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KYUNG HEE ACUPUNCTURE & HERB CLINIC

PATIENT INFORMATION

NAME : (LAST) _____ (FIRST) _____

ADDRESS : _____

CITY : _____ STATE : _____ ZIP : _____

DATE OF BIRTH : _____- _____-_____

MARITAL STATUS: S M W D SEP SEX: MALE FEMALE

WEIGHT : _____ HEIGHT : _____

PHONE : CELL _____ WORK _____

EMAIL : _____

EMPLOYER: _____ OCCUPATION : _____

IS YOUR CONDITION RELATED TO:

EMPLOYMENT? YES / NO WORK INJURY DATE: (MM) _____ (DD) _____ (YY) _____
AUTO ACCIDENT? YES / NO AUTO INJURY DATE: (MM) _____ (DD) _____ (YY) _____

SPOUSE OR PARENT/GUARDIAN

NAME : _____

RELATIONSHIP TO PATIENT : _____ PHONE _____

EMERGENCY CONTACT

NAME : _____

RELATIONSHIP TO PATIENT : _____ PHONE : _____

HOW DID YOU HEAR ABOUT US?

YELP : _____ GOOGLE : _____ OTHER: _____

SIGNATURE : _____

NEW PATIENT QUESTIONNAIRE

NAME: _____ TODAY'S DATE: _____

1. What is your chief complaint?

_____

2. When did this begin?

_____

3. Any treatments received by other physicians?

_____

4. Date of most recent physical exam?

_____

5. Are you experiencing any of the following symptoms in relation to your main concern? (Circle one)

Constitutional symptoms: fever, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision, blurred vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitation

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, indigestion, constipation, diarrhea, blood in stools

Genitourinary: irregular period, vaginal bleeding after menopause, frequent/painful urination, bloody urine, impotence

Skin: rash, changing mole, diseases

Neurological: headache, dizziness, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness, stiffness, tenderness, restricted movement

Psychiatric: depression, anxiety, anger, insomnia

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hay fever

6. Do you have any other concerns? If yes (list below)

_____

7. List any allergies to medications or substances.

_____

8. Do you (currently) or have you had (previously) any major medical problems? If yes (list below)

_____

9. Have you had any surgeries? If yes (list below)

_____

10. Does anyone in your family have a major medical illness such as Diabete, HTN, high cholesterol, cancer or other? If yes (list below)

_____

11. What do you do for exercise? _____ How long? _____How often? _____

12. Circle which substance you use. Write how much and how long you use.

Caffeine _____ Tobacco _____ Alcohol _____

13. Circle the stress level in your life 0 1 2 3 4 5 6 7 8 9 10

14. How much does it affect you? 0 1 2 3 4 5 6 7 8 9 10

15. Describe the major stresses in your life at present (ongoing or resolved?)

_____

_____

_____

_____

_____

_____

Patient Signature : _____

FAMILY HISTORY

	Alive	Decreased	Cause of Death	Present Age/Age of Death
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
SIBLING	_____	_____	_____	_____
SIBLING	_____	_____	_____	_____
SIBLING	_____	_____	_____	_____

Please list the areas in which you experience discomfort. Please also indicate degree of pain, if you have, with pain scale of 0 to 10(0 for no pain at all, 10 for extreme pain.)

MEDICATION LIST

Patient's Name: _____

Please list all medications you are currently taking, including prescribed medicine, over the counter medication and herbal or vitamin supplements. (if you have allergy symptom(s) to specific drug, chemical or fume etc., please indicate it (them).)

Medication	Start Date:	Herbs & Supplements	Start Date:

PATIENT CONSENT & AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending Acupuncture and it is the responsibility of the staff to carry out the instructions of the Acupuncture.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Kyung Hee Acupuncture & Herb Clinic for benefits applicable and otherwise payable to me, but not to exceed the physician's regular charges. I specifically direct any second or third party to accept this assignment and pay the physician directly. I understand that I am financially responsible for charges that the insurance carrier declines to pay. In the case that a check is made to the patient or this office and the patient, for services rendered by this office, this document serves as a power of attorney for endorsement on the patient's behalf.

LIEN: In the event that a lien is necessary to protect and ensure payment to Kyung Hee Acupuncture & Herb Clinic, this document serves as notice of lien on any claim I may have and serves as a power of attorney for signature on my behalf on such lien form should it be needed.

RELEASE OF INFORMATION: I authorize the release of information contained in my chart to relevant insurance companies, third parties, attorneys and employers as may be needed to process and manage my case and claims.

REQUEST FOR INFORMATION: I authorize any custodian of records to release medical records and diagnostic studies (including X-Rays) to Kyung Hee Acupuncture & Herb Clinic for the purposes of case management.

HMO DISCLAIMER: I certify that I am not presently enrolled in any health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of my enrollment in an

HMO will constitute responsibility for payment of claim on my part.

MINOR'S RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed examination and treatment for the minor.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the doctor prior to any X-Ray or onset of care.

_____ _____

Patient's Name Date

_____

Patient, Patient's Parent/Guardian Signature

OFFICE POLICIES

Thank you for choosing Kyung Hee Acupuncture & Herb Clinic for your health care needs. All patients receive a full Acupuncture evaluation after which Dr. Won Kim decides what course of treatment, if any, will benefit you. All treatments are provided under the direction and supervision of Dr. Won Kim..

PAYMENT POLICIES

All visits must be **paid in full** at the time of service **unless prior** arrangements have been made and approved by our office manager. The only exceptions to this policy is a ***Personal Injury*** with a lien signed by an attorney. We gladly accept cash, checks, Visa, Master Card and most insurance policies.

APPOINTMENT / HERB PICK UP POLICIES

All visits are on an appointment basis. Emergency patients will be seen on first come first served basis or between regularly scheduled patients. This means we have specifically reserved a time slot for you. If you need to change or cancel an appointment you must give 24 hours notice or you will be charged **full** for that appointment. Also, for those don't pick up herbs on time will be charged **full** for that amount.
By initialing here, you give Kyung Hee Acupuncture & Herb Clinic authorization to charge your credit card for the amount of the missed appointment.
Initial _____

Credit Card #_____ Exp. Date_____ cvv # _____

INSURANCE COVERAGE

We follow both California State Insurance Laws. All patients are responsible for their deductibles and co-payments. For the aforementioned reasons insurances billings, receipts and statements for every procedure or treatment are billed under Kyung Hee Acupuncture & Herb Clinic or Dr. Won Kim. We have only one set of fees, which are set by the State of California Relative Value System.

INSURANCE INFORMATION

Patient Name : _____

Primary Insurance Company : _____ Member ID# : _____

I have read and understand the office policies.

Patient's Signature : _____ Date :_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Kyung Hee Acupuncture & Herb Clinic to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

_____

Signature of Patient

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IMPORTANT

I have a pacemaker placed in my chest or abdomen to help control abnormal heart rhythms.
Yes ( ) No ( )

Tengo un marcapasos que han depositado en mi abdomen o Corazon para ayudar a controlar a ritmos cardiacos anormales.
Si ( ) No ( )

심장에 맥박조정 장치 하셨나요?
예 ( ) 아니요 ( )

Patient's Name: _____

Signature: _____Date: _____

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