Acupuncture
Wellness Center Of Coral Springs
10139 NW 31 Street #101 Coral Springs, FL 33065
Suzanne Swearengen, DOM, A.P.

First: _____ Middle Initial: _____ Last: _____ Today's Date: _____
Height: ____' ____" Weight: _____lbs. _____ Male _____ Female
Birth date: _____/_____/_____ Age: _____ Last 4 digits of your SS#: _____
Guardian (if under 18): _____
Marital Status: __ Single __ Married __ Separated/ Divorced __ Widowed
Referred By: _____ Occupation: _____ Employer: _____
Address: _____
City: _____ State: _____ Zip:_____
E-Mail:_____ Cell Phone #:_____
Home Phone #:_____ Work Phone #:_____

We WILL use contact information that you provide, such as email addresses & phone numbers for messages and / or texts, to leave confidential messages (including but not limited to appointment reminders, scheduling changes, or messages asking for a return call). Please be sure that you are providing numbers where messages of this nature are acceptable. If you require special arrangements, please SPEAK TO OUR STAFF, and indicate here: _____

Health Concern/Reason for Visit: _____
What symptoms are you having:_____
Does anything limit you from Care? ( ) Y ( ) N If yes, explain: _____
Other physicians/ therapists seen for this condition: _____
Medications/Supplements/ Vitamins: _____
Allergies: _____
Is this visit related to an Automobile Accident? **Y / N** If YES, what was the date of the accident? _____
Is this visit related to a Worker's Comp Injury? **Y / N**
Please List Past Surgeries: _____
Do you smoke? **Y / N** If Yes, How much? _____
Do you drink coffee/black tea? **Y / N** If Yes, How much? _____
Do you use alcohol? **Y / N** If Yes, How much? _____
Do you Exercise? **Y / N** If Yes, How often? _____

In Case of Emergency: Can medical information be shared with this person?
Contact: _____ Relationship: _____ **Y / N**
Phone Number: _____
Secondary Contact: _____ Relationship:_____ **Y / N**
Phone Number: _____

Patient's Signature: _____

Questionnaire continues on next page

Check any you have had in the past:

__ Diabetes
__ Stroke
__ Asthma
__ Mumps
__ Meningitis
__ Epilepsy
__ Paralysis
__ Allergies
__ Heart Disease
__ Pneumonia
__ Bleeding Tendency
__ HIV
__ Hepatitis
__ Cancer
__ Glaucoma
__ Vein Condition
__ Emphysema
__ Chicken Pox
__ Polio
__ High Blood Pressure
__ Migraines
__ Measles
__ Thyroid Disorder
__ Multiple Sclerosis
__ Nervous Disorder
__ Mononucleosis

…continued from page one

Please check ANY of the following that pertain to you:

Overall Temperature (Kidney Function):
__ cold hands __ cold feet __ sweaty hands __ sweaty feet
__ hot body temperature (sensation) __ cold body temperature (sensation) __ perspire easily
__ afternoon flushes __ night sweats __ heat in hands, feet and chest __ lack of perspiration
__ hot flashes any time of the day __ thirsty __ take water to bed
Overall Energy (Lung, Kidney function):
__ shortness of breath __ general weakness __ easily catch colds __ feel worse after exercise
__ low energy
Blood (Liver, Spleen, Heat function):
__ dizziness __ see floating black spots
Heart Function:
__ palpitations __ anxiety __ sores on the tip of the tongue __ frequent dreams
__ restlessness __ mental confusion __ chest pain __ wake un-refreshed
Lung Function:
__ nasal Discharge __ cough __ nose bleeds __ sinus congestion __ sneezing
__ dry mouth __ dry throat __ dry skin __ allergies __ stiff Neck
__ alternating fever and chills __ stiff shoulders __ sore throat __ difficulty breathing
__ Headache (location: _____) __ achy body __ sadness __ melancholy
__ smoke cigarettes (#per day _____)
Spleen Function:
__ low appetite __ abrupt weight gain __ abrupt weight loss
__ abdominal bloating __ abdominal gas __ gurgling in the stomach
__ fatigue after eating __ prolapsed organs __ easily bruised
__ hemorrhoids __ pensive __ over-thinking
__ worry
Spleen, Stomach, Large Intestine, Small Intestine Function:
__ loose stools __ constipated __ incomplete __ diarrhea
__ blood in stools __ mucous in stools __ undigested food in stools
Dampness Trapped in the body:
__ general sensation of heaviness in the body __ mental sluggishness __ snoring
__ mental heaviness __ mental fogginess __ nausea __ chest congestion
__ swollen hands __ swollen feet __ swollen joints
Stomach Function:
__ large appetite __ bad breath __ canker sores __ bleeding gums
__ heartburn __ acid reflux __ stomach ulcers __ belching
__ hiccoughs __ stomach pain __ vomiting __ pain after eating
Liver, Gall Bladder Function:
__ chest pain __ tightness in chest __ bitter taste in mouth __ tingling sensation
__ anger easily __ frustration __ depression __ numbness
__ irritability __ muscle twitching __ convulsions __ unable to adapt to stress
__ alternating diarrhea and constipation __ skin rashes __ muscle spasms
__ headache at the top of the head __ muscle cramping __ seizures
__ lump in the throat __ neck tension __ shoulder tension
__ drink alcohol __ gall stones
Eyes (liver function):
__ itchy __ bloodshot __ hot __ dry __ far-sighted __ near-sighted
__ watery __ gritty __ blurred vision __ decreased night vision
Kidney, Urinary Bladder Function:
__ frequent cavities __ easily broken bones __ sore knees
__ weak knees __ cold sensation in the knees __ low back pain
__ memory problems __ excessive hair loss __ kidney stones
__ fear __ easily startled __ bladder infections
__ lack of bladder control __ wake twice or more during the night to urinate

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients complete our Patient Consultation Information/History Sheet before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMEX AND DISCOVER.

Regarding Insurance:

We will verify coverage prior to the first treatment. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for each treatment until verification is obtained. We cannot bill your insurance company unless you provide all insurance information. You insurance policy is a contract between you and your insurance company. We are not part of that contract. In the event that your insurance company will not assign benefits to our office, any balance due on your account is your responsibility whether your insurance company pays or not. Our fees are determined by the complexity of the particular case and the different modalities used during treatment. In signing this document, you are agreeing to turn over, or reimburse the complete amount of any and all insurance checks which may be given to you, the patient. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Regarding Payments on Date of Service

In an effort to minimize costs and create the best possible atmosphere for healing, payments are due at the time services are rendered. If you are on a payment plan, payments are due as specified in your specific plan.

Missed Appointments

By signing this document you agree to give 24 hours notice if you need to cancel or change an appointment, otherwise you will incur a $30 fee. Please keep in mind that your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. We are best able to serve you when you keep your scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. By signing this document you agree that you have read and understand the terms of our Financial Policy.

A photocopy of this document shall be considered as effective as the original.

X _____ Date: _____
Signature of Patient or Responsible Party

X _____ Print Name

Acupuncture Wellness Center of Coral Springs
954.755.1292

Patient Consent Form
HIPPA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent Form. The terms of our office Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

_____

This Consent was signed by : _____ Date: _____

Print Name: _____

Relationship to Patient (if other than patient): _____

Witness: _____
(Sign and Print Name)

Date : _____

Consent Form

I, _____ voluntarily consent to be treated at **The Acupuncture Wellness Center of Coral Springs**. Treatments may include (but are not limited to) Acupuncture, Homeopathic or Chinese Herbal Medicine, Massage / manual therapy, Injection therapy, Laser therapy, Hypnosis, etc.

I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture or Chinese Herbal Medicine treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that No guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop treatment at any time.

I agree that I will give at least 24 hours notice if I need to change or cancel an appointment and I will be charged for the appointment $30 if such notice is not given.

SIGN NAME _____

PRINT NAME _____

DATE _____

WITNESS _____