PATIENT RECORD & MEDICAL HISTORY

Name _____ Age _____ Birth Date _____ Today's Date _____

Home Address _____ City_____ State _____ Zip _____

Mobile Phone ( ) _____ Email Address_____

Preferred Pronouns _____ Gender _____ Occupation_____ Work/Commute Hours/Week _____

Relationship Status _____ How many children or dependents do you have at home? _____

Emergency Contact _____Phone ( ) _____ How did you hear about us? _____

Medical History: *please check all boxes below that are or have been a part of your personal health history*

	Current	*Past*		*Current*	*Past*		*Current*	*Past*
Allergies	[ ]	[ ]	High Cholesterol	[ ]	[ ]	Men's Health Issues	[ ]	[ ]
Anemia	[ ]	[ ]	Chronic Fatigue	[ ]	[ ]	Musculoskeletal Injuries	[ ]	[ ]
Angina (Chest Pain)	[ ]	[ ]	Depression	[ ]	[ ]	Neurological Problems	[ ]	[ ]
Anxiety	[ ]	[ ]	Diabetes	[ ]	[ ]	Psychological Problems	[ ]	[ ]
Asthma	[ ]	[ ]	Digestive Problems	[ ]	[ ]	Respiratory Problems	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Endocrine Problems	[ ]	[ ]	Urogenital Problems	[ ]	[ ]
Low Blood Pressure	[ ]	[ ]	Headaches	[ ]	[ ]	Vertigo or Dizziness	[ ]	[ ]
Cancer	[ ]	[ ]	Insomnia	[ ]	[ ]	Women's Health Issues	[ ]	[ ]

Any other health issues other than your chief complaint below?

Family history of any of these problems? Please specify:

Please list all past surgeries or major procedures and approximate dates:

Please list all medications you are currently taking:

Chief Complaints: *please describe the major health concerns you would like to have addressed*

Do you have faint easily or often?	Yes	No	How frequently do you smoke? _____	
Do you have a pacemaker?	Yes	No	How frequently do you drink coffee? _____	
Do you bleed for a long time?	Yes	No	How frequently do you drink alcohol? _____	
Are you pregnant?	Yes	No	Do you follow a special diet? Specify _____	
Do you take birth control pills?	Yes	No	What supplements or herbs are you taking? _____	
Do you exercise regularly?	Yes	No	_____	

East Bay Acupuncture & Natural Medicine, INC.
2346 Stuart St., Berkeley, CA 94705
p: (510) 457-8886 ♦ f: (510) 705-8520 ♦ info@ebacupuncture.com

Late Cancellation, No-Show, and Late-Arrival Policies

To cancel or reschedule an appointment **we *require advance notice of one full business day***. For example, a 3pm appointment on Wednesday should be cancelled before Tuesday at 3pm. A 9am appointment on Monday should be cancelled before the previous Friday at 9am. Cancellations can be done through your online patient portal, or by emailing, calling, or texting the office.

Late cancellations or not showing up to an appointment will result in an automatic credit card charge of $50, *regardless of the reason*. We do understand that life is full of unexpected events and challenges, and that medical, personal, and family emergencies come up. For that reason, we will waive the late-cancel fee for return visits one time each year.

If you have cold, flu or Covid symptoms, we ask that you take a Covid test before coming to your appointment. If the test is negative, we recommend coming to your appointment, as acupuncture and herbal medicine can be very helpful in supporting wellness and immune health. We do ask that you wear a mask if you have any symptoms that could be related to cold, flu or Covid (sore throat, fever, cough, etc.).

Please plan to arrive at least 5 minutes before your scheduled appointment time, so that you can change into comfortable clothing, if necessary. If you expect to be more than 5 minutes late, please call or text us. Informing us of a late arrival as soon as possible helps us do our best to accommodate you. Sometimes we are unable to accommodate arrivals later than 10 minutes.

I have read and agreed to the terms of the preceding paragraphs. Please let us know if you would like a copy for your records.

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Financial Agreement

We offer two options for payment of services rendered, Self-Pay or 3rd-Party Pay. Please let us know which option you prefer. We accept cash, check, and all major credit cards (*with a 3% convenience fee for credit card charges over $300)*.

Self-Pay:
The self-pay option means that all fees are paid by you on or before the day the service is rendered. The fees listed here are discounted for payment at the time of service.

- The initial visit is $185.
- Return visits are $105.
- Packages of 12 visits ($1,092, *14% savings*) and 6 visits ($588, *7% savings*) can be purchased after the initial visit.
- The price for self-pay visits includes all treatment modalities recommended by your provider.

3rd-Party Pay:
If you have insurance, or there is another 3rd party payer (worker's compensation, lien-based personal injury, Veteran's Affairs), we will submit claims to the payer for you as a courtesy. Important notes when choosing this option:

- Please give us all information necessary to confirm benefits before your initial visit.
- Copayments or payments towards a deductible are the responsibility of the patient. We usually know what those amounts will be and charge you at the time of service. But, at times, copay or deductible amounts applied can't be confirmed until after we submit the claim. In that case, we will bill or refund you once the amount is confirmed by the 3rd party.
- We will verify your benefits and bill your insurance in a timely manner, but complications can arise. If your insurance does not pay, you are responsible for any unpaid balances.
- Payment of medical benefits is authorized by you to be made directly to this office. If your insurance carrier sends payment to you for services given at this office, you agree to remit that payment to us.
- You authorize this office to release any medical or other information necessary to process the claim, when requested from the payor.
- Herbs and supplement purchases, and late-cancellation fees are not billable to 3rd party payors.

Privacy Policy

East Bay Acupuncture & Natural Medicine, INC. follows all HIPPA regulations, as required by law, to maintain the privacy and confidentiality of your protected health information. Our full HIPPA compliance policy is available by request.

I have read and agreed to the terms of the preceding paragraphs. Please let us know if you would like a copy for your records.

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Medical Informed Consent for Acupuncture & Related Modalities

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named, for whom I am legally responsible) by licensed acupuncturists at this facility. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bums and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

By voluntarily signing, 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. Please let us know if you would like a copy of this document.

Name _____ Signature _____ Date _____

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