ Light Period
- ☐ Painful Period
- ☐ Irregular Period
- ☐ Clots
- ☐ Breast Lumps
- ☐ Profuse Leukorrea
- ☐ Yellowish Leukorrea

Are You Pregnant: ☐ Yes ☐ No

Expected Due Date: ___ /___ /_____

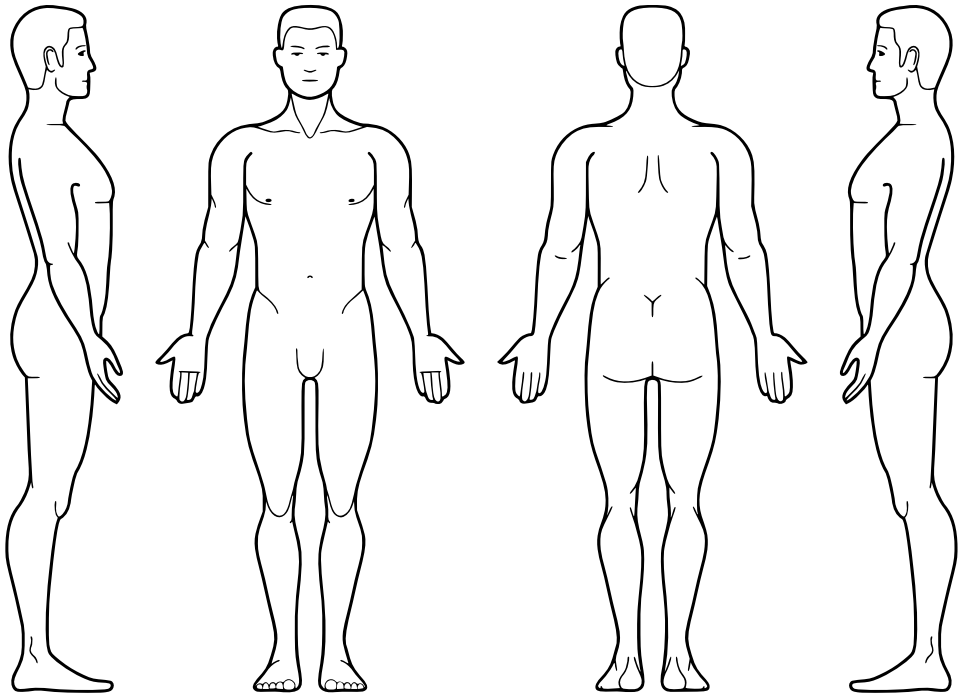
Number of Pregnant: _____
Number of Births: _____
Miscarriages: _____
Abortions: _____

Describe Your Main Complaint(s)

Complaint Description: _____ _____

When did problem begin? _____ _____

Diagnosis Given? _____ _____



	1	2	3
Area of Pain (locate on images to the left)			
Pain Level (1-10)	____	____	____
☐ Aching	☐	☐	☐
☐ Burning	☐	☐	☐
☐ Constant	☐	☐	☐
☐ Cramping	☐	☐	☐
☐ Dull	☐	☐	☐
☐ Fixed	☐	☐	☐
☐ Muscular Weakness	☐	☐	☐
☐ Numbness	☐	☐	☐
☐ Radiating	☐	☐	☐
☐ Shooting	☐	☐	☐
☐ Spasms	☐	☐	☐
☐ Stabbing	☐	☐	☐
☐ Throbbing	☐	☐	☐
☐ Tingling	☐	☐	☐

Agrravating Factors:
- ☐ Sitting
- ☐ Lifting
- ☐ Cold
- ☐ Heat
- ☐ Bending Forward
- ☐ Weather Change
- ☐ Other: _____

Relieving Factors:
- ☐ Rest
- ☐ Exercise
- ☐ Cold
- ☐ Heat
- ☐ Other: _____

Patient Signature: _____ Date: ___ /___ /_____

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ACUPUNCTURE OF TCM CLINIC, LLC.

Acupuncture Agreement for Insurance

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We are currently providers for some networks. For more details, please contact us with requisite information.

As a courtesy, we will accept your insurance assignment as soon as this office verifies your coverage. We will file your claim for you as soon as you supply this office with all required information as dictated by the parameters of your insurance coverage. **YOU** must make all arragements for policy requirements.

Please remember that regardless of any statements by your insurance company, **YOU ARE ULTIMATELY RESPONSIBLE** for any and all fees for services rendered at this office. It is standard practice for insurance claims to be paid or denied within 30 days of submission. If your insurance company has not paid within 60 days, **YOU ARE THEN RESPONSIBLE FOR ANY BALANCE DUE ON YOUR ACCOUNT.** If your insurance policy covers acupuncture, you will receive the same network benefits as you would with any other specialist. Many insurance policies now cover acupuncture and will pay out of network as well.

We are required to break down every aspect of your treatment into as many different CPT codes as applicable. Every insurance company processes claims differently. When you receive an EOB (Explanation of Benefits) detailing filed claims, the breakdown may or may not be as we submitted it. This office has no control over the processing of claims by any insurance company. We submit claims the same regardless of the insurance carrier. Each insurance company will apply the contracted fee accordingly. Please keep in mind that the patient is not responsible for the difference between the amount charged by health care professional and the amount allowed by the contract. However, the patient is responsible for any deductible, coinsurance amounts and amounts over the annual benefit limits for this service, up to the eligible expense.

If this office accepts your insurance assignment, you will be required to sign any other form, assignment or lien forms required by your insurance company on, but not limited to, your first visit. This office will NOT enter into a dispute with your insurance company over your claim. **THIS IS SOLELY YOUR RESPONSIBILITY AND OBLIGATION**.

Worker's Compensation

YOU must make all arrangements for your worker's compensation benefits PRIOR to beginning treatments at this office. This office cannot be your treating physician of record under Ohio's Workers Compensation Guidelines. YOU must make arrangements for a referral for acupuncture treatments from your treating physician, and have the approval of your adjuster for that referral. We must have a copy of each of these items in your file.

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Group / Individual

This office must adhere to the boundries of your particular insurance policy. If your policy requires a deductable, you will be responsible for treatment fees at the time services are rendered until the time your deductible is satisfied. The billed fee may or may not be applied to your deductible - ONLY YOUR INSURANCE CARRIER determines that. YOU are responsible for any and all copays or coinsurance payments at the time servie are rendered. If your policy requires a referral of any kind, YOU must arrange that referral BEFORE beginning treatment at this office.

We are required by law to record every aspect of your particular treatment. This results in breaking down your treatments into CPT codes as previously defined. Every insurance company processes claims differently. When you receive an EOB (Explanation of Benefits) detailing filed claims, the breakdown may or may not be as we submitted it. THIS OFFICE HAS NO CONTROL OVER THE PROCESSING OF CLAIMS BY ANY INSURANCE COMPANY. We submit claims the same regardless of insurance carrier.

This office also has no control over the usual and prevailing or reasonable and customary charges as defined by any given insurance company processing CLERK at any given time. Legally there is no such thing as usual and prevailing, but insurance companies have agreed to a unified concept of this average charge for a medical service or treatment. Companies often do not agree on an exact or consistent average.

All payments received from your insurance carrier will be credited to your account in a timely manner. If there is an overpayment, you will know by your EOB and we will send you a refund if your account is paid in full.

AGAIN, YOU ARE ULTIMATELY RESPONSIBLE FOR ALL FEES DUE THIS OFFICE FOR SERVICES RENDERED. THIS OFFICE WILL NOT ENTER INTO DISPUTE WITH YOUR CARRIER OVER ANY CLAIM. IT IS YOUR RESPONSIBILITY AND OBLIGATION TO MAKE SURE THIS OFFICE IS PAID.

Please ask our staff should you have any questions. Thank you for choosing this office for your health care.

PATIENT SIGNATURE

(Date)

X

(Or Patient Representative)

(Indicte relationship if signing for patient)

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ACUPUNCTURE OF TCM CLINIC, LLC.

PERMISSION TO TREAT A MINOR

ACUPUNCTURE
OF TCM CLINIC, LLC.

I _____ give permission to treat my child _____ age _____
(Name of Guardian) (Name of Child) (in years)

to attend his/her appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Acupuncture of TCM Clinic, LLC. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all payments, copays and coinsurance.

This authorization is effective on: _____ and expires _____.
(Today's Date) (Date Authorization is no longer valid)

Child's Health Information:

Current Prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, Illnesses or other comments: _____
_____

Emergency Contact Information for Parents / Guardians:

Where / how can you be contacted in case of emergency? _____ Phone: _____
Comments: _____
_____
_____

Temporary Guardian Information if Parents / guardians are not available:

Name: _____ Phone: _____
Address: _____

Health Insurance Information:

☐ No change since last visit

Insurance Company: _____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

X

Parent or Legal Guardian's Signature (Date)

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