Goshorn Acupuncture

721 Ridge Road, Webster, NY 14580
585-490-1415 • Goshornacupuncture.com

Traditional Chinese Medicine is based on the principle of balancing an individual's body, mind, and spirit. The following confidential questionnaire is a detailed and invaluable source of information about you. It provides Allison with a complete sense of you as a unique individual as opposed to a collection of symptoms.

Date: _____

Name: _____

Address: _____

_____

City *State* *Zip*

Sex: □ M □ F Age: ____ Birthdate _____

□ Single □ Married □ Significant Other
□ Widowed □ Separated □ Divorced

Occupation: _____

Employer: _____

Spouse/Partner's Name: _____

Whom may we thank for referring you?

_____

Phone Numbers:

Home: _____

Work: _____

Cell: _____

Best time & place to reach you: _____

_____

In case of emergency, contact:

Name:_____

Relationship:_____

Phone: _____

Insurance:

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Company: _____

Group #: _____

Is patient covered by additional insurance?

□ Yes □ No

Subscriber's Name: _____

Birthdate: _____

Relationship to patient _____

Insurance Co.: _____

Group #:_____

Present Health Concerns:

Please list your most important health concerns in order of their significance.

1._____ Approximate date of Onset: _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _____

2._____ Approximate date of Onset: _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _____

3._____ Approximate date of Onset: _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Other therapies tried: □ Medications □ Surgery □ Chiropractic □ PT □ Other _____

Please list all **medications** that you are currently taking with dosages:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that are you presently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past medical history: Please list past injuries, broken bones, surgeries and hospitalizations, with approximate dates:

_____

_____

Personal Habits:

□ Tobacco packs/day: _____
□ Alcohol drinks/wk: _____
□ Coffee/Tea cups/day: _____
□ Recreational drugs times/wk: _____

Work Activity:

□ Sitting % of time: _____
□ Standing % of time: _____
□ Light labor % of time: _____
□ Heavy labor % of time: _____

□ High Stress Level Reason: _____

Do you follow any diet regimens/restrictions?
□ Yes □ No
If yes, describe: _____

Exercise:
Do you exercise regularly? □ Yes □ No
If yes, describe & tell how often:
_____

Comments: Please let me know of any other concerns you would like to address:

Disclosures: Please read carefully the following disclosure and sign the corresponding agreements and acknowledgements of consent.

Consent for Treatment:

I, _____, voluntarily consent to receive acupuncture treatment by Allison Goshorn of Goshorn Acupuncture, who is certified by the state of New York and are certified by the National Certification Commission of Acupuncture and Oriental Medicine to practice acupuncture. I understand her training is in acupuncture and oriental medicine and that she is not, nor claims to be, a medical doctor. I understand that the evaluation, diagnosis, and the treatment I receive are not a replacement for western medical care.

I have provided a full and accurate medical history and understand the ongoing need to communicate my complete medical status with my provider. I understand that no guarantee has been made concerning the effects of acupuncture and I may cease treatment at any time. I understand that treatment consists of the insertion of fine, sterile needles, with or without electro-stimulation, through the skin, and/or the application of heat therapy to the skin. I acknowledge that, although rare, certain side effects may result, including, but not limited to, minor bruising, minor pain at needle site, dizziness or fainting.

_____ _____

Signature of Patient Date

Insurance Agreement:

I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the acupuncturist's office will prepare any necessary claims and forms to make collections from the insurance company on my behalf. However, I clearly understand that all services rendered me are charged accordingly and that I am personally responsible for payment should insurance coverage fail to pay for any reason. I also understand that if I suspend or terminate, any fees due will be immediately payable. Goshorn Acupuncture does not process Worker's Compensation and No-Fault claims. If it is Worker's Compensation or No-Fault, the patient is responsible for full payment of treatment at the time of service.

_____ _____

Signature of Patient Date

HIPAA Compliance Policy:

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

_____ _____

Signature of Patient Date

Please note Goshorn Acupuncture's cancellation policy:

All cancellations or reschedules require a 24 hour notice or they will be subject to a charge. Appointments cancelled or rescheduled with less than a 24 hour notice will result in a charge of half price of the scheduled service. Appointments that are missed that neglected to give notice (no call, no show) will result in a charge of full price of the scheduled service. Missed appointments without notice prevents us from using the appointment time for other patients needing to be seen.