PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name Last Name

Address: City: State: Zip:

Home Phone ( ) Cell ( ) Work ( )

SS#: Age: DOB:

Drivers License #: Male □ Female □

Employer: Occupation:

Married □ Single □ Divorced □ Name of Spouse:

Emergency Contact: Telephone ( )

Referred by: Friend □ Relative □ Insurance □ Other □

PRIMARY INSURANCE Cash □ Group □ Work/Comp □ Auto □ Other □

Name of Insurance Co.: ID#: Group#:

Name of Insured: Relationship to Patient: Self □ Spouse □ Parent □

Secondary Insurance: Name of Insured:

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print):_____Patient Signature:_____Date:_____

If you are under 18 years of age, please have your parent or legal guardian sign below.
I have read and agree to the terms above. All of the information is true to the best of my knowledge.

Parent/Legal Guardian (print):_____Parent/Legal Guardian Signature:_____Date:_____

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

Dr. Scott S. Bahng, L.Ac. takes pride in the quality of care he offers his patients. In order to do this he has a strict cancellation policy. Dr. Scott S. Bahng, L.Ac. requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the credit card we have on file.

I, _____authorize Dr. Scott S. Bahng, L.Ac. to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

_____ - _____ - _____ - _____ Ex _____ / _____ Visa □ / MC □

Patient Name (print):_____Patient Signature:_____Date:_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatment and other procedures within the acupuncture scope of practice on me (or on the patient named below for whom I am legally responsible) by the acupuncturist below.

I understand that methods of treatment may include but are not limited to, acupuncture, moxibustion directly or indirectly applied on skin, cupping, guasha, electrical stimulation, Oriental massage,Tui-Na (acupressure), Oriental herbal medicine, and/or nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method of treatment, but that it may have some side effects including pain, bruising, numbness, swelling or tingling sensation near the needling sites that may last a few days or sometimes/rarely over 1-6 months and dizziness or fainting.

Bruising and, or scarring, blisters are a common side effect of cupping/or guasha and, or blood letting with cupping, Cupping: prick bleed using a lance to dramatically enhance blood or qi movement; this will cause bleeding and may also cause local bruising or swelling, scarring, blisters and may last a few days or sometimes/rarely over 1-6 months.

Burns, blisters, and, or scarring are a potential risk of moxibustion burning moxa and may last a few days or sometimes/rarely over 1-6 months.

Burns or scarring, blisters are a potential risk of when treatment involves the use of heat lamp or infra-red and may last a few days or sometimes/rarely over 1-6months.

A patient may have an allergic reaction after receiving an acupuncture treatment with sterile needles. Some of the allergic reactions may be in the form of itchiness, rash, swelling, infection, and small purulence.

Unusual risks of acupuncture include miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large dosages. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are: nausea, gas, stomachaches, vomiting, liver or kidney damage, headache, diarrhea, rash, hives and tingling sensation of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand that the provider will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment.By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ Date:_____/_____/_____

PATIENT SIGNATURE (Or Representative) Month Day Year

Scott S. Bahng, L.Ac.,Dip.O.M.
Acupuncture Provider

Dr. Scott S. Bahng, L.Ac., Dipl.O.M.

1525 EAST ONTARIO AVE. SUITE 104
CORONA, CA 92881

PHONE: (951) 279-8900

PATIENT HIPAA AWARENESS

Consent for Purposes of Treatment, Payment & Healthcare Operations

THIS DOCUMENT IS INTENDED TO COMPLY WITH 45 CFR § 164.520 (c) AND 45 CFR § 164.510. IF YOU HAVE ANY QUESTIONS ABOUT THIS DOCUMENT, PLEASE CONTACT THE PRIVACY OFFICER AT (951) 279-8900.

I hereby acknowledge that I received the Notice of Privacy Practices from Dr. Scott S. Bahng, L.Ac.

I consent to the use or disclosure of my Protected Health Information (PHI) by Dr. Scott S. Bahng, L.Ac. for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my heath care bills or to conduct health care operations of Dr. Scott S. Bahng, L.Ac. I understand that analysis, diagnosis or treatment of me by Dr. Scott S. Bahng, L.Ac. may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Scott S. Bahng, L.Ac. is not required to agree to the restrictions that I may request. However, if Dr. Scott S. Bahng, L.Ac. agrees to a restriction that I request, the restriction is binding on Dr. Scott S. Bahng, L.Ac.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Scott S. Bahng, L.Ac. has taken action in reliance on this Consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected 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 have been provided with a copy of the Notice of Privacy Practices of Dr. Scott S. Bahng, L.Ac. and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Scott S. Bahng, L.Ac. This Notice of Privacy Practices also describes my rights and duties of Dr. Scott S. Bahng, L.Ac. with respect to my protected health information.

Dr. Scott S. Bahng, L.Ac. does not authorize the use of still picture, video, audio or any other type of recording on the premises without prior, explicit written consent from Dr. Scott S. Bahng, L.Ac.

Dr. Scott S. Bahng, L.Ac. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the Dr. Scott S. Bahng, L.Ac. Privacy Officer at (951) 279-8900 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing this form, I am allowing Dr. Scott S. Bahng, L.Ac. to use and disclose my PHI disclosures in reliance upon my prior consent.

PARENT OR GUARDIAN

SIGNATURE: _____ NAME: _____

DATE: _____

Dr. Scott S. Bahng, L.Ac., Dipl.O.M.

1525 EAST ONTARIO AVE. SUITE 104
CORONA, CA 92881
PHONE: (951) 279-8900

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
INITIAL USES AUTHORIZATION FORM

Effective: April 14, 2003
Initial Acknowledgement and Uses

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides Information about how we may use and disclose you protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. Scott S. Bahng, L.Ac., Dipl.O.M.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. Scott S. Bahng, L.Ac., Dipl.O.M.
1525 EAST ONTARIO AVE. SUITE 104
CORONA, CA 92881
PHONE: (951) 279-8900
A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Patient Name (Print): _____

Signature: _____

Date: _____

Staff complete only if NO signature is obtained.
If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

_____ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

_____Other: _____

Staff Signature: _____ Date: _____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine
For questions, please call ASH at 800.972.4226

Patient Name_____ Birthdate_____ Primary Language_____ Gender M / F
Last First

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ PCP Phone #_____
(Required) (Required)

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions?_____

Please describe your current health problem(s)_____

How and When it began_____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy
☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_____

Please describe your progress: ☐ Worse ☐ No Change ☐ 0-25% Better ☐ 26-50% Better
☐ 51-75% Better ☐ 76-100% Better

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____ _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures_____
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks_____ If pregnant, are you under a medical doctor's care? ☐Y ☐ N
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ **Medications**_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co- managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ **Date**_____

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: _____

_____

_____

_____

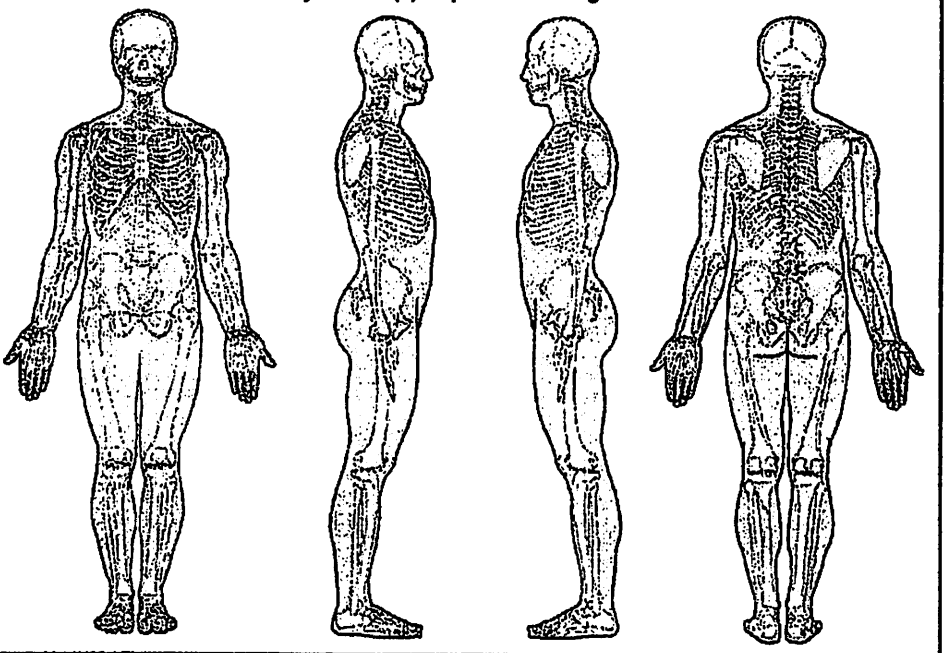
How long have you had this condition? _____ Is it getting worse? ☐ yes, ☐ no _____

Does it bother you (check appropriate box): ☐ work, ☐ sleep, ☐ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	☐	☐	_____
... had any mental disorders?	☐	☐	_____
... had any broken bones?	☐	☐	_____
... had any strains or sprains?	☐	☐	_____
... ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

☐ Alcoholism	☐ Cancer	☐ High blood pressure
☐ Anemia	☐ Diabetes	☐ High cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed easily	☐ Heart disease	☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____