동양전재한의원

Oriental Acupuncture Clinic

2148 Westlake Ave. N.
Seattle, WA 98109
(206) 851-3204

New Patient Information-1/6

1. Patient Name: _____
Last, First Middle

Nickname: _____ Name in Other Language : _____

2. Address: _____
Street

_____
City State Zip Code

3. **E-Mail Address:** _____
Cell Phone or Primary Contact Number: ( ) _____
Home Phone Number: ( ) _____Work Phone Number: ( ) _____

4. Date of Birth: _____/_____/_____ Age: _____
Gender: ○ Female ○ Male

5. Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widow ○ Or_____

6. Occupation: _____
Employer or School: _____

7. Spouse's or Partner's Name: _____ Phone ( ) _____
Kin's or Other's Name: _____Phone ( ) _____

8. **Primary Health Insurance Information:**
In Order to Bill Your Insurance, We Must Have a Copy of Your Insurance Card. Insurance company: _____ Employer: _____ Relationship to the patient: ○ Self ○ Spouse ○ Dependent ○ Or_____ Name of Subscriber:_____ Subscriber's Date of Birth:_____

9. **Injury Information:** ○**Automobile Accident** ○**Work** ○**Other**
Date of Injury: _____
Claim Number: _____
Insurance Company Name**:** _____
Insurance Company Phone: ( ) _____Adjuster's Name: _____
Address of Insurance**:** _____
Name of an Attorney: _____
Address: _____
Phone Number: ( ) _____Associate's Name:_____

10. **Referred by** _____

○ Family ○ Friend ○ Health care professional ○ Other

I understand that I am financially responsible for all charges and I agree to pay for services. I authorize the acupuncturist to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment to be made directly to the acupuncturist.

_____ _____
Signature Date

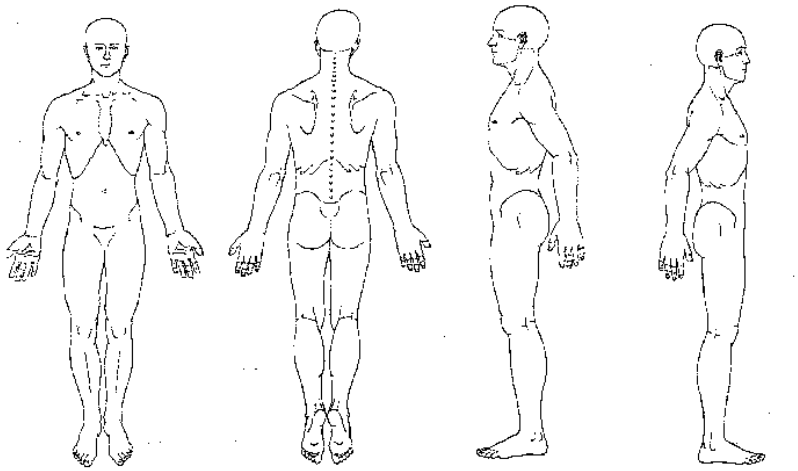
Oriental Acupuncture Clinic

New Patient Information- 2/6

1. Patient Name:_____ Date:_____
2. **Current Health Problem or Concern**: _____
   _____
3. When and how it occurred: _____
4. Worse in the certain time of the day or night: _____
5. Have you had this condition or similar condition before?
   Please explain: _____
6. What type of pain are you experiencing?
   ☐ Constant ☐ Occasional ☐ Tingling ☐ Burning ☐ Throbbing
   ☐ Sharp ☐ Aching ☐ Shooting ☐ Numbness
7. Have you taken any of the tests for this problem?
   ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Other
8. What ease your symptoms?
   ☐ Medication ☐ Heat ☐ Ice ☐ Resting, Laying down
   ☐ Changing Position ☐ Stretching ☐ Exercise ☐ Nothing
   ☐ Other_____
9. What activities increase your symptoms?
   ☐ Sitting ☐ Twisting ☐ Lifting ☐ Rising ☐ Walking ☐ Standing
   ☐ Bending ☐ Driving ☐ Reaching ☐ Squatting ☐ Kneeling ☐ Coughing
   ☐ Repetitive Motion ☐ Other _____
10. Have you had acupuncture before? ○ Yes ○ No
    If yes, for what symptom and when? _____
11. Please list any medications you are currently taking:_____
    _____
    _____
12. Please list any E.R., hospitalization, surgeries, injuries or accidents:_____
    _____
13. Please check the current level of pain

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

14. Please indicate on the picture the locations of pain:



Front Back Left Side Right Side

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New Patient Information – 3/6

Patient name: _____ **Date:** _____

1. How would you rate your overall health?
Poor Fair Good Excellent

2. Please check any you have had in the last three months:

General: Poor Appetite Fatigue Weight Loss Weight Gain
Mood: Irritable Nervousness Depressed Overwhelmed
Sleep: Poor sleep Oversleep Many Dreams Easily Awake Restlessness
Head: Dizziness Blurring Vision Ringing in the Ears Pale Face or Lips
Nasal: Congested Running Frequent Nosebleeds Sinusitis
Cough: Wheezing Hoarse Gasping Sputum/Phlegm : Clear Thick
Stomach: Bloated Distension Heartburn Belching
Urination: Frequent Excessive Little During Night (How many? ___)
Bowel: Normal Constipation Loose How often? _____
Tendencies: Cold Hands, Feet, Knee, Abdomen Numbness of Hands, Feet or Leg
Bearing-Down Sensation on Abdomen or Anus Spontaneous Sweating
Night Sweat Heat Sensation in Palms and Soles Tremor

3. Habits: Please check

Tobacco: Cigarettes Pipe Cigar / Daily amount _____ Number of years _____
Caffeine: Coffee Tea Soda / Number of cups per day _____
Alcohol: Beer Wine Liquor / None Every Night, Number per week _____
Exercise: Yes No If yes, how many days a week? _____

4. Health History

Please check, if you have had any of the following. If your parents or siblings have had any of the following, please indicate on the lines below.

Allergies _____
Anemia
AIDS or HIV
Arthritis, Rheumatoid Arthritis
Cancer (type)_____
Depression/Psychiatric Condition
Diabetes
Epilepsy/Seizures
Headache, Migraine, Head Injuries
High Blood Pressure, Stroke, Pacemaker
Kidney Disease, Stone, Transplant
Liver Disease: Jaundice, Hepatitis
Lung, Asthma, Emphysema, Pneumonia,TB
Parkinson's Disease
Scoliosis
Stomach or GI Problems, Ulcer
Thyroid
Other _____

_____

5. Women's Health History:

Are you currently pregnant? Yes No If yes, how many month? _____
Number of pregnancies ___Miscarriages ___Number of deliveries: ___ Natural ___ C-Sections___
Age of first menstruation _____ Age of menopause _____
Estrogen replacement? Yes No If yes, since when :_____
During your menstruation: PMS Pain Cramps Excess Clots Irregularity
Type of contraception _____ If pills, how many years? _____
Any history of breast surgery: _____

Oriental Acupuncture Clinic

New Patient Information- 4/6

Patient Acknowledgement of Privacy Practices

E.J. Han, L.Ac., Ph.D. from Seattle Office

I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996, HIPPA.
I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly.

Obtain payment from third party payers for my health care services, such as auto accident cases, individual health carrier or another third party liability carrier.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient if not self: _____

Cancellation and No-Show Policy

I understand that you may need to cancel your appointments due to sickness or other things that may come up: I request at least 24 hours advanced notice.
I am often completely booked and someone else may need that time slot. Your appointment time is very important to me! I would appreciate the courtesy of providing advanced notice in the event of a cancellation. There will be a $ 70 charge for a no show with less than 24 hours advance notice.

Please add initials _____

Oriental Acupuncture Clinic

New Patient Information- 5/6

E.J. Han, L.Ac., Ph.D. from Seattle Office

Informed Consent and Disclosure Form

We only use disposable needles.
We use extremely fine acupuncture needles that usually have a 0.25mm to 0.40mm diameter. At the Seattle office, E.J. uses Japanese disposable needles unless the size is not available.

The scope of practice for licensed acupuncturists are prescribing traditional Chinese or Korean herbs, to give cuppings, moxibustion(moxa), electrical stimulation and TuiNa-Chinese acupressure massage.

Acupuncture performed by a licensed acupuncturist is a safe method of medical treatment. However, an acupuncture treatment may possibly cause side effects such as tingling, heaviness or numbness on the acupuncture point location during or right after the session for a few minutes to a short period of time.
Brusing may occur on the acupuncture point locations after the session.
It is highly unlikely but light-headedness or fainting may possibly occur.

Prescribed Chinese and Korean herbs may possibly cause an abdominal distention, nausea, skin irritation as hives or rashes. A tingling sensation of the tongue or throat for a few minutes to a brief period of time may possibly occur.

I have read the above and I consent to the treatment of Oriental Medicine, acupuncture, prescribing traditional herbs and its scope of practice.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient if not self: _____

Health Care Provider-Patient Arbitration Agreement - 6/6

Article 1: Agreement to Arbitrate: It is understood that any dispute as to professional malpractice, that is as to whether any professional services rendered under this contract were unnecessary to unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California or Washington law, and not by a lawsuit or resort to court process except as California or Washington law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the health care provider including any heirs or past, present or future spouses(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in the arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person and entity shall be stayed pending arbitration.

The parties agree that the provisions of the California or Washington Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including, but not limited to, sections establishing the right to introduce evidence of any amount payable as benefit to the patient as allowed by law (CA Civil Code 3333.1), the limitation on recovery for non-economic losses (CA Civil Code 3333.2) and the right to have a judgment for future damages conformed to periodic payment (CA CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient.

Article 5: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial on the right.

_____
Patient's Initials

Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

***Notice**: By signing the contract you are agreeing to have any issue of professional malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of the contract.*

_____ X_____

Health Care Provider's Signature and Date

Patient's or Parent's Signature and Date

_____ _____

Health Care Provider's
Authorized Representative's Signature and Date

Patient's Representative's Signature and Date

Translated by_____