Date: _______________

Patient Intake

Please fill out the following information accurately & completely.

(if patient IS a MINOR-- please be sure to fill out the responsible party section also)

PATIENT INFORMATION

Last Name: ___________________________ First Name: __________________________ Middle Initial: ____ Preferred Name: __________________________

Sex: ☐ M ☐F ☐ Other Have you had acupuncture before? ☐ yes ☐ no Marital Status: S ☐ M ☐ D ☐ W☐

Mailing Address: ____

City: ___________________________________ State: _______ Zip: ___________ Age: _________ Birth Date _____________

E-Mail Address: _________________________________ News Letter Opt Out ☐ Social Security #: ____

Home Phone: __________________ Work Phone/Employer: _____________________________ Cell Phone: _____________________________________

Where can we leave a detailed message for you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Don't leave a message

How did you hear about Fort Collins Family Acupuncture? ____

EMERGENCY CONTACT INFORMATION

Contact Name: ____ Relationship: _____________________Phone: _____________________________

RESPONSIBLE PARTY (Legal guardian's information-- IF PATIENT IS A MINOR)

Last Name: ___________________________ First Name: __________________________ Middle Initial: _______ Sex: ☐ M ☐F

Mailing Address: ____

City: ___________________________________ State: _______ Zip: ___________Social Security #: ___________________

Age: _________Birth Date _____________Status: S ☐ M ☐ D☐ W☐

Home Phone: __________________ Work Phone/Employer: ______________________ Cell Phone: _________________

BILLING INFORMATION (Who are we billing for you)

Self-Pay ☐ Insurance/Medicare ☐ Work Comp ☐ Motor Vehicle accident ☐

--If we are billing insurance/Medicare, we need a copy of the card as well as the information below, filled out----

Insurance Company Name: ____ID#_____________________ GRP#_________________

Policy Holder Information (If you are NOT the policy holder)

Last Name: ______________________First Name: _______________________Middle Initial: ____ Birth Date: ________ Sex: ☐ M ☐ F ☐ Other

Mailing Address: ____

City: __________________________________ State: _________________ Zip: ______________

Social Security #: ____________________________ Hm Phone: ______________ Wk Phone/Employer: _______________Cell Phone: _______________

E-Mail Address: _______________________________ Relationship to patient______________________________

Where can we leave a detailed message for you? ☐ Hm Ph ☐ Wk Ph ☐ Cell Ph ☐ Don't leave a message

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Please identify your health concerns that have brought you in today, with a brief history in order of importance.

1.____Onset Date: ___________

2.____Onset Date: ___________

3.____Onset Date: ___________

4.____Onset Date: ___________

Allergies: if applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include your reaction)

Allergy&Reaction_________________________Allergy&Reaction ____________________________________

Medications: Please list any over the counter or prescription medication and dosage, you are currently taking (Attach list as needed).

Medication&dosage_______________________Medication&dosage___________________________________

Medication&dosage_______________________Medication&dosage___________________________________

Vitamins/Supplements: Please list any vitamins or supplements, the dosage you are currently taking (Attach list as needed).

vit./supp.&dosage_________________________vit./supp.&dosage ___________________________________

vit./supp.&dosage_________________________vit./supp.&dosage ___________________________________

Hospitalizations and Surgeries: Please List all

Reason&date: ___________________________Reason&date: _______________________________________

Reason&date: ___________________________Reason&date: _______________________________________

Past Medical History & Family History: Please check all that apply

Condition				
Alcohol/Drug Abuse	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Depression/Anxiety	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Anemia/Blood Disorder	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Mental Health Disorder	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Arthritis	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHID
High Cholesterol	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Allergies/sinus	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Heart Disease	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Celiac Disease	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Gluten Intolerance	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Birth Defect	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
High Blood Pressure	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Obesity	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Diabetes	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Thyroid Disorder	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Stroke	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Cancer: _________	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD
Other: __________	☐ SELF	☐ MOTHER	☐ FATHER	☐ CHILD

Name any other Diagnosis you have received from a Doctor or Provider: ______________________________

____

____

313 West Drake Road Suite 210, Fort Collins, CO 80526 • 970-472-0955 • www.ftcollinsfamilyacupuncture.com

Lifestyle: please complete the following questions
Do you typically eat at least three meals per day? ☐ yes ☐ no (if no, how many?) ____

Which of the following best describes your diet?
☐ ***Vegan*** (no egg, dairy, meat of any kind)
☐ ***Vegetarian*** (eat vegetables, fruit plus eggs, dairy products)
☐ ***Omnivore*** (eats all foods)
☐ ***Fast Food***
Please give a brief description of what you eat daily:

Breakfast:
____

Lunch:
____

Dinner:
____

Snacks:
____

Do you Exercise? ☐ yes ☐ no If so please describe routine: ____

Do you have a good support system (family, friends, spiritual community, other)? ☐ yes ☐ no

How many hours per night do you sleep? ______ Do you wake rested? ☐ yes ☐ no

Occupation: ______________________ Employer: _____________

Hours/Week: ____Do you enjoy work? ☐ yes ☐ no Why? or Why not? ____

Nicotine packs per day_________ Alcohol drinks per week_________ Caffeine drinks per day_________ Coffee drinks per day________

Diet soft drinks per week_________ Hard Drugs________ Marijuana Use: _______ Do you have a pacemaker? ☐ yes ☐ no

Have you experienced any major traumas ☐ yes ☐ no if yes, please explain: ____

____
Are you open to discussing your trauma? ☐ yes ☐ no

Woman only: age of menses onset: ________ age of menopause onset: ______________ Total # of children: _______
Total # of pregnancies: __________ Total # of Miscarriages: __________ Total # of Terminations: _______

If you had a pregnancy/pregnancies did you have complications? ☐ yes ☐ no

If yes, please explain: ____

Men Only: Have you experienced any of the listed:

☐ Erection Problems ☐ Low testosterone ☐ Vasectomy ☐ Vasectomy reversal ☐ Urination problems ☐ elevated PSA

NAME OF PATIENT: ____DOB____________

Statement of Patient of Financial Responsibility

Fort Collins Family Acupuncture appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full.

As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. We recommend you call your insurance carrier to see what your acupuncture plan benefits are. Some carriers view certain procedure codes (97140, 97026) as physical therapy modalities and may deduct benefits or reduce the available visit count from both acupuncture and physical therapy benefit levels. This is sometimes the way certain carriers disperse benefits and not something that we can appeal for you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I authorize my insurer to pay any benefits directly to Fort Collins Family Acupuncture, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Consent for Treatment and Authorization to Release Information

I hereby authorize Fort Collins Family Acupuncture through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.
I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.

Cancellation / No Show Policy

Fort Collins Family Acupuncture has a 24-hour cancellation policy. In order to provide excellent service to all patients, patient appointments cancelled in less than 24 hours will be charged up to the full treatment rate fee. *I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. Fort Collins Family Acupuncture will notify me in writing, via certified mail, if I am discharged from care.*

Self-Pay or Time of Service Payment

If I do not have health insurance I will be responsible for services rendered at Fort Collins Family Acupuncture. I agree to pay Fort Collins Family Acupuncture, the full and entire amount of treatment given to me or to the above-named patient at each visit.

New Patient Exam with Acupuncture	*$120*
Existing Patient Acupuncture	*$80*
Cupping only	*$40 -$60*
Herb Consultation (no Acu)	*$40-60*
Herbs and Supplements	*Varies*

Notice of Privacy Practices (HIPAA): *This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.)* This notice includes all occupants of Fort Collins Family Acupuncture.

OUR COMMITMENT TO RESPECT PRIVACY:

Fort Collins Family Acupuncture is required to:

- Keep your information private
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and/or give out your information as listed below and as the law permits, unless we have your permission to do more.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR:

- Treatment: Such as when our providers and employees discuss your care.

• Payment: Such as when we bill your insurance company for services provided to you.
• Other Ways: Such as when we share information to protect the health and safety of others or you; when we send disease reports to county and state health offices as required by law; when we provide information to researchers, organ donation groups, or funeral directors; and when we respond to court requests. We may also send you appointment reminders, greeting cards, and newsletters.

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION:
You have the right to:
• Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask, where the law requires otherwise.
• Get and inspect a copy of your health record.
• Add information to your health record.
• Ask that your health information be sent to a different address or that we call you at a different phone number.
• Change your mind if you told us we could use or share your information for reasons other than those listed above.
• Get a list of the times we gave out your information (this will be a list of the times the law requires us to keep a record of releasing your information). As we serve our clients, we may modify what we do with your information. If we make a change, we will give you a new notice the next time you visit us. You may call or write us to inquire about any changes.

COMPLAINTS: ***You will not be mistreated for filing a complaint.***
If you think your privacy rights have been violated, you may complain to Fort Collins Family Acupuncture.
Contact Info: 313 West Drake Road, Suite 210, Fort Collins, CO 80526. Phone (970) 472-0955 Fax (970) 372-4437

Acupuncture Informed Consent to Treat

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 acupuncturists 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 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 and 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 the 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 bruising, 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 (pneumothorax). 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 from 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 a clinical staff member who is caring for me if I am or become pregnant.
While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.
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 future condition(s) for which I seek treatment.
(Or Patient Representative – please indicate relationship if signing for patient)

Colorado Mandatory Disclosure Statement

Education and Experience

Kimberley Benjamin earned her Master of Acupuncture and Oriental Medicine degree from Five Branches University in June 2008. This four-year program consists of 3,500 hours of education including 1,000 hours of clinical practice. She was certified as a Diplomat in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in August of 2008. This includes certification in Clean Needle Technique and Chinese Herbology. Kimberley's training includes adjunctive therapies such as moxibustion, tuina, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Kimberley is also likened in the state of CA.

Heidi Golding earned her Master of Acupuncture & Oriental Medicine degree from Pacific College of Oriental Medicine in 2014. This four-year program consisted of over 3210 hours of education including over 1000 hours of clinical work. She completed her Doctor of Acupuncture and Chinese Medicine Degree in 2017. She is nationally board certified via the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique. Savannah's training includes adjunctive therapies such as moxibustion, tuina, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.

Savannah Russell earned her Masters of Science in Traditional Oriental Medicine degree from Pacific College of Oriental Medicine in April 2015. This four-year program consists of 3,510 hours of education, theory, and clinical practice. She was certified as a Diplomat in Acupuncture and Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in November of 2015. This includes certification in Clean Needle Technique. Savannah's training includes adjunctive therapies such as moxibustion, tuina, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Savannah completed her Acu-Detox Specialist certification with the National Acupuncture Detoxification Association in 2017.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if know.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
- The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

I have read, understand and agree to all of Fort Collins Family Acupuncture Policies, including: Statement of Patient Financial Responsibility, privacy practices (HIPAA), Informed Consent to Treat, and the CO Mandatory Disclosure Statement. I understand that this authorization will remain in effect for as long as I, and/or my dependent, remain a patient. I understand that these may be subject to change periodically without notice. I verify that all the above information is true and accurate to the best of my knowledge.

Date

Patient Name (or patient representative– please indicate relationship if signing for a patient.)

Signature of patient or patient representative

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Fort Collins Family Acupuncture reserves the right to charge a fee of $50-$80 for each and every missed appointment ("no show") and appointments that, absent a compelling reason, are not cancelled with 24-hour advance notice.

This fee may be waived if the patient reschedules their missed service to take place within 48 hours.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. (If you purchase packages, the fee may be applied by deducting a visit from your package.) Multiple 'no shows' in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____________________________________ _______________________

Printed Name Date

____

Signature

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Updated 8/2018

INSURANCE VERIFICATION

Please call your insurance carrier prior to your appointment and ask the questions below so that you are aware of your benefit levels. Please bring this form to your appointment with you.

Patient Name ____ Date of Birth _____________________

Insurance Company Name ____________________________________ Phone _________________________

ID # ____ Group # _____________________________________

Claims Mailing Address ____________________________________ City____________ State _______ Zip __________

Policyholder Name ___________________________________ Relationship _____________Date of Birth _____________

Call date ______________ Representative______________________________ Call reference # ____________________

Acupuncture coverage: ☐ yes ☐ no Effective date ___________ Combined w/ Chiropractic ☐ Massage ☐ Physical Therapy ☐

Any Pre-existing Conditions: ☐ yes ☐ no If yes, specify ____

Participating insurance plans:

To verify participating provider status provide Tax ID # 263580008

In network benefits: Copay ____________ Co-insurance % ___________ Deductible ____________ Met? ☐ yes ☐ no

visits per year ________________________________ How many used ____

Procedure codes (specifically ask the representative if the codes below are covered under your plan if provided by an Acupuncturist).

• Office Visits
99203, 99204 (new patient)
99213, 99214 (established patient)

• Acupuncture Procedures
97810, 97811
97813, 97814

• Other Treatments
97026 Infared
97140 Cupping/Moxibustion/Gua sha
Myofascial/Tuina,/Acupressure
97110 Therapeutic Procedures

Pre-authorization or referrals required for any acupuncture procedures? ☐ yes ☐ no

Referring provider ____ Phone ______________________________

Are there any limitations on services? ____