Client Billing Information

Olympia Family Acupuncture 1800 Cooper Pt Rd. SW #24b Olympia, WA 98502 360-357-5353

Name:		Birth Date: :	SS#	
Address:		City:	State:	Zip:
Phones: (Home) ( )	(Work) ( )	(Cell) ( )	Email Address	@
Physician:		Emergency Contact Person		#
Occupation/Employer	Age;	Height Weight	Gender: M / F___	Ethnicity Relationship Status:

* **Cash Client:** I agree to keep my account current by paying at the time services are rendered,
* **S**hould I defer full payment, I agree to pay the full non-discounted price for services rendered, within 7 days of service.

I have read and understand the policies and procedures of this office including financial obligations to receiving care.

X **Client/Guardian Signature:** _____ Date: _____

X **Insurance Client:** *If insurance is covering any part of your care, please complete the rest of this form and sign below.*

Personal Health Insurance Information.

Please present a copy of your insurance identification card so we may photocopy it for our records.

IT IS YOUR RESPONSIBILITY TO CONFIRM YOUR COVERAGE WITH YOUR INSURANCE COMPANY PRIOR TO TREATMENT

Insurance Company _____ Policy/ID #: _____ Group #_____

Benefit Plan_____ Policy Holder: _____Self / Spouse/Child/Other

Annual Benefits: # of Visits_____ / Expected Copay:_____ Annual Deductible _____ Need Authorization Y N ?

Insurance Company: Telephone #_____ Address_____

Policy Holder's DOB _____ Ss#:_____ Address: _____

Secondary Plan Information or PIP Automobile Insurance — Circle one Secondary PIP/auto

Policy Holder:_____ Policy #_____ Claim #: _____

Client's Insurance Company: _____ Adjusters Name _____

Insurance Co. Address:_____ Phone #: _____x_____

Policies Please sign the agreement below.

* I accept full financial responsibility for services rendered, independent of my coverage, and agree to pay all balances in full within 30 days of receiving an itemized statement.
* I acknowledge that fees may accrue for late payment.
* I hereby authorize the release of any acquired information concerning my medical conditions or otherwise, by Olympia Family Acupuncture, for the purposes of securing payment for any claim on my account.
* I hereby authorize my insurance company to send payments directly to Olympia Family Acupuncture for the services rendered to me.
* I recognize that certain, recommended procedures including Cupping, Moxa, Tui Na, Herbal and Nutritional Guidance may not be covered by my insurance, and hereby agree to pay for all such services not covered by my plan.
* I have read and understand the policies and procedures of this office including financial obligations to receiving care.
* I agree to notify Olympia Family Acupuncture if there is any change regarding my coverage or contact information.

X Client / Guarantor Signature:_____ Date:_____

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

Denise Robison is a licensed acupuncturist in the State of Washington, License number 592, dated 10-21-1999. Her didactic and clinical training was completed between 1995-1999. She received her Master of Science in Acupuncture from the Northwest Institute of Acupuncture and Oriental Medicine (NIAOM) and her Bachelor of Science in Oriental Medicine from Bastyr University in 1999. Denise holds a certificate in Chinese Herbal Medicine from the Northwest Institute of Acupuncture and Oriental Medicine.

If You Are Pregnant Or Think That You May Be Pregnant
If You Have A Severe Bleeding Disorder
If You Have A Pacemaker
PLEASE MAKE SURE THAT THESE CONDITIONS ARE KNOWN PRIOR TO TREATMENT SO THAT CONSIDERATIONS CAN BE MADE

I, the undersigned, hereby authorize Denise Robison EAMP and licensed Associates at Olympia Family Acupuncture to administer care on my behalf using the following procedures to activate my body's healing process:

Stimulation of Acupoints, Meridians and Energy flow using

- Acupuncture
- Acupressure
- Electro-Acupuncture
- Moxibustion
- Cupping
- Sound Therapy
- Gua Sha
- Tui Na/Chinese Massage
- Plum Blossom
- Qi Gong

Nutritional Herbal and Lifestyle Guidance based in TCM

*These procedures fall within the scope of practice specifically described by the Washington State law for Licensed Acupuncturists. Selected procedures for your care will be discussed prior to administration.

I understand that, at any time, I may discontinue and verbally withdraw my consent and participation in any or all of these procedures.

I realize that no guarantees have been given to me by Olympia Family Acupuncture or Denise Robison, EAMP regarding cure or improvement of my condition.

I recognize that there are possible benefits to these procedures including the elimination or prevention of my presenting condition; painless and drugless relief from my present symptoms; and the improved balance of energy which may generate and improve my overall health.

I recognize that there are potential side effects which occur in a small percentage of patients, such as

- Discomfort at the site of needle insertion
- Bruising, dizziness or weakness
- Temporary aggravation of pre-existing symptoms.

I also recognize that these procedures carry the rare but potential risks of needle breakage or infection.

With this knowledge, I voluntarily consent to the above procedures and hereby release Denise Robison, EAMP and Olympia Family Acupuncture., from any and all liability which may occur in connection with the above-mentioned procedures, save for failure to perform the procedures with appropriate medical care.

SIGNATURE OF PATIENT or
AUTHORIZED GUARDIAN _____ DATE _____

PRINTED NAME OF THE ABOVE SIGNED_____ ___DATE _____

WITNESSED BY_____DATE_____

Denise Robison M. Ac., L. Ac.
1800 Cooper Point Rd. SW, Bldg. 24b Olympia, WA 98506 *tel. 360.357.5353*

Health History Questionnaire

PLEASE FILL OUT THIS FORM AS THOROUGHLY AS YOU ARE ABLE ~ **ALL INFORMATION WILL BE KEPT CONFIDENTIAL**

Name_____Today's Date_____Date of Birth _____Age____
Address_____ Age_____ Height_____ Weight_____
_____ Occupation_____
Relationship Status: (optional) Married Cohabitating Single Divorced/Separated Other _____

What brings you here today?/What is your main goal?

_____

Have you had Acupuncture before? _____

Which Modalities are you interested in receiving? Acupuncture ☐ Herbs and Medicinals ☐ Health Consultation ☐

Please list your health concerns here:

Concern	Onset	Known Cause
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To what extent does these problems interfere with your daily activities (work, sleep, sex)?

_____

_____

Has your MD, or another physician(specify), given a diagnosis for your condition(s)? _____ If so, what?_____

Are you currently using any therapies (including prescription and other medications) to remedy your condition?

Please specify?_____

Otherwise, what medications or supplements are you taking?(over last two months)

Medication/supplement	Reason for taking	Dosage/Frequency

Personal Medical History

Please circle if you have any of the following / Family History ? Please write in **F**

Cancer Diabetes Heart Disease Hepatitis STD's HIV Asthma Seizures Rheumatic Fever
High blood pressure Please Specify _____

PMH CONTINUED

Are Any Of The Following Applicable To You? circle or note

□ Surgeries _____

□ Recent Injury –date / /

□ Significant Childhood Illness(es)

□ Environmental Exposure

□ Significant Dental Work

□ Significant Trauma - auto accidents, falls, etc.:

□ Adverse Response to Vaccines or Medication

□ Occupational Stress - Chemical, Physical, Psychological

□ Respiratory Problems?

□ Sinusitus □ Athsma □ Recurring Colds

□ Allergies – Food / Skin / Airborne

□ Digestive Problems? Upper □ Middle □ Lower □

_____.

□ Emotional Problems?

□Depression □ Anxiety □ Insomnia □ Temper □ Mood Swings

□ Structural Problems?

□ Pain □ Numbness □ Fatigue □ Spasm □ Stiffness

□ Circulatory Problems? Chest □ Extremities □ Head □

□ Significant Dental Work - type and date(s):_____

□ Occupational Stress - Chemical, physical, psychological

□Childhood sickness/Life or Birth History (anything predominant)_____

□ Vaccinations_____

Gynecological History

Age of first period_____First date of last period__/__/___, Menses Length_____ Cycle Length_____ Typical Ovulation day_____

Current Contraceptive_____ Contraceptive History_____

Are you Trying to Conceive?_____ Naturally □ Fertility Support IVF□ IUI□ Alternative □ other_____

Are you currently Pregnant? Yes No Maybe Due Date_____ Week _____ Care provider?_____

History of Pregnancies- _____Pregnancies _____Births Please give Dates / Ages of children_____

Age Peri-Menopause began_____ ended_____ Are you on HRT?_____

Gynecological Complaints? Vaginitis PID Yeast Endometriosis/Cramping PCOS Cysts PMS PMD Surgeries _____

Habits - please indicate usage per day or week

Cigarettes _____ Per ____Coffee _____ Per ____

Cola _____ Per ____ Tea _____ Per ____

Alcohol _____ Per ____ Sugar _____ Per ____

Drugs _____ Per ____ Other _____ Per ____

Do you eat regularly? Y N circle all: * FRESH FOOD * HOME COOKED * FAST FOOD *ORGANIC SPECIAL DIET Please describe your average daily diet / routine: _____

Morning

Afternoon

Night

Other Notes:

_____

_____

_____

ESSENTIAL AGREEMENTS

OLYMPIA FAMILY ACUPUNCTURE AGREES TO KEEP ALL INFORMATION CONFIDENTIAL AT ALL TIMES.

YOUR TRUST IN OUR CARE IS GREATLY VALUED AND RESPECT FOR YOUR PRIVACY IS FIRST AND FOREMOST.
OUR OFFICE STAFF IS A PART OF YOUR CARE AND FOR REASONS OF SCHEDULING OR BILLING, MAY ACCESS THE SIMPLEST FORM OF IDENTIFYING INFORMATION, DIAGNOSTIC CODES AND PROCEDURES INCLUDING HERBAL SUPPLEMENT INFORMATION IN ORDER TO EXECUTE SUCH OFFICE PROCEDURES. WE AGREE TO THE STANDARDS SET FORTH BY THE HIPPA REGULATING BODY TO INSURE YOUR PRIVACY AND ACCESS TO QUALITY CARE. WE AGREE TO BILL INSURANCE COMPANIES TO THE BEST OF OUR ABILITY IN ORDER TO SIMPLIFY YOUR CARE.
WE AGREE TO NOTIFY YOU OF ANY BALANCE NOT READILY COVERED BY YOUR INSURANCE.
---DENISE ROBISON AND STAFF

CLIENT AGREEMENTS I, _____, HAVE REVIEWED AND UNDERSTAND BOTH THE INFORMED CONSENT AND THE POLICIES/PROCEDURES FOR THE OFFICE OF DENISE ROBISON L. AC. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED BY THE OFFICE OF DENISE ROBISON LAC. AND AGREE TO PAY FOR ALL PRODUCTS AND SERVICES PROVIDED TO ME REGARDLESS OF INSURANCE COVERAGE OR PROCESSING.

I AGREE TO GIVE AT LEAST 24 HOURS NOTICE FOR CHANGES IN SCHEDULING, INCLUDING CANCELATIONS AND RESCHEDULING. I AGREE TO OFFER $60 IN COMPENSATION FOR ANY APPOINTMENT MISSED OR CHANGED WITHOUT AT LEAST 24 HOUR NOTICE.

I AGREE TO RECEIVE EMAIL CORRESPONDENCE REGARDING SCHEDULING, OPEN BALANCES AND SELF CARE INSTRUCTIONS.
My email address is _____

OPT OUT: YOU MAY OPT OUT OF EMAIL CORRESPONDENCE HOWEVER WE ASK THAT YOU PAY YOUR BALANCES (ie Co-payments) IN OFFICE AT THE TIME OF SERVICE. JUST WRITE THE WORDS “OPT OUT” INSTEAD OF PROVIDING YOUR EMAIL ADDRESS AND SIGN BELOW TO AGREE TO THIS ARRANGEMENT.

PRINTED NAME_____ DATE_____/_____/_____

CLIENT/ GUARANTOR SIGNATURE X _____

CASH ARRANGEMENT

I AGREE TO PAY CASH PRICE OF $ _____ FOR A SIMPLE ACUPUNCTURE SESSION ON THE DOS.

ONCE PAID IN CASH AT ANY DISCOUNTED RATE, I AGREE NOT TO ENGAGE ANY THIRD PARTY FOR REIMBURSEMENT FOR SERVICES RENDERED.

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's 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 health care providers, insurance companies, workman's comp and your employer, and other third part 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 questions about our privacy guidelines, please call us during regular business hours at 1-360-357-5353.

Yours truly,

Denise Robison EAMP
Olympia Family Acupuncture
1800 Cooper Point Rd. SW #24-B
Olympia, WA 98502

OLYMPIA FAMILY ACUPUNCTURE

Denise Robison EAMP Phone: 360-357-5353
1800 Cooper Pt. Rd. SW #24-b ` Fax: 360-841-7616
Olympia, WA 98502

Consent for Purposes of Treatment, Payment and Health Care Operation

I _____ consent to the use or disclosure of my identifiable health information by Olympia Family Acupuncture (hereafter noted as OFA) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *OFA* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *OFA* is not required to agree to the restrictions that I may request. However, if OFA agrees to a restriction that I request, the restriction is binding upon OFA.

I have the right to revoke this consent, in writing, at any time except to the extent that *OFA* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review OFA's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Olympia Family Acupuncture. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.OlympiaFamilyAcupuncture.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Olympia Family Acupuncture with respect to my identifiable health information.

Olympia Family Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name and Relationship