PRAHM

11520 SW 220th St
Vashon, WA 98070
www.VashonPRAHM.com

206-463-9066

For your first visit:

Wear comfortable clothes that allow easy access to the legs, arms and stomach. If you are not able to wear such clothes we have sheets available.

Do not plan on any strenuous or altering activities during the same day of treatment. Examples of activities to avoid might be over use of alcohol, anything that worsens your condition, sex, or too much caffeine. This allows the treatment to be more effective.

If you are having treatments that involve the face and you wear makeup, allow time to remove your makeup prior to treatment. You might also want to allow time to reapply your make up after treatment. If possible, please do not wear any perfume or cologne.

We recommend keeping a journal of some kind during your treatment. Things to note are changes in your condition energy levels, cravings, bowel movements, urination, libido, sleep and/or moods. This helps us to pinpoint patterns in your body to assist us in your treatment.

Your appointment will be on Vashon Island. Maps can be found on the Contact page of each website. More information and updates on what we offer can also be found on the websites. We are very excited about our clinic. I hope that you will enjoy it as well and give feedback on your experience.

***Please remember to bring all of your forms and payment information.**
While we appreciate your promptness please allow for 10-15 min of waiting. We believe in the experience of your treatment, starting as soon as you arrive, and do our best to offer a relaxing waiting area. Please let us know if you have any feedback for us.

Thank you for your trust in us and we look forward to working with you on your health!

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NEW PATIENT INFORMATION

* = required info

*Date of Birth____/____/______ Age__________*Gender_____________*SS#______________________

*Last Name_______________________First Name________________________ M.I.______________________

Email____

* Mailing address____

* Home phone__________________________________ Work______________________________________

**May we leave a message on your phone or email?___________ If no, how can we contact you?______________*

*Emergency contact_______________________*Phone____________________*Relationship________________

Do you have insurance? Y N if yes, please provide a copy of your insurance card and the following info

Insured name (if not client) ________________________Birth date _______/____/______SS#________________

Insurance carrier ____

Number (include alpha) _________________________________Group#_________________________________

Health History

Primary Health concern____

Secondary Health concern ____

Name of last physician____Date of last check-up________________

Your health as a child good fair poor Childhood illnesses_____________________________________

Hospitalizations year reason year reason

____

Surgeries year reason year reason

____

Immunizations____

Length of being breast fed____

Any Birth traumas?____

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Current Medications

Prescription_______________________________________ Non prescription__________________________________

Vitamins_______________________________________Herbs ____

Allergic Reactions

Drugs____Foods ____

Environmental ____

List any chemical, metals, dusts, or fumes that you have been repeatedly exposed to.

Diet

Do you have a special diet?__________________________Cravings ____

Exercise

Type/s____ Times per week _____________How long _____________

Sleep

Average hours per night______________Quality of sleep______________ # of times wake to urinate____________

Work

Employer___________________________ Hours per week_______Stress Level scale 1-10 *(1= no stress)*_________

Stress reducing activities____

Hobbies/recreations ____

Alcohol use history

Frequency____________ Type________________Alcohol problems: Y N Previously *(circle one)*

Nicotine use history

Cigarette smoking Y N # of packs per day___________________# of years smoking___________________

If you have stopped # of years stopped____

(please answer frequency question for when you did smoke)

Other nicotine: ____

Caffeine Use

Type____Frequency per week_______________________________

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PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS AND CHECK ANY THAT HAVE BEEN A PAST ISSUE:

General:
- Poor appetite
- Fevers
- Sweat
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst
- Thirst no desire to drink
- Poor sleeping
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Changes in appetite
- Weight gain
- Weight loss
- Tend towards feeling cold
- Tend towards feeling hot

Skin and hair:
- Rashes
- Itching
- Dandruff
- Changes in hair or skin
- Ulcerations
- Eczema
- Loss and/or thinning of hair
- Hives
- Pimples
- Recent moles
- Oily skin
- Dry skin
- Other hair or skin problems

Cardiovascular:
- high blood pressure
- anemia
- irregular heart beat
- cold hands or feet
- blood clots
- low blood pressure
- dizziness
- swelling of hands
- difficulty in breathing
- other heart or blood vessel problems

Head, eyes, ears, nose and throat:
- Dizziness
- Glasses
- Poor vision
- Cataracts
- Ringing in ears
- Sinus problems
- Grinding teeth
- Concussions
- Eye strain
- Night blindness
- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- spots in front of the eyes
- recurrent sore throats
- sores on lips, tongue or mouth
- headaches: where and when
- other head or neck:

Respiratory:
- cough
- bronchitis
- difficulty in breathing
- when lying down
- production of phlegm
- what color?
- coughing blood
- pneumonia
- asthma
- pain with a deep breath
- congestion
- other lung problems
-

Gastrointestinal:
- nausea
- constipation
- black stools
- bad breath
- abdominal pain or cramps
- chronic laxative use
- vomiting
- gas
- blood in stools
- rectal pain
- diarrhea
- belching
- indigestion
- acid reflux
- hemorrhoids
- other stomach or intestinal problems

Genito-urinary:
- pain or urination
- urgency to urinate
- decrease in flow
- frequent urination
- unable to hold urine
- impotency
- blood in urine
- kidney stones
- sores on genitals
- cloudy urine
- dark colored urine
- waking to urinate
- other urinary or genital problems

Neuropsychological:
- Seizure
- Areas of numbness
- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other neurological problems
- Have you ever been treated for emotional problems? ____________

  Have you ever considered or attempted suicide? ____________

Pregnancy and Gynecology:
- # of pregnancies ________
- # of births ________
- premature births
- miscarriages
- abortions
- age of first menses_____
- days between menses____
- duration
- date of last menses_____
- painful periods
- heavy periods
- light periods
- vaginal discharge
- PMS
- Clots
- Irregular periods
- Vaginal sores
- Breast lumps
- Do you Practice birth control?
- What type? ____________
- How long? ____________
- Last pap? ____________

Musculoskeletal:
- Neck Pain
- Back pain
- Hand/wrist pain
- Muscle spasms
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain
- Muscle weakness

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FAMILY MEDICAL HISTORY

List the present age or the age of death of each of the following members of your family, also if living add if their health is good, fair, or poor and what disease may have. If deceased, list the cause of death.

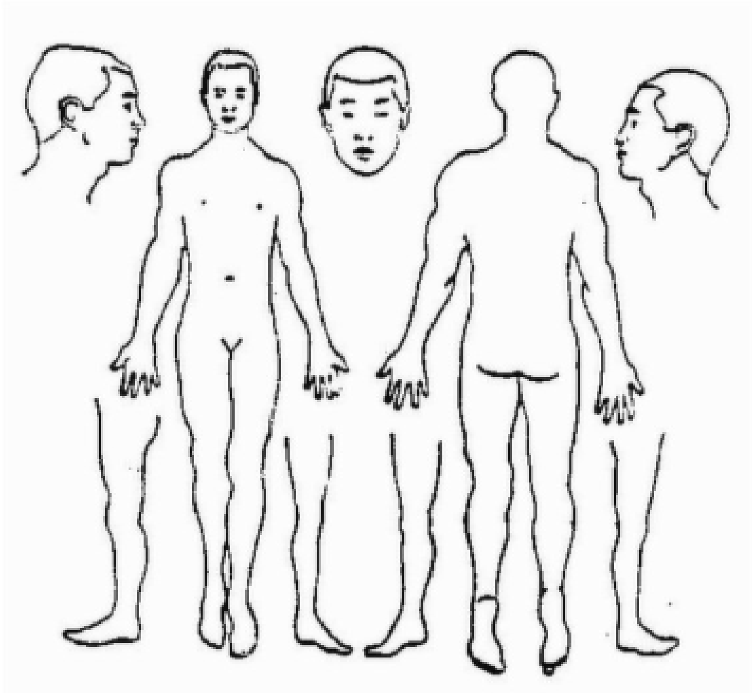
Father____Mother ____

Brother/s_____________________________________Sister/s____

Spouse/Partner________________________________

Son/s____Daughter/s______________________________________

Grandparents (father)_____________________________Grandparents (mother)____________________________



Draw in on the above picture noting any area of pain, numbness,

Please add any additional information: ____

____

____

YOU SHOULD MAKE THE FOLLOWING CONDITIONS MADE KNOWN TO THE PRACTIONER PRIOR TO TREATMENT SO THAT CONSIDERATIONS CAN BE MADE

If You Are Pregnant or Think That You May Be Pregnant
If You Have a Severe Bleeding Disorder
If You Have a Pacemaker

Do you want to be acknowledged as a client outside this office? Y N

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POLICIES

Payment is due at time of service/ Insurance relations

Payment Options:

1. Prepayment for ten extended 45-60min sessions is $900.00
   Prepayment for ten regular 25-40min sessions is $600.00
   Cosmetic Acupuncture for Abdomen cost is $1300 paid on first of ten visits.
   Cosmetic Acupuncture for the face cost is $1400 paid on first of ten visits.
   There is no guarantee of cure or cosmetic results with a prepayment plan.
2. SimpleCare™ – a non-profit healthcare network www.simplecare.com. **Payment is due at the time of service** or we are legally obligated in Washington State to charge a billing fee. Please sign up before your first visit and provide us with your Member ID.
   First Office Visit 60 min - 90 min is $135.00
   Return Office Visit 45-60 min is $95.00
   Return Office Visit 25-40 min is $65.00 – most common
   Community Clinic- $30-50 per treatment- separate charges for consult $60-70
   AcuGraph™ reports and exam are included in the first visit and cost $15 with longer appointments for future exams.
   Please talk with your acupuncturist about which amount of treatment time is best for you.
3. Billing as in the case with insurance:
   First Office Visit is $140 - $240.00
   Return Office Visit is $105.00 - $210.00

We are a small business that bills insurance as a service for you. To help all of us have a smooth relationship with the insurance billing. Please do the following:

1. **Prior to the visit, contact your insurance carrier to confirm coverage or other restrictions and let us know what they are at your first visit.**
2. **When you get your Explanation of Benefits (EOB) in the mail, please review it for deductibles, coinsurance and copays. If you owe money, please consider this EOB as an invoice and send in the amount due to PRAHM. If you have questions, please call us so we can work with you.**
3. **Copays and Products are due at time of service - we have a payment box in the waiting area where you can place a check and we take credit cards- just ask. It is important to indicate whose account to credit the payment and to state the purpose/s of the payment. You may either use the memo space on your check or fill out a breakdown slip. This is especially important for cash payments.**

While we will do what we can, it is the patient's responsibility to resolve lack of payment issues. Finance charges are applied after 60 days to all unpaid balances (calculated from date of service).
I acknowledge that I have read and understand the above information. I herby instruct and direct my insurance company to pay by check made out to PRAHM for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the final charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. I agree to pay, in a current manner, any balance of said professional services charges not covered by insurance.

Cancellation Policy

All cancellations should be done 24 hours prior to scheduled treatment time. Unless there is an emergency, failing to call and cancel 24 hours in advance will result in regular charge of the scheduled services. Email reminders are a courtesy; please keep track of your appointments.

I ____ have read and understand the above information, have discussed any concerns or question related to the above information prior to treatment, and consent to treatment at PRAHM.

Signed____Date____________________________________

Signed____Date____________________________________

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Disclosure

In the State of Washington acupuncturists can use all of the following listed modalities to stimulate and regulate the flow of Qi in meridians and points, as well as give dietary advice based on Chinese Medicine Theory.

- Acupuncture Needles- insertion of special sterilized needles through the skin into underlying tissue on specific points
- Moxibustion- indirect burning of artemisiae vulgaris over an area or point
- Acupressure- applied pressure to a point or meridian area
- Cupping- a technique in which heat or suction is used to pull skin and Qi up into a glass or plastic cupping device
- Dermal friction technique (Gua-Sha)- a rubbing on the skin with a blunt or rounded device
- Infa-red the use of infra-red device to stimulate point or a lamp placed over and area
- Sonopuncture- the use of device such a tuning fork to direct sono- waves into the points or meridians
- Lasarpuncture- the use of lasers to stimulate point or meridians
- Point injection therapy (aqua puncture)- the use of a syringe to inject substances into points or meridians
- Electrical, mechanical or magnetic devices

Some common side effects of acupuncture included soreness, tingling, and achy or itchy sensation at the sight or around the sight of acupuncture. A less common side effect of acupuncture is bruising. Also increases and decreases in energy are common side effects after acupuncture. Most people do not have any bleeding after acupuncture, but some will. This is usually a very small amount of blood. Many people experience no undesired side effects from acupuncture.

If you receive a cupping treatment it is important to know that bruise like marks will most likely occur in the area treated.

Extremely rare side effects of acupuncture include infection, broken needle, cardiac tamponade and pnuemothorax (a puncturing causing a collapsed lung). The possibility of adverse effects decreases with a higher number in years of training that your practitioner has had in Oriental Medicine and Acupuncture*. Most all pnuemothoraxes in the United States and have occurred when acupuncture was performed by a medical doctor. Internationally serious side effects are twice as more common among medical doctors than Acupuncturist (2:1) **.

I understand that discussion about how long a disorder may take to resolve is in no way a guarantee or said to be a cure. Oriental Medicine is a beautiful and effective medicine for a wide variety of ailments. Every person's body is different. Every person will experience different results based on treatment frequency and each person's constitution.

With the above said, I am looking forward to working with you and helping you reach your ideal level of health. Oriental Medicine has been used for thousands of years as a safe and effective way to treat and manage health issues.

I ____have read and understand the above information, have discussed any concerns or question related to the above information prior to treatment, and consent to treatment in the care of acupuncturists at PRAHM.

Signed____Date____

Signed____Date____

This signed form will stay with our office. You may request a copy for your home files.
Thank you very much for your patience in filling out these forms.

*Bensoussan A, Myers SP. Towards a safer choice. The practice of traditional Chinese medicine in Australia. Sydney, Australia: Macarthur; 1996.

**The National Health Institute in 1997 concluded that serious complications related to acupuncture are 2-3 times more likely to occur when administered by a medical doctor.

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Consent for Purposes of Treatment, Payment and Health Care Options

I understand that diagnosis and/or treatment at Paradise Ridge Acupuncture, Herbs and Massage (PRAHM) may only be conditioned upon my consent, as evidenced by my signature on this document. I consent to any laboratory, imaging, medical and/or clinic services rendered to me at PRAHM. I understand that no guarantee or assurance has been made as to the results that may be obtained during my treatment.

I consent to the use and/or disclosure of my protected health information by PRAHM for the purpose of diagnosing or providing me with health care, obtaining payment for my health care, and/or conduct the health care operations of PRAHM. This information may include the following: HIV testing and treatment, sexually transmitted disease testing and treatment, or alcohol and drug treatment records.

I understand I have the right to request a restriction regarding how my protected health information is used and/or disclosed in order to carry out treatment, payment, or the health care operations of the practice. The physicians at PRAHM are not required to agree to the restrictions that I may request; however if they agree to a restriction that I request that restriction is binding. I have the right to revoke this Consent, in writing, at any time, except to the extent that a physician at PRAHM has already taken action in reliance on this Consent.

"Protected health information" means any information, including demographic, collected from a patient and created and/or received by another physician or health care provider, health plan, employer, or health care clearinghouse. Protected health information relates to ones past, present, and/or future physical and/or mental health condition/s which may identify the patient.

I have been provided with PRAHM'S *Notice of Privacy Practices and/ or accessed the Notice at www.vashonPRAHM.com*. I understand that I have a right to review PRAHM*'s 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, which may occur in my treatment, payment of my bills, or in the performance of the health care operations of PRAHM. The *Notice of Privacy Practices* also describes my rights and the duties of PRAHM with respect to my protected health information. PRAHM 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 office and requesting a revised copy through the mail, or by asking for one at the time of my next appointment, or by visiting either of our websites.

____
Signature of Patient or Personal Representative   Date Signed

____Name of
Patient or Personal Representative   Relation to Patient

Is the patient a minor? Y N

Permission to treat minors

I, the undersigned, give my permission to PRAHM providers to treat ____________________________ for any medical problem that may arise during my absence.

Signature____Relationship______________________ Date _______