Dawa Acupuncture
1580 Lemoine Ave #7, Fort Lee, NJ 07024/ Tel. 201-676-0088

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nn Note: This is a CONFIDENTIAL questionnaire to help us determine the best treatment for you.
If you have any questions, please ask. Thank you.

PERSONAL INFORMATION:

Name: _____ Sex: Male Female
Date of Birth: _____/_____/_____ Weight: _____ Height: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
To Confirm Appointments Contact me at: _____
EMAIL: _____
EMERGENCY CONTACT: _____ Phone: _____
Who can we thank for referring you to our office? _____
Occupation: _____
Marital Status: Single Married Divorced Widowed # of Children_____
Have you received Acupuncture Therapy before? Y N When: _____

Please indicate any significant medical history you have had: Surgery, Cancer, Hepatitis, Diabetes, Heart Disease, Pacemaker, Thyroid disorder, Digestive disorder, Anxiety, Insomnia etc.

_____
_____
_____
_____

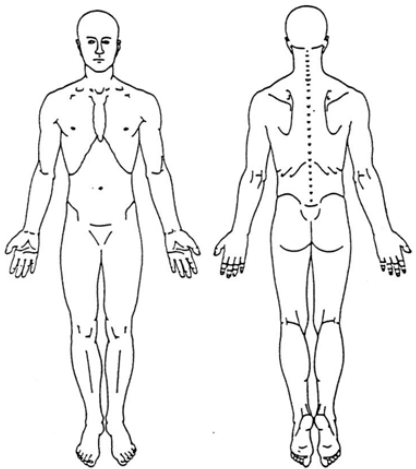
Please describe your pain area and symptoms (How and when did your symptoms start?)

_____
_____
_____
_____
_____

Average pain intensity:

Last 24 hours:	**no pain**	**1 2 3 4 5 6 7 8 9 10**	**worse pain**
Past week:	**no pain**	**1 2 3 4 5 6 7 8 9 10**	**worse pain**

PLEASE INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:



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Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from Traditional Oriental Medicine by a licensed acupuncturist at DAWA Acupuncture clinic. I understand that acupuncturists practicing in the state of New Jersey are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I understand that it is my responsibility to inform my treating acupuncturist(s) if I become pregnant or suspect that I am pregnant before each treatment begins.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles 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 in an attempt to treat bodily dysfunction 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 could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing 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.

Direct moxibustion/Infrared Therapy: I understand that if I receive direct moxibustion and/or infrared heat as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances Traditional Oriental Medicine may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but 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 these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call DAWA Acupuncture Clinic as soon as possible.

Cupping/Guasha: I also understand that cupping modality may be used as part of my treatment plan. Cupping refers to an ancient Chinese practice in which a cup is applied to the skin and the pressure in the cup is reduced (by using change in heat or by suctioning out air), so that the skin and superficial muscle layer is drawn into and held in the cup. There may be skin discoloration over the area where the cup was applied; however these skin discoloration will usually resolve within a few days. Guasha involves palpation and cutaneous stimulation in which the skin is pressured in strokes by a round-edged instrument that results in the appearance of small red petechiae. There may also be bruising over the area where guasha was applied; however the petechiae and bruises usually resolve in a few days.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage 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 could 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 may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that methods of treatment may include but are not limited to acupuncture, acupressure, Tui-Na massage, electrical stimulation, moxibustion, cupping and Guasha therapy, Chinese herbal medicine and nutritional counseling. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Date	
Print Patient Name	Patient Signature
Print L.Ac. Name	L.Ac. Signature
*Print Patient Rep	*Patient Rep Signature

* To be completed by patient's representative if the patient is a minor or is physically or legally incapacitated.*

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Assignment Of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your medical benefit is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treat, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO THE ACUPUNCTURIST.

_____ _____

Signature of Patient/Responsible Party Date

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NOTICE OF PRIVACY PRACTICES FOR HIPAA REGULATIONS

Dear Valued Patient,

This notice describes our office policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

SAFEGUARDS IN PLACE AT OUR OFFICE INCLUDE:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone and faxes sent) are kept on permanent file.

TYPES OF INFORMATION THAT WE GATHER AND USE:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From heat care providers, insurance companies, workman's compensation and your employer and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – e.g. your name, address, Social Security number, etc.)

We value our relationship, and respect your right to privacy. If you have any questions about our privacy practice guidelines, please call us at 201-676-0088

Yours Truly,

Hyun Jung Kim, Dipl. OM, L.Ac.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A COPY OF THE DAWA ACUPUNCTURE CLINIC P.C. NOTICE OF PRIVACY PRACTICES.

IN ADDITION, I HAVE BEEN THEREFORE ADVISED OF HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED IN THIS OFFICE AND HAVE BEEN INFORMED ON HOW I MAY GAIN ACCESS TO AND CONTROL THIS MEDICAL INFORMATION.

Print Name : _____

Signature : _____

Date : _____

* Further information regarding HIPAA is available upon request*