L U M O S A C U P U N C T U R E

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H E A L T H Q U E S T I O N N A I R E

Date: ____________________
Legal Name: ____
Phone: ____________________ OK to leave a message? Y N
Address: ____________________ City/Zip: ____________________
Email: ____________________ OK to email? Y N

Gender: ________________________ Preferred Pronoun: ___________________
Age: __________ DOB: ___________ Place of Birth: ___________________
Height: ________ Weight: __________ Relationship Status: ___________________
Employer: ________________________ Job Title: _____________________
Family Physician: _________________ Referred By: _____________________
Emergency Contact: _________________ Phone: _____________________
How did you learn about my clinic? ____
Have you been treated by acupuncture or East Asian Medicine before? Y N

Main Concern(s):

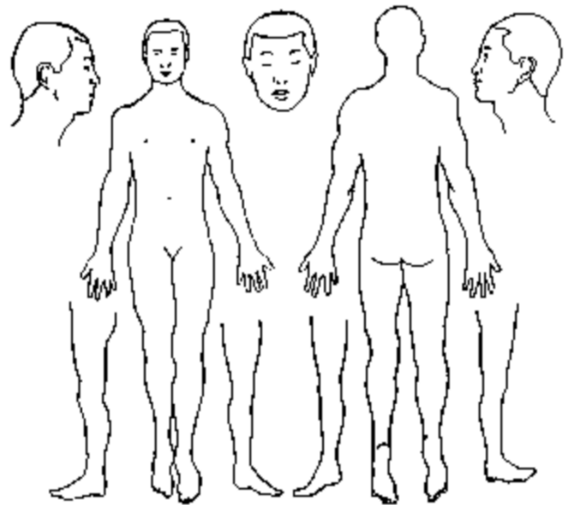
When did this problem begin?

To what extent does this problem interfere with your daily activities (walking, exercising, sleeping, relationships, etc.)?

Have you been given a Western diagnosis for this problem?

What treatments have you tried?

Indicate areas of concern
(pain, numbness, weakness, rash, etc.).
Rate severity of problem 0-10/10.
(0: No problem; 10: Unbearable).



Medical History

	Self	Family Member		Self	Family Member
Allergies			Rheumatic Fever		
Asthma			Thyroid Disease		
Cancer			Seizures		
Diabetes			Pacemaker		
Hepatitis			STI		
Anemia			HIV/AIDS		
Bleeding Disorders			Eating Disorder		
High Blood Pressure			Depression/Mental Illness		
Heart Disease			Other ________________		

Surgeries (type and date): ____

____

____

Significant Trauma (auto accidents, falls, etc.): _________________________________

____

____

Significant Dental Work (type and date): _________________________________

Allergies (drugs, chemicals, or foods and result): _________________________________

____

____

Medicines taken within last three months (vitamins, drugs, herbs, etc.) and reason for taking:

___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Occupational Stress (psychological/physical/chemical/etc)

Do you consider yourself an active person? Y N

Do you have a regular exercise program? Y N Please Describe:

How often do you do the following?

Tobacco (packs/day): ____

Caffeine (coffee, tea, and soda) (cups/day): ______________________________

Alcohol (beer, wine, and liquor) (drinks/week): ____________________________

Marijuana (smoke, vape, and edibles) (times/week): __________________________

Check symptoms you have experienced in the last three months:

General

Poor Appetite	Strong Thirst (cold or hot)	Fatigue
Fevers	Thirst, No Desire to Drink	Poor Sleep
Chills	Cravings	Night Sweats
Sweat Easily	Appetite Change	Tremors
Localized Weakness	Weight Gain	Poor Balance
Bleed or Bruise Easily	Weight Loss	
Peculiar Tastes or Smells	Sudden Energy Drop – Time ______	

Musculoskeletal

Neck Pain	Muscle Weakness	Hip Pain
Back Pain	Shoulder Pain	Other
Hand/Wrist pain	Knee Pain	______________
Muscle pain	Foot/Ankle Pain	

Skin and Hair

Hair or Skin Changes	Eczema	Recent Moles
Rashes	Psoriasis	Hair Loss
Itching	Hives Recent Moles	Dandruff
Ulcerations	Pimples Hair Loss	Other _______

Head, Eyes, Ears, Nose, and Throat

Facial Pain	Night Blindness	Nose Bleeds
Concussions	Spots/Floaters	Teeth Problems
Migraines	Color Blindness	Grinding Teeth
Dizziness	Cataracts	Jaw Clicks
Glasses	Ringing in Ears	Recurrent Sore Throats
Poor Vision	Poor Hearing	Sores on Lips or Tongue
Eye Strain	Ear Aches	Headaches – where and when _________________
Blurry Vision	Sinus Problems	

Cardiovascular

High Blood Pressure	Dizziness	Feet Swelling
Irregular Heartbeat	Hands Swelling	Phlebitis
Cold Hands or Feet	Breathing Difficulty	Other Heart or Blood Vessel Problems
Blood Clots	Chest Pain	_____________________
Low Blood Pressure	Fainting	

Respiratory

Cough	Production of Phlegm Color ______________	Asthma
Bronchitis	Pain with a Deep Breath	Last Cold/Flu? ______________
Pneumonia	Difficulty Breathing when Lying Down	Other _______
Coughing Blood		

Gastrointestinal

Bad Breath	Black Stools	Diarrhea
Nausea	Abdominal Pain or Cramps	Hemorrhoids
Vomiting	Chronic Laxative Use	Gas
Belching	Rectal Pain	Indigestion
Constipation	Blood in Stools	Other ______________

Genito-Urinary

Pain with Urination	Blood in Urine	Do you wake up to
Urgency to Urinate	Kidney Stones	urinate? Y N
Frequent Urination	Sores on Genitals	How often? _________
Unable to Hold Urine	Impotency	Other ______________

Neuropsychological

Seizures	Lack of Coordination	Anxiety
Areas of Numbness	Easily Susceptible to Stress	Other Neurological or
Concussion	Depression	Psychological Problems
Bad Temper	Poor Memory	_____________________

Pregnancy & Gynecology

# of Pregnancies _______	Vaginal Discharge	Vaginal Sores
# of Births ____________	- Color ___________	Last Pap
Premature Births _______	Changes in body/psyche	Breast Lumps
Miscarriages __________	prior to Menstruation	Are you sexually active?
Abortions _____________	Unusual Character	Y N
Age at First Menses _____	(heavy, light, frequency)	Do you use birth control?
Days Between Menses ___	Irregular Periods	Y N
Duration ______________	Painful Periods	What type and for how long?
First Day of Last Menses	Clots	_____________________

P A T I E N T H E A L T H I N S U R A N C E V E R I F I C A T I O N F O R M

Complete if you plan on using your insurance for acupuncture treatments.

Reference the following information when speaking with insurance representatives:

Lumos Acupuncture LLC | Samantha Chin, DAHM, EAMP | NPI 1003352345

509 Olive Way, Suite 652, Seattle, WA 98101 (253) 237-2476

Patient Name: ____ DOB: __________________

Insurance Plan Name: ________________________________ Phone: _________________

ID# (include prefix):___________________________ Group #: ____________________________

Effective Date of Insurance Plan: ________________

Date of Call: _____________ Representative you spoke with: ____________________________

Reference No. for Phone Call: ____

	Circle One	
1. Is provider in-network?	Yes	No
2. Does plan cover acupuncture (CPT codes 97810, 97811)?	Yes	No
3. Does plan cover manual therapy (CPT codes 97140, 97026)?	Yes	No
4. Is there an additional copay for office visits (E&M code 99202, 99203, 99213, 99214)?	Yes	No
4a. If yes, copay is ___________		
5. Does plan require a referral? If yes, from whom? ___________	Yes	No
6. Does plan require preauthorization for acupuncture (97810, 97811)?	Yes	No
7. Are benefits from other disciplines (Chiropractor, Massage, Naturopathic) taken from the same pool as acupuncture?	Yes	No

8. Is acupuncture benefit subject to deductible?

Individual deductible:_________________ Met: _________________

Family deductible: ___________________ Met: _________________

9. In-Network:

Is there a copayment or % I am responsible for? Yes No

If yes, Paid at: _______________% Copay: _______________

What is annual acupuncture limit ($ Dollar amount and # of visits)? $__________/#__________

How many visits have been used this year to date? ______________

10. Are there Out-of-Network benefits for acupuncture? Yes No

If yes: Paid at: _______________% Copay: _______________

What is annual acupuncture limit ($ Dollar amount and # of visits)? $__________/#__________

How many visits have been used this year to date? ______________

11. Are there any exclusions or restrictions for acupuncture? ____________________________

____

Patient Signature: ____ Date: __________________

NOTICE OF PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

YOUR RIGHTS

Get a copy of your health and claims records. You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information. You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Electronic Notice. If you receive a notification electronically, you are entitled to receive the notice in writing as well.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in payment for your care, 2) Share information in a disaster relief situation, and 3) contact you for fundraising efforts. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permissions: 1) Marketing purposes and 2) Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive. We can use your health information and share it with professionals who are treating you. E.g. A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Appointment Reminders. Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, emails, or letters. The provider may also write a thank you card to whomever referred you.

Run our organization. We can use and disclose your information to run our organization and contact you when necessary. E.g We use health information about you to develop better services for you. We are not allowed to use

genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Pay for your health services. We can use and disclose your health information as we pay for your health services. E.g. We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan. We may disclose your health information to your health plan sponsor for plan administration. E.g. Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues. We can share health information about you for certain situations such as: 1) Prevent disease, 2) Helping with product recalls, 3) Reporting adverse reactions to medications, 4) Reporting suspected abuse, neglect, or domestic violence, and 4) Preventing or reducing a serious threat to anyone's health or safety.
Do research. We can use or share your information for health research.
Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral doctor. We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you for 1) Worker's compensation claims, 2) Law enforcement purposes or with a law enforcement official, 3) With health oversight agencies for activities authorized by law, and 4) Special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.
OUR RESPONSIBILITIES
We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ntoiceapp.html.

____________________________________ ____________________
Signature Date

INFORMED CONSENT FOR TREATMENT AND FINANCIAL POLICY

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of East Asian medicine on me (or on the patient named below, for whom I am legally responsible) by Dr. Samantha Chin, DAHM, EAMP, LAc of Lumos Acupuncture and other licensed acupuncturists who now or in the future treat me while employed by, working with, or associated with Lumos Acupuncture.

I understand and consent to methods of treatment within the scope of East Asian medicine that include, but are not limited to: **Acupuncture** – insertion of sterilized, single use needles through the skin into underlying tissues at specific points. This includes the use of needles or lancets to directly or indirectly stimulate acupuncture points and meridians and use of electrical, mechanical, manual pressure or magnetic devices to stimulate acupuncture points and meridians; **Moxibustion/Moxa and TDP Lamps** – indirect or direct burning of mugwort leaf (artemesia) and infra-red heat therapy over the body; **Bodywork** – massage therapy forms and techniques such as Tui Na, Shiatsu, and Trigger Point releases rely heavily on the use of the practitioner's hand and range from shallow to deep pressure. Bodywork entails close physical contact and at certain parts of the bodywork protocols the practitioner may be on the treatment table with the patient. <u>**Please inform your practitioner if there is a specific medical condition she needs to be aware of</u>

before doing bodywork**; **Cupping** – cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device. Temporary bruising and skin discoloration may result; **Gua Sha** – rubbing or scraping an area of the body with a blunt, round instrument. Temporary bruising and skin discoloration may result; **Plum Blossom, Seven Star Hammer, and Bleeding** – light tapping of an area of the body with a small sterile hammer which has seven points. Pin-prick bleeding with a sterile, one-time use lancet; **Herbal Prescriptions** – May be given in the form of raw herbs, pills, powders, tinctures, pastes, and plasters and derive from plant, animal, and mineral sources. Herbs will either need to be consumed or applied topically according to instructions provided orally and in writing. **I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with consumption or application of herbs. I will notify the practitioner if I do not want animal-based products in the herbs**; **Dietary and Lifestyle Advice** – recommendation of breathing, relaxation and East Asian exercise techniques such as qi gong, advice regarding changes in diet and lifestyle, and recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements.

I have been informed acupuncture is a generally safe method of treatment, but that it may include side effects such as bruising, numbness, or tingling near the needling sites that may last a few days, dizziness or fainting, and needle sickness. Occasionally, needles can break. Burning and/or scarring are potential risks of moxibustion and 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. Herbs and nutritional supplements are considered safe, but some herbs may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, headache, rashes, hives, and tingling of the tongue. I understand some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist if I am taking any medication or supplements concurrently with Chinese herbs. I understand some herbs may be inappropriate during pregnancy.
I will notify the acupuncturist caring for me if I am or become pregnant. Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema must inform practitioners prior to any treatment.

I understand results are not guaranteed. I understand the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western Primary Care Provider (i.e. Family Physician, MD) for those services and routine check-ups.

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to Dr. Samantha Chin, DAHM, EAMP, LAc, Proprietor and Owner of Lumos Acupuncture LLC. **In the event that my insurance coverage expires or denies payment, I understand I am personally responsible for all fees incurred unless other arrangements have been made.**

I will provide my acupuncturist with at least 24-hours notice if I need to cancel or reschedule an appointment. I understand if I cancel or reschedule an appointment with less than 24-hours notice or do not show up for an appointment, I will be charged in full for that appointment.

By voluntarily signing below, I show I have read or have had read to me the above consent to treatment and financial policy. I have been told 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. I hereby release Lumos Acupuncture and its practitioners from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

______________________________________ ____________________

Signature

Date