Longevity Health Center 1212 N Washington Ste 206, Spokane, WA 99201
(509) 838-1770, fax (509) 838-2020
Jodi McMahon MSAOM, EAMP NPI# 1659431138
Michaela Wehner M.Ac., EAMP NPI# 1790124352

PERSONAL HEALTH HISTORY

Office use only

PERSONAL DATA

Name: _____ Date: _____ Referred by: _____

Address: _____ Phone (Home): _____

City/State/Zip: _____ Phone (Work): _____

Phone (Cell): _____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with primary provider? Please initial if yes. ☐ Yes _____ ☐ No Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

ACUPUNCTURE HISTORY/TREATMENT INFORMATION

Have you ever received acupuncture before? ☐ Yes ☐ No If yes, frequency _____ Date of last treatment: _____

Reason for coming in today: _____

What results do you want from your acupuncture treatments? _____
_____
_____

Are you currently seeing a medical practitioner? Please explain if Yes. ☐ Yes ☐ No _____
_____
_____

List stress reduction and exercise activities. Include frequency. _____
_____
_____

List current medications, including aspirin, ibuprofen, and supplements etc. _____
_____
_____

PREVIOUS HISTORY (include year and treatment received)
Hospitalizations: _____
_____
_____

Have you ever been in a car accident or injured on the job? ☐Yes ☐ No
Dates of Accident or Injury: _____ **Injuries treated** _____
_____
_____
_____

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HEALTH HISTORY Please check those that apply, date & give location

MUSCULO-SKELETAL

_____ Bone or joint disease
_____ Tendonitis
_____ Bursitis
_____ Broken/fractured bones
_____ Arthritis
_____ Sprains/strains
_____ Low back
_____ Hip pain
_____ Leg pain
_____ Neck pain
_____ Shoulder pain
_____ Arm pain
_____ Headaches
_____ Head injuries
_____ Spasms/cramps
_____ Jaw pain/TMJ
_____ Lupus
_____ Other _____
_____ Sciatica

CIRCULATORY

_____ Heart condition
_____ Varicose veins
_____ Blood clots
_____ High blood pressure
_____ Low blood pressure
_____ Lymphedema
_____ Breathing difficulty
_____ Sinus problems
_____ Allergies
_____ Other _____

SKIN

_____ Allergies
_____ Rashes
_____ Athletes foot
_____ Warts
_____ Other _____

INFECTIOUS DISEASE

_____ Disease name (s):_____

DIGESTIVE

_____ Constipation
_____ Gas/bloating
_____ Diverticulitis
_____ Irritable bowel syndrome
_____ Other _____

NERVOUS SYSTEM

_____ Herpes/shingles
_____ Numbness
_____ Tingling
_____ Chronic pain
_____ Fatigue
_____ Sleep disorders
_____ Seizures/Epilepsy

REPRODUCTIVE

_____ Pregnant? Stage _____
_____ PMS
_____ Menopause
_____ Irregular periods
_____ Painful periods
_____ Other _____

OTHER

_____ Osteoporosis
_____ Cancer
_____ Tumors
_____ Diabetes I/ Diabetes II
_____ Scoliosis
_____ Eating disorders
_____ Depression
_____ Panic attacks
_____ Drug/alcohol use, frequency?
_____ Nicotine use, frequency?
_____ Caffeine use, frequency?

FAMILY MEDICAL HISTORY (include illnesses and status of living or deceased)

Mother_____
Father_____
Siblings_____
Grandparents _____

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OFFICE POLICIES

CANCELATION POLICY

When we schedule our patients we confirm the date and time for them. We try to assist you by calling you the day before your scheduled appointment, to reconfirm your date and time. If you find that you are unable to keep that appointment, we request a 24 hour notice of cancellation. Please let us know by **4pm the day before your appointment** in order to avoid being charged a cancellation fee. This will allow us adequate time to fill the appointment from our long waiting list of patients that are in need.

Our cancellation policy is to charge a fee of $85.00 for a no show appointment or same day cancellation.

While we understand that emergencies or unforeseen events happen, we have reserved a specific date and time especially for you and need the advance notice to provide the opportunity to another patient in need.

The cancellation fee of $85.00 needs to be paid prior to your next appointment. Three no show visits may result in a release from further treatments.

We appreciate your consideration of all our patients and understanding of our office policy.

FINANCIAL POLICY

We offer several methods of payment for your acupuncture treatment and you may choose the plan which best suits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. If special financial arrangements are necessary, please consult with the office manager.

OUR MAIN CONCERN IS YOUR HEALTH AND WELL-BEING AND WE DO OUR BEST TO HELP YOU.

PLAN ONE:

The **Prompt Pay** plan means that all fees will be paid in full at the time treatment is rendered. A prompt pay discount is reflected in the treatment price for this plan.

PLAN TWO:

If you have **Insurance**, we will bill for them for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment, co-insurance or remaining balance after insurance payments. We do participate in many insurance plans that may allow nominal out of pocket expense. **Your copayment is due at the time treatment is rendered.** You are also responsible for portions of your bill that exceed your insurance limits.

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time treatment is rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account.

PLEASE CIRCLE WHICH PLAN YOU WOULD LIKE TO USE:

PLAN ONE- Prompt Pay **PLAN TWO- Insurance**

Please sign below to indicate your understanding of our office policies. If you do not understand, please allow us to review the policies with you until they are clear.

_____ _____
Patient/Guardian Signature Date

_____
Printed Name

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LHC Staff _____ Date _____

CONSENT TO TREATMENT WITH ORIENTAL MEDICINE

By signing below, I do hereby voluntarily consent to Oriental Medicine therapies performed by the provider(s) at Longevity Health Center. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is encouraged by Longevity Health Center's provider(s).

Acupuncture: I understand that acupuncture is performed using sterilized, disposable needles that are inserted through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body for the purpose of treating physiological dysfunctions or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Electro-Acupuncture: EA involves micro current stimulation of the acupuncture needle and point. I am aware that certain adverse side effects my result. These may include, but are not limited to: electric shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Moxibustion: Moxibustion is a form of heat therapy using dried Artemisia. I understand that there is a slight risk of burning or scaring with moxibustion and I will tell my practitioner if the heat is becoming too intense right away. I will also notify my practitioner of any other discomforts during this treatment.

Cupping/Guasha/Tui-Na: I understand that tui-na or cupping may be performed as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I will notify my practitioner if I become uncomfortable and I may stop the treatment at any time.

Chinese Herbal Medicine/Supplements: I understand that supplements may be recommended to me to treat physiological dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these supplements, but I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking some supplements. These may include, but are not limited to: changes in bowel movements, abdominal pain for discomfort, and the possible aggravation of symptoms existing prior to supplement treatments. Should I experience any problems, which I associate with taking these supplements, I should stop taking them and call Longevity Health Center as soon as possible. I understand that some supplements may be inappropriate during pregnancy and I will inform my practitioner immediately of my pregnancy status.

I have carefully read, or had someone read to me, and I understand all of the above information and I am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanations. I give my permission and consent to treatment.

Are you pregnant? YES NO History of Epilepsy/Seizures? YES NO
Do you have a pacemaker? YES NO

Patient/Guardian Signature _____ Date _____

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Practitioner's Signature _____ Date _____

Please fill form out legibly and completely to avoid delay in insurance billing.

Patient

Name _____ Male / Female

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ SS # _____ Married Single Other
(optional)

Insured Information (if different than patient)

Responsible Party _____ Relation to Patient: Self Spouse Child Other

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Birthdate _____ Age _____ SS # _____ Married Single Other
(optional)

Insurance Company _____
(Copy of card below)

Name & address of any additional person you authorize this office to communicate with regarding your account:
_____

Date of Injury _____ **Work Related?** Yes / No **Auto Accident** ? Yes / No

Referring Physician _____ Diagnosis (by provider) _____

I state that I have insurance as noted above and assign all benefits payable directly to PROVIDER. I understand that my insurance company is billed as a courtesy to me and agree by signing below to pay the charges in full in the event of non-payment by my insurance company within 60 days of billing. I understand that it is my responsibility to meet any referral requirements of my insurance plan and that I will be responsible for payment if claims are denied due to violation of referral policy. I authorize

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PROVIDER and BILLING SERVICE to release all information necessary (including chart notes) to my insurance company to secure payment of benefits.

Patient Signature _____ Date _____