

WELCOME TO OFFICE OF LAWRENCE MILLER, L.Ac.

We find that communicating our office policies will assist us in providing you with optimal service. Should you have any questions regarding these guidelines, please feel free to ask us.

Payment is required at the time services are rendered. If you have an insurance carrier, present your insurance membership card so that we can determine whether your insurer covers acupuncture treatment, and to what degree of reimbursement. If your insurance company covers acupuncture, you will be required to pay the balance beyond the amount your insurer will cover for treatment.

In certain cases, Lawrence Miller, L.Ac. may recommend lifestyle modification, follow-up visits, or additional outside medical care/consultation. If the patient refuses to comply with these recommendations, Lawrence Miller, L.Ac. can not be held liable for any health conditions which may arise due to patient non-compliance. Optimal health requires diligence and some effort on the patient's part—it is not something that is *done* to you! Understanding this is important to achieve optimal health.

Should you need to reschedule an appointment, 24 HOURS NOTICE is required. If you fail to notify us 24 hours in advance, you may be charged in full for your missed appointment. A missed appointment is a loss to everyone. For a Monday cancellation, please call on Saturday.

I understand these policies.

Signature

Date

PATIENT CONFIDENTIAL INFORMATION

Date _____ Name _____

Address _____

Sex: M F Age: _____ Date of Birth (mm/dd/yyyy) _____

Driver's License No. _____ SSN: _____

Occupation _____ Employer _____

Referred to this office by: _____

PHONE/EMAIL CONTACT INFO

Home: _____ Work _____ Email: _____

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

PATIENT MEDICAL INFORMATION AND HISTORY

Thank you for providing this personal information; it will enable me to more completely understand your individual pattern and come up with the most accurate diagnosis for your condition. Everything you disclose will be held in the utmost confidentiality, *and will not be shared in any circumstance without the patient's expressed, written consent.*

Primary reason(s) for visit: _____

Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No

Are you under the care of a physician now? Yes No If yes, for what? _____

Who is your physician? _____ Physician's phone _____

Other concurrent therapies _____

YOUR PAST MEDICAL HISTORY

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sinus/Ear infections |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Migraines | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Parasites | <input type="checkbox"/> Urinary Tract infections |
| <input type="checkbox"/> Birth Trauma
(your own birth) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Intestinal Disorder/IBS | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shingles | _____ |

Please list all past surgeries (include dates):

Please list any major traumas (accidents, falls, etc.), hospitalizations or severe illnesses (include dates):

Pharmaceutical drugs taken in the last 2 months: _____

Vitamins/Herbs/Supplements taken in the last 2 months: _____

FAMILY MEDICAL HISTORY

Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	mother	father	sibling	spouse	children
cancer or tumors					
diabetes					
blood or bleeding disorders/anemia					
seizures					
high blood pressure/heart disease					
allergies					
stroke					
drug abuse					
depression or mental illness					
age of death					
hepatitis					
kidney disorders					
thyroid disorders					
musculo-skeletal disorder					
blood transfusion (if before 1985)					

DIET & LIFESTYLE

My Level of Thirst is Low High

How many glasses of water/liquid do you drink per day? _____

My Appetite is Low Moderate High

I prefer Hot Cold food and drinks

I tend to crave sweets sour bitter salty foods spicy foods

I regularly consume Coffee Soft Drinks Artificial Sweetener Sugar Fast food

I am Omnivorous Vegetarian Lacto-ovo Vegetarian Vegan Strict Carnivore

AVERAGE DAILY MENU

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke tobacco? Yes No Occasionally

Alcoholic drinks per week, on average: _____

Do you smoke marijuana? Yes No Occasionally

Do you use other recreational drugs? Yes No Occasionally

(all information provided is held in the utmost confidentiality, and will not be shared without the patient's expressed, written consent.)

Regular Exercise:

Type _____ Frequency _____

Type _____ Frequency _____

PLEASE ANSWER THE FOLLOWING:

Do you have a tendency to faint? Yes No

Do you have a pacemaker? Yes No

Are you HIV positive? Yes No

Are you currently on blood-
thinning medication? Yes No

Do you have hepatitis? Yes No

Are you pregnant? Yes No Due Date _____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids

- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Other

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative

Date

Print patient name

Patient Birth Date

CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient Signature

Date