Kate Chilson, LMP, LAc

340 15th Avenue E., Suite 203 Seattle, WA 98112 **(206) 290-8019**

Please contact your insurance company to determine your eligibility for my services and to ensure the best chance that I will be reimbursed in a timely fashion. It is important that you understand your insurance policies in order to budget for your acupuncture services. You are personally responsible for all charges incurred in my office. I expect payment in full until your insurance coverage has been verified, or until I have received any required referrals or prescriptions. I recognize that completing this form is an added burden to you and thank you very much for your assistance.

Patient Information

Name ____________________
Date of Birth ____________________
Phone ____________________
Address ____________________
City ________ State ____ Zip ________
Employer's Name or School Name ________
____

Insured's Information (if other than patient)

Name ____________________
Date of Birth ____________________
Phone ____________________
Address ____________________
City ________ State ____ Zip ________
☐Male ☐Female
Employer's Name or School Name ________
____

Patient status ☐Male ☐Female
☐Single ☐Married/Partnered ☐Other

Patient relationship to insured
☐Self ☐Spouse/partner
☐Child ☐Other

Insurance Information

Insurance plan ____________________ Member ID # ____________________
Date and time you called ________________ Name of customer service rep ________________
Does the plan cover acupuncture? ☐Yes ☐No Is a prescription or referral required? ☐Yes ☐No
Who can authorize treatment by either a prescription or referral? ☐MD ☐DC ☐ND ☐PT ☐Other ____
How often does the referral need to be updated to ensure continuous coverage? ________________
Is there a Preferred Provider list for acupuncturists? ☐Yes ☐No Is Kate Chilson on the list? ☐Yes ☐No
Deductible $ __________ Satisfied to date $ __________ Co-pay $ ________________
Maximum allowable benefits for acupuncture:
In network $ __________ -OR- # visits ________ Remaining $ ________ -OR- # visits ________
Out of network $ __________ -OR- # visits ________ Remaining $ ________ -OR- # visits ________
Are these limits just for acupuncture? ☐Yes ☐No
If no, what other types of treatment do they include? ____________________
(i.e. chiropractic, physical therapy, occupational therapy, naturopathy etc)

Financial Responsibility and assignment of benefits

I ____________________, being a patient of Kate Chilson LMP, LAc, do hereby acknowledge that certain services may not be covered by my insurance under the terms of my Health Plan. I understand that it is my responsibility to know and understand my insurance policy coverage and its benefits. I give my authorization to this office to release information regarding my care and treatment to my health plan and its agents for purposing of managing my health benefit payments to me and/or my practitioner. I hereby assign to this office any payments my health plan makes for services rendered to me and my eligible family members by this office by reason of its contractual relations with my health plan and its agents. I understand that I am responsible to pay for services received at this office and I agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance plan, including but not limited to, any deductibles, co-payments, co-insurance, or charges for non-covered services.

Signature ______________________________ Date ____________________

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Patient Information

Name ____________________
Date of Birth ____________________
Address ____________________
City/State/Zip ____________________
Phone: Home ____________________
Work ____________ Cell ____________
Email ____________________
Employer ____________________
Occupation ____________________
Emergency Contact ____________________
Phone: Home ____________________
Work ____________ Cell ____________
Relationship: ☐single ☐in a relationship
☐married/dp ☐divorced/separated ☐widowed

Health Care Providers

Name ____________ Specialty ________
Clinic ____________ Phone ____________

Name ____________ Specialty ________
Clinic ____________ Phone ____________

Name ____________ Specialty ________
Clinic ____________ Phone ____________

I give Kate Chilson permission to contact my health care providers regarding my health and treatment.
Comments ____________________
Initials ____________ Date ____________

Current Health Information
List primary reason(s) for coming in:

1. ____________________
Is this a ☐mild ☐moderate or ☐major concern?
Or rate it on 0-10 scale (10 is worst): ________

2. ____________________
Is this a ☐mild ☐moderate or ☐major concern?
Or rate it on 0-10 scale (10 is worst): ________

3. ____________________
Is this a ☐mild ☐moderate or ☐major concern?
Or rate it on 0-10 scale (10 is worst): ________

Exercise and stress reduction
Activity Frequency
1. ____________________
2. ____________________
3. ____________________

How much of the time do you enjoy your job?

How many hours do you work per week?

Please list all medications, vitamins, supplements you are taking ____________________
____
____
____

Diet
Do you eat 3 meals per day at regular times?
☐Yes ☐No

Number of 8oz water glasses per day: ________

Have you ever been on a restricted diet?
☐Yes ☐No
If yes, please explain: ____________________
____

Foods you crave: ____________________
____

Foods that are difficult to digest: ____________
____

Are you satisfied with your current diet?
☐Yes ☐No
If no, please explain: ____________________
____

Habits
Cigars or cigarettes per day: ____________
Quit smoking, when: ____________
Coffee/cola per day: ____________
Alcohol per week: ____________

Health History Please list and explain. Include dates and treatment received.

Major illnesses:

___

___

___

Significant dental work:

___

___

___

Surgeries or hospitalizations:

___

___

___

Allergies to drugs, chemicals, food, environment:

___

___

___

Major accidents or injuries:

___

___

___

What do you know about your own birth?

- ☐ forceps
- ☐ breech
- ☐ cord wrapped
- ☐ mom had c-section
- ☐ vacuum extraction
- ☐ shoulder first
- ☐ mom was induced
- ☐ mom had anesthesia

___

___

Location of scars:

___

___

Check All Current and Previous Conditions Please Explain

General

now past
- ☐ ☐ fatigue or low energy
- ☐ ☐ frequent colds
- ☐ ☐ weight loss or gain
- ☐ ☐ fever or chills
- ☐ ☐ HIV
- ☐ ☐ sleep difficulties

Ave hrs sleep/night___

Overall energy (1=low, 10=high) ___

Muscles and Joints

now past
- ☐ ☐ arthritis
- ☐ ☐ osteoporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones ___
- ☐ ☐ spinal problems ___
- ☐ ☐ spasms, cramps ___
- ☐ ☐ sprains, strains ___
- ☐ ☐ tendonitis, bursitis ___
- ☐ ☐ stiff or painful joints ___
- ☐ ☐ weak or sore muscles ___
- ☐ ☐ neck, shoulder, arm pain ___
- ☐ ☐ low back, hip, leg pain

___

Nervous System

now past
- ☐ ☐ numbness or tingling
- ☐ ☐ dizziness
- ☐ ☐ poor balance or coordination
- ☐ ☐ concussion or head injury
- ☐ ☐ poor memory
- ☐ ☐ foggy headed
- ☐ ☐ other ___

Emotions

now past
- ☐ ☐ anxiety
- ☐ ☐ depression
- ☐ ☐ grief or sadness
- ☐ ☐ easily stressed / on edge
- ☐ ☐ mood swings
- ☐ ☐ manic periods
- ☐ ☐ irritable

Head (EENT)

now past
- ☐ ☐ headaches or migraines
- ☐ ☐ sinus congestion
- ☐ ☐ TMJ / jaw problems
- ☐ ☐ facial pain ___
- ☐ ☐ dry eyes or throat or mouth
- ☐ ☐ bleeding nose or gums
- ☐ ☐ ringing ears
- ☐ ☐ hearing or smell or hair loss
- ☐ ☐ eye strain
- ☐ ☐ poor vision / glasses
- ☐ ☐ spots in front of eyes
- ☐ ☐ difficulty swallowing
- ☐ ☐ swollen glands

Skin

now past
- ☐ ☐ rash or itching ___
- ☐ ☐ dryness ___
- ☐ ☐ acne
- ☐ ☐ psoriasis or eczema

Heart and Lungs

now past
- ☐ ☐ chest pain or tightness
- ☐ ☐ racing or fluttering heartbeat
- ☐ ☐ irregular heartbeat
- ☐ ☐ shortness of breath
- ☐ ☐ asthma or wheezing
- ☐ ☐ chronic cough
- ☐ ☐ bronchitis or pneumonia

Circulation

now past
- ☐ ☐ difficult temp. regulation
- ☐ ☐ swollen ankles, hands, face
- ☐ ☐ cold hands / feet
- ☐ ☐ anemia
- ☐ ☐ bruise easily
- ☐ ☐ varicose veins
- ☐ ☐ blood clots

☐ ☐ heat or cold intolerance
☐ ☐ night sweats
☐ ☐ excessive day sweats
☐ ☐ high or low blood pressure
☐ ☐ high cholesterol
☐ ☐ bleeding disorder

Digestion
now past
☐ ☐ poor appetite
☐ ☐ nausea
☐ ☐ gas or bloating
☐ ☐ ulcer
☐ ☐ belching / burping
☐ ☐ heartburn or acid reflux
☐ ☐ abdominal pain or cramps
☐ ☐ excessive thirst or hunger
☐ ☐ gall stones
☐ ☐ hepatitis
☐ ☐ diarrhea or constipation
☐ ☐ hemorrhoids
☐ ☐ diabetes
Ave # BM/day____________________
Stools are generally:
☐ formed ☐ loose/unformed
☐ dry ☐ soft
☐ undigested food in stool

Kidneys and Bladder
now past
☐ ☐ frequent infections
☐ ☐ painful or difficult urination
☐ ☐ frequent urination
☐ ☐ kidney stones
Ave # urinate/night ________________
Color of urine:
☐ pale yellow ☐ orange
☐ bright yellow ☐ cloudy

Men
now past
☐ ☐ sexual difficulties
☐ ☐ genital discharge or sores
☐ ☐ other ___________________

Women
now past
☐ ☐ birth control
what type and how long? ___________
____
____
# of pregnancies__________________
# of births _______________________
# of premature births ______________
# of miscarriages ________________
# of abortions ___________________

age at first menses ________________
# of days of cycle _________________
# of days of period ________________
date of most recent period __________
menopause, age___________________
Periods:
now past
☐ ☐ painful
☐ ☐ irregular
☐ ☐ light or heavy flow
☐ ☐ clots
☐ ☐ mid-cycle spotting
Color of blood:
☐pale ☐dark ☐bright red
now past
☐ ☐ PMS
☐ ☐ breast pain / swelling
☐ ☐ breast lumps or discharge
☐ ☐ fibroids or cysts
☐ ☐ infertility
☐ ☐ abnormal PAP smear
☐ ☐ sexual difficulties
☐ ☐ genital discharge or sores

CONSENT FOR TREATMENT

Treatment may include, but is not limited to these **methods to stimulate specific acupuncture points:** inserting sterile hair-thin needles, manual pressure, creating a vacuum with a glass cup on the skin, application of minute intradermal needles or pellets for 3-5 days, attaching a positive/negative polarity device to needles, drawing a small amount of blood with a sterile lancet, burning mugwort directly or indirectly on the skin, vibrating sound with tuning forks or Manaka wooden hammer.

Acupuncture is a generally safe treatment but it may have some side effects including, but not limited to, discomfort or pain; minor bruising; minor blistering where direct heat is applied; nausea, fainting; or temporary aggravation of symptoms. Infection is another risk, but the clinic uses sterile single-use needles and maintains a safe and clean environment. Potential benefits include relief of symptoms and stimulation of the body's own self-balancing mechanisms in order to restore health within the body.

Please notify your practitioner *prior to treatment* if you have any of the following conditions: bleeding disorder, currently taking anticoagulant medications; weakened immunity; neuropathy; pace-makers or other implanted devices. Also if you are or become pregnant.

Financial policy: I understand that I need to give 24 hours notice if I need to cancel my appointment. If adequate notice is not given, I understand that I will be charged the full fee for the missed appointment.

By signing below I recognize that no guarantees or claims are being made to the improvement or cure of my presenting condition and that I am giving my consent on a voluntary basis to the above-mentioned acupuncture procedures. I understand that I am free to withdraw my consent and discontinue treatment sessions at any time.

I, ________________________________ recognize the potential risk and benefit of these procedures.
Patient's Printed Name

________________________________ ________________________
Patient's Signature *Date*

NOTICE OF PRIVACY PRACTICES

Effective 11/16/09

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure of Your Health Care Information

Health information includes your name, contact information, intake forms, chart notes (including communication among health care providers), progress reports, and billing statements.

This health information will be protected by storing it in a locked file cabinet in a locked office as well as on a password-protected computer. All electronic data transmission will use a firewall-protected secure internet connection. I may disclose your health information for purposes of treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, I may need to share information with other health care providers or specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, I may disclose treatment information when billing an insurance company for services provided to you by my office.

Health Care Operations include the business aspects of running my practice. This includes contacting you to set up appointments and communicate about your care.

Other Disclosures: Unless you request otherwise, I may disclose health information to a family member, friend, or other individual to the extent necessary to help with your health care (for example in the case of an emergency) or with payment for your health care. I will use my professional judgment in disclosing your health information as required by law.

Your Health Information Rights

You have the right to:

- request restrictions on certain uses and disclosure of your health information
- inspect and copy your health information
- request amendments be made by this office to your protected health information file
- receive an accounting of disclosures of your protected health information
- request to be contacted at an alternate location
- to file a complaint
- receive a paper copy of this Notice of Privacy Practices at any time upon request

By signing below, I signify that I have read the **Notice of Privacy Practices**. I give Kate Chilson my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

______________________________ ______________________

Patient's Signature *Date*