LORAN
SCRUGGS
Licensed Acupunturist

Classical Five Element Acupuncture

Name _____ Phone (main)_____

I would like appointment reminders. Yes No Phone (other)_____

How do you prefer your communication? Circle all that apply. Text Email Phone/Vmail

Address _____ City_____ State _____ Zip _____

Date of Birth _____ At birth: Male Female Preference_____

Employed by _____

Occupation _____

Circle all that apply: Married Single Have Sweetie Co-Habituating Roommates

Closest Friend or Relative_____ Phone _____

Physician _____ Phone _____

Other Care Providers _____

Patient Referred by _____

I hereby accept responsibility for treatment charges and for missed appointments or cancellations with less than 24 hours' notice.

I understand that payment is due on the day of treatment unless another arrangements have been made prior to treatment.

Signature of Patient _____ Date _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of
Parent/Legal Guardian _____ Date _____

Print Name _____

Consent for Care

I do hereby voluntarily consent to be treated by acupuncture administered by Loran Scruggs, Licensed Acupuncturist.

I understand that treatment may include manipulation of the skin, massage, application of heat (moxabustion), and/or insertion of fine sterile needles on or near the surface of the skin, and that all needles will be removed prior to completion of each visit.

I understand that I may experience temporary side effects from treatment such as local bruising, bleeding, lightheadedness, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

I understand that no guarantee is made concerning the use and effect of this treatment has been given to me and that I may stop treatment at any time.

I understand that Five Element treatment does not preclude the administration to me of conventional medical therapy by a licensed physician of same when in her/his discretion such therapy is deemed appropriate.

I agree to inform my Acupuncture practitioner of any and all other forms of treatment that I am now undergoing or considering including allopathic, naturopathic, chiropractic, homeopathic, dietary, herbal, massage, and other forms of energetic balancing, and/or dental work.

I understand that a record will be kept of the services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative or if required by law.

I agree to make arrangements for payment at the time of services received. For cancellation less than 24 hours prior to appointment, full fee will be due.

I certify that all questions I have asked concerning this consent form have been answered before signing.

Signature of Patient _____ Date _____

Print Name _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of
Parent/Legal Guardian _____ Date _____

Print Name _____

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Loran Scruggs Lac
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Acknowledgment of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of (Doctors Name), detailing how my information may be used and disclosed as permitted under federal and state law.

Signature of Patient _____ Date _____

Print Name _____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Signature of
Parent/Legal Guardian _____ Date _____

Print Name _____

Loran Scruggs ● Classical Five Element Acupuncture

Insurance Release of Information

I would like to take a moment to welcome you to my office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office I would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements
We require that you pay $20 towards today's charges and $20 on each visit.
If you have a specific contracted amount for co-payment that amount is due on each visit.

Assignment of Benefits
By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Signature_____ Date_____

Print Name: _____

Insurer _____ ID# _____ Date of Birth _____

Group#_____ Plan Name _____

Insurance Mailing Address_____

Insurance Phone Number _____

Acupuncture coverage _____Treatments/Limits_____

Deductible _____

Medical History **This Information is Confidential**

This information is essential for the diagnosis procedure and helps to provide you with a better treatment. Please fill out as accurately as you can.

Name_____ Date of Birth_____ Height _____ Weight _____

Describe Your Principe Complaint: _____

_____

_____

What has been diagnosed (ByMD) _____

_____

Adult Illnesses: Any surgery or accidents? _____

Age: _____

_____

Age: _____

_____

Age: _____

_____

Age: _____

_____

Medications: Please note all medications, herbs, vitamins and minerals you take even if you take them occasionally, include birth control, hormone replacement, etc.

_____

_____

Tobacco, Alcohol, Recreational Drugs: _____

_____

Do you have any scars? Note location of all operations or injury scars even minor ones: _____

_____

_____

Name _____Todays Date_____

Any problems during your birth _____

_____

Vaccination History: Any reactions you remember? Any Unusual vaccinations? _____

_____

Childhood Illnesses: Any surgery or accidents? _____

Age: _____

_____

Age: _____

_____

Adolescence Illnesses: Any surgery or accidents? _____

Age: _____

_____

Age: _____

_____

_____

Family History: Please note all major illness in your family. Like diabetes, heart disease, blood pressure, neurological disorders, blood disorders, orthopedic, etc

Mother: _____

_____

Father: _____

_____

Siblings and Other: _____

_____

_____

_____

Symptom List

Name _____Todays Date_____

Circle/Now: Circle any problem, disease, or symptom you have now.
Underline/Past: Underline items that affected you in the past.

Skin: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

Heart and vascular: Fast pulse (over 100 beats/min.) slow pulse (less than 60 beats/min.) palpitation irregular pulse feeling of pressure in the chest short of breath chest pain dizziness migraine headache with nausea cold hands/cold feet Raynaud's disease flushed face anemia high blood pressure low blood pressure cold sweats red face feel dizzy or faint when standing up quickly or standing for a long time

Gastrointestinal: constipation diarrhea no appetite stomach pain indigestion heartburn intestinal gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spasm peritonitis pancreatitis irritable bowel polyps GI tumors

Respiratory: asthma bronchitis emphysema cough wheeze pneumonia lung abscess

Hormonal imbalance: low thyroid overactive thyroid diabetes hypoglycemia blood sugar

Other hormone imbalance _____

Male: impotence premature ejaculation prostate gland problem vasectomy infertility

Female: menstrual problems cramping heavy/light/irregular periods PMS emotional reactions menopause symptoms tubal ligation infertility low libido

Autoimmune and inflammatory conditions: Hashimoto's disease (thyroid) rheumatism systemic lupus erythematosus colitis Crohn's disease alopecia (baldness) allergy food allergy atopic dermatitis neurodermatitis cellulitis sinus allergy vulvitis low immunity

Effects of focal infections: rheumatic disease rheumatic fever arthritis skin disease
Connective tissue or ligament diseases: Myofascial pain syndrome fibromyalgia tendinitis ligaments pericarditis constant slight fever glomerulonephritis plantar fasciitis scarlet fever ear infections streptococci infections staphylococci infections easily catch cold or sore throat swollen glands

Ear, nose & throat: deafness tinnitus (ringing in the ear) itchy ear ear pain frequent ear infections sinus head aches yellow mucus stuffy nose post-nasal-drip dry throat itchy throat constant sinus congestion streptococci throat infections sore throat

Oral disease: bleeding gums periodontitis dental abscess mumps stomatitis (inflammation of the mouth) TMJ toothaches without cavities.

General: insomnia psychosomatic weakness exhaustion emotional problems (angry, irritable, depressed, anxious) difficult concentrating on a task easily get car sick, sea sick, or air sick no appetite for breakfast moody in mornings unusual sweating (palm, sole, or elsewhere) never sweat

Before noon time: no energy feel spacey, scattered minded energetic all evening through midnight, but hate to wake up early in the morning long shower or bath makes you feel dizzy or faint.

Medication and drugs: Birth control pill cigarettes alcohol cocaine marijuana

Other:

Email Communication Consent Form

Your email will not be sold or shared. We will not be sending you any newsletters or advertisements. This is a HIPAA compliant form required in order to allow correspondence between you and Eva Hosseinion, L.Ac. as well as our staff and billing department. Listed below are some examples of email correspondence:

- Request supplements.
- Receive exercises/treatment plans.
- Correspond with our billing department, including receive balance due statements.
- Appointment reminders.

Risk and Conditions of Using Email

I have been advised that:

- Emails should not be used to communicate sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, substance abuse, etc.
- All email correspondence will become a part of my health record.
- Email is not confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their system.
- There is not a way to assure the privacy of email on a shared computer or email account.
- Email communications travel across the public Internet. It is not possible to verify that emails are actually received, opened and red by the addressee.

Text Messages

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information and sensitive information contained in such text may be misdirected, disclosed or intercepted by unauthorized third parties

I authorize Loran Scrugga Lac to contact me by automated SMS Text Message for appointment Reminders. I understand that message/data rates may apply to message sent by Loran Scruggs Lac under my mobile phone plan.

By signing below I have read and understand the information above. I have asked questions to clarify things that are not clear to me.

Signature_____ Date _____

Print Name_____