Premier Acupuncture & Complementary Medicine, Inc.
1901 N Hemmer Road, Suite 208
Palmer AK 99645
907-745-7928

www.PremierAcupuncture.com

Solutions for Health

THIS IS A FILLABLE PDF FORM. PREFERABLY, COMPLETE THIS FORM ON YOUR COMPUTER, PRINT, SIGN AND BRING TO YOUR INITIAL APPOINTMENT.

PERSONAL INFORMATION

Marital Status ☐ Married ☐ Single How do you wish to be addressed? _____

Last Name _____ First Name _____ MI _____

Mailing Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Can we leave a message if you are unavailable? ☐ Yes ☐ No

Date of Birth _____ Age _____ Social Security # _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse Date of Birth _____ Phone _____

Your Email Address _____

PATIENT / RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____ Phone _____

Address: City/State/ Zip _____

Employer _____ Phone _____

INSURANCE INFORMATION (Complete ONLY if your insurance covers our services - we do not bill secondary Ins.)

VETERANS – Simply put VA under Primary Insurance

PRIMARY Insurance _____ Insurance Phone _____

Claims Address _____ City/State/Zip _____

Name of Insured _____ ID# _____

Insured DOB _____ Group Name/Number _____ Claim # _____

How did you hear about us? ☐ **Community Presentation** ☐ **Internet** ☐ **Facebook**

☐ **Google AdWords** ☐ **Walked by the office** ☐ **Phone Book** ☐ **Family / Friend /Physician**

Referred by _____

Signature_____ Date _____

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PATIENT RESPONSIBILITIES

Cancellations: The staff at Premier Acupuncture will make every effort to provide you with the best care possible and to do so being respectful of your time. Should you need to cancel an appointment, please allow us to provide someone else the same level of care by cancelling your appointment at least 24 hours prior to your scheduled appointment time.

Cancellations occurring with less than 24 hours' notice will incur a $50 cancellation fee. Please be aware your insurance will not cover this charge and this amount cannot be applied to any outstanding balance. Exceptions will be made on a case by case basis.

If your appointment is not cancelled at least 24 hours in advance and we are unable to communicate with you at the time of your missed appointment, any future appointments you have scheduled will be cancelled, and you will need to call to reschedule.

Appointments for existing patients are typically scheduled every 20 minutes. Please make every effort to be on time. If you are more than 7 minutes late we will need to reschedule your appointment in most cases. This is necessary so we can respect the time of the person that has the appointment following yours. Please arrive a few minutes early so you can complete the PCA (Patient Condition Assessment) form which is required with each appointment. You can also complete the form online, print and bring it with you. If you choose to complete online, please do so as close to your appointment as possible.

Miscellaneous:

- If you become pregnant, please notify us as this may alter your treatment plan.
- If you have questions or concerns about our care, we invite you to call us anytime and ask rather than waiting until your next appointment. We are here to serve your needs and encourage you to contact us any time you have a question, concern, or require assistance with insurance or your account.
- If you are taking supplements that are special ordered, please provide us with at least a two week notice that you will need a refill, unless you have already arranged with us to keep a supply on hand. If you are taking an herbal formula that is specific to you and requires time to prepare, we ask that you notify us at least 24 hours before needing to pick up the refill.
- Patient records request should be made at least 2 business days before you intend to pick them up.
- There is a $25 fee for a bounced check

We look forward to working with you to provide you the best in natural medicine health care. Thank you for being here!

PACM Staff

I understand and agree to the above listed Patient Responsibilities.

Signature_____

Printed Name

Date

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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments or other procedures within the scope of practice of an acupuncturist on me (or on the patient named below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working with, associated with, or serving as backup for the acupuncturist named below, including those working at the clinic or office listed below or any other clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, electro-acupuncture, laser therapy, electrotherapy, pain neutralization technique, infrared heat, cupping, Chinese herbal medicine, western herbal medicine, nutritional therapy and counseling. If I experience any problems or concerns with any recommendation or treatment, I will immediately notify a member of the clinical staff.

Acupuncture (and other treatments utilized by Premier Acupuncture & Complementary Medicine, Inc.) are generally safe (very safe) methods of treatment but there may be some side effects. These may include bruising, numbness, soreness, or tingling near the needle sites that may last from a few seconds to a few days, sore muscles, dizziness, and fainting. The most common side effect, although still uncommon, is a small bruise at the needle site. Other very rare side effects may include miscarriage, nerve damage, and organ puncture. Infection is always a concern and is a possibility anytime the skin is punctured. We ONLY use disposable needles which have been sterilized by the manufacture and your skin is prepared with alcohol prior to acupuncture treatment. We always maintain a clean and safe environment. <u>You will never be exposed to needles used by another patient</u>. Herbal and nutritional medicine is generally a very safe treatment method. Side effects, which are uncommon, include, but are not limited to, nausea, abdominal cramping, loose stools, diarrhea, and allergic reactions. These are the same side effects that may be associated with consuming anything orally, be it medicine or food. Although herbal and nutritional medicines are generally very safe, it is possible to respond in a manner that is unexpected, for example, headaches, increase in blood pressure, negative interaction with pharmaceuticals, etc. Additionally, great care is given when providing oral supplements (herbs and other nutritional compounds) in the presence of pregnancy. It is your responsibility to inform the clinical staff if you are pregnant or plan to become pregnant, and to inform them of your current medications, medical history, and/or any current allergies or side effects you may experience. This is no different than what is expected when you are taking prescription medications. Helping you obtain the best health possible is our primary goal. We need your help by keeping us informed.

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While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise their best judgment during the course of treatment, which, based on the facts known, they think is in my best interest. I understand that results are not guaranteed.

I understand that clinical and administrative staff may need to review my patient records and lab reports or other pertinent medical information, but all my records will be kept confidential and will not be released without my written consent except as required by law.

Michael Wedge, L.Ac. has been educated and holds graduate degrees in Acupuncture and Oriental Medicine and Clinical Hypnosis. He is licensed as an acupuncturist by the state of Alaska, is board certified in acupuncture through the NCCAOM, and is board certified in medical thermal imaging. He is not a medical doctor.

By voluntarily signing below, I acknowledge that I have read or have had read to me, and understand the above consent to treatment information, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and have them answered to my satisfaction. I intend this **Informed Consent** form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

With the knowledge provided in this **Informed Consent** form and having my questions answered to my satisfaction, I voluntarily consent to the above procedure(s) as deemed medically necessary, realizing that no guarantees have been given to me by Michael Wedge, L.Ac., or the staff of Premier Acupuncture and Complementary Medicine, Inc. regarding cure or improvement of my condition(s). I hereby release Michael Wedge, L.Ac., and the staff of Premier Acupuncture and Complementary Medicine, Inc. (or any future name Premier Acupuncture and Complementary Medicine, Inc. may operate under) and any of its staff from any and all liability which may occur in connection with the above mentioned procedures/treatment, except for failure to perform the procedures/treatment with appropriate Medical Care. I understand that I am free to withdraw this consent in writing and to discontinue participation in these procedures at any time.

Signature of patient _____ Date
(or guardian if under 18)

Print Name Relationship to Patient

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INSURANCE COVERAGE

We strongly recommend that you contact your insurance carrier to verify benefits prior to your appointment. We will be happy to assist you by making the call for you if you provide us with the necessary information. Ultimately you are responsible for charges incurred by you.

1. If your insurance approves and then later declines coverage, you remain financially responsible for charges.
2. You are responsible for all balances owed after insurance payment, less any contractual write-offs required by your insurance company.
3. In cases where payment from your insurance has not been received within 60 days of claim submission, you agree to be responsible for charges. We will continue to assist you in obtaining reimbursement from your insurance company. In the event this situation arises, and we ultimately receive payment from your insurance company, we will reimburse you the amount paid by your insurance.

PLEASE READ AND SIGN

We require a credit card / debit card be on file (in our secure system) to cover any outstanding insurance deductible, co-payment, or payment of charges if payment from your insurance company has not been received within 60 days of claim submission. Your information is kept in an encrypted file within our accounting software program.

Authorization

I authorize Premier Acupuncture to release any information required to process my insurance claims. I hereby authorize my insurance benefits to be paid directly to Premier Acupuncture. I understand that I am responsible for all fees, regardless of insurance coverage. I understand I will be billed for services if my insurance company denies payment and / or if payment from my insurance company has not been received within 60 days of claim submission. I authorize Premier Acupuncture to charge my credit card to cover the aforementioned situation, or any other reason I agree to in the future. I authorize the release of any medical records to my insurance company which are necessary to process any and all claims filed now or in the future. I authorize Premier Acupuncture to email mail me at the email address I have provided. Emails containing private medical information will be sent via encrypted, HIPAA compliant email.

Signature _____ Date

Printed Name

HIPAA

I have received a copy of PREMIER ACUPUNCTURE & COMPLEMENTARY MEDICINE'S **Notice of Privacy Practice & HIPAA Statement**.

Signature _____ Date

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Patient Name _____ **DOB** **Date** _____ **Weight**

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HEALTH HISTORY

MAIN COMPLAINTS	Intensity	
In the space below, please list the reason you are here today. Please list in the order of importance. Use seperate sheet of paper if more room is required.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = ***no discomfort,*** 10 = ***extreme discomfort***)	
	on **AVERAGE** your complaint is	at **WORST** your complaint is:
1.		
2.		
3.		
4.		
5.		
6.		

	Onset	What have you tried doing to resolve these problems that DID NOT work?
	Your best guess as to when complaints began	**Please list past and current treatments that have not worked or have had limited effect.**
1	Date began:	
2	Date began:	
3	Date began:	
4	Date began:	
5	Date began:	
6	Date began:	

	Frequency	Duration
	How often are these complaints present (Constantly, ____ days per week ___ days per month ___ Other)	When you are feeling your symptoms, how long do your symptoms last? (min, hrs, days, constant)
1		
2		
3		
4		
5		
6		

What Aggravates or Alleviates your Chief Complaints?		
	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?
1		
2		
3		
4		
5		
6		

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Patient Name: _____ **DOB**: _____ **Date:** _____

How are your health problems interfering with the following areas of your life?	
Work	
Family	
Hobbies	
Life	

How have you taken care of these complaints in the past?

- ☐ Medications
- ☐ Surgery
- ☐ Injections
- ☐ Exercise
- ☐ Dietary Modifications
- ☐ Vitamins & Supplements
- ☐ Acupuncture
- ☐ Herbal Medicine
- ☐ Chiropractic
- ☐ Massage
- ☐ Other: _____

How did the previous methods work for you?

_____

What do you desire from treatment? (choose one)

- ☐ Just want relief from symptoms then will see what happens
- ☐ Want to correct the cause of the problem and start a program directed at addressing these causes

Other: _____

If we were to sit down and discuss your life 2 years from now and look back at today, what would have to have happened for you to be happy with your progress during our time addressing your health concerns? ie. able to engage in activities you love, off pain meds, etc.

_____

What potential barriers do you foresee that would prevent you from achieving your health goals?

_____

Do you feel it is possible to eliminate or reduce these barriers to achieving your goals?

_____

Rate on a scale of 1-10 *(1 being lowest, 10 being highest):*

How important is it for you to resolve your health concerns? _____

Are you prepared to make the necessary changes to achieve your goals?

ARE YOU PREGNANT? ☐ Yes ☐ No If yes, what is your due date _____

How much exercise do you get? _____

Do you smoke? ☐ Yes ☐ No How much water do you drink? _____ Do you drink soda? ☐ Yes ☐ No

Do your work activities mostly involve: ☐ Sitting ☐ Light Labor ☐ Heavy Labor

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Patient Name _____ **DOB** _____ **Date** _____

If the following imaging methods are relevent to your currunt compaint(s) please complete. Otherwise you can skip this part.

IMAGING & TESTS	DATES	RESULTS
X-ray		
MRI's		
CT Scan		
Mammogram		
Ultrasound		

Please list all health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

List all medical conditions you are currently being treated for (include the dates of when you were diagnosed if known, approximate if needed):

List all types of surgeries you have had in the past (include dates if known month and year, approximate if needed):

List all significant accidents you have had in the past (include dates if known - month and year, approximate if needed):

List all Allergies (food, medications, pollen, etc.):

List all Medications (prescription & over-the-counter) you are currently taking (include dosage if known):

List all nutritional supplements, herbs, or vitamins you are currently taking:

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Patient Name: _____ **DOB:** _____ **Date:** _____

The bottom section of this page is a fillable PDF, the image section is not. In order to complete the image section found below, you will need to print and complete manually.

If you are being seen for a pain related problem, or if you are experiencing pain but being seen for a non-pain related problem, please provide the requested information below.

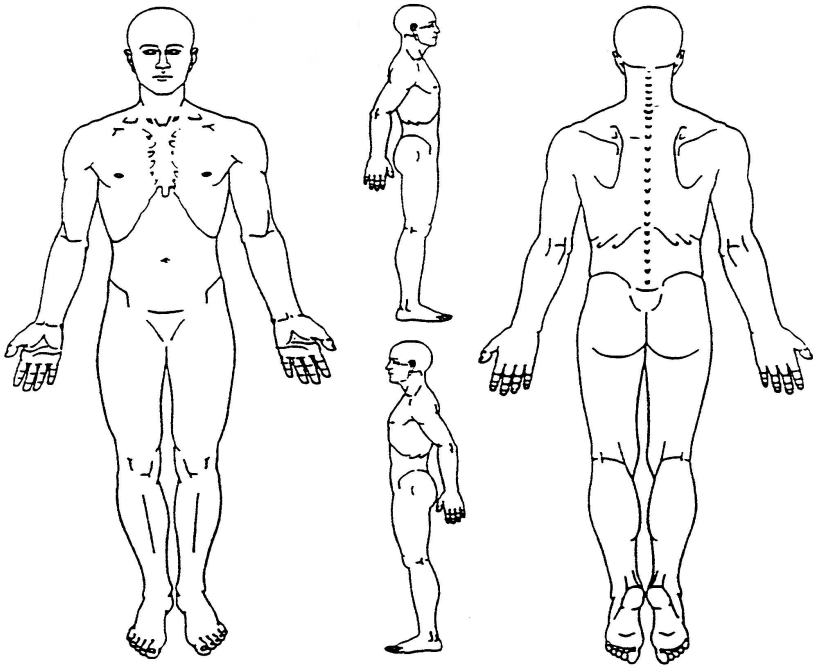
Please Show Areas Of:

Primary Pain using - ***

Secondary Pain using - 0

Numbness using - ////

Pins and needles using - P



If there is any additional information you think would be helpful that has not been asked previously, please include it below. You can complete this section online - the section below is a fillable PDF.

Patient Name _____ **DOB** _____ **Date** _____

Please check all symptoms you experience. These questions may not seem to be related to your current complaint, but they will aid in evaluating your health and in looking for contributing factors to your current healh concerns.

- ☐ Shortness of breath / wheezing / difficulty breathing
- ☐ Easily catch colds / chronic infections
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Cough
- ☐ Snoring loss of smell / taste
- ☐ Dry nose / mouth dry
- ☐ Dry skin
- ☐ Allergies
- ☐ Alternating fever & chills
- ☐ Excessive sweating
- ☐ Difficult sweating
- ☐ Headaches
- ☐ Chronic sadness
- ☐ Constipation / hemorrhoids
- ☐ Alternating diarrhea & constipation
- ☐ Sores on tip of tongue
- ☐ Trouble falling / staying asleep
- ☐ Waking up unrefreshed, tired
- ☐ Blood or mucus in stools
- ☐ Undigested food in stool
- ☐ Diarrhea / constipation
- ☐ Bloating, excess flatulence
- ☐ Acid Regurgitation / sore throat
- ☐ Bad breath
- ☐ Sores in mouth
- ☐ High stress / over-thinking everything / ADD / ADHD / anxiety
- ☐ Irritable, angry & frustrated frequently
- ☐ Mental sluggishness / fogginess
- ☐ Mood swings / suffer from depression
- ☐ Cold hands / feel cold all the time
- ☐ Hot flashes & night sweats
- ☐ Thirsty all the time
- ☐ Fast heart beat (>100 beats/min)
- ☐ Slow heart beat (<50 beats/min)
- ☐ Irregular heart beat
- ☐ Palpitations / heart Fluttering / tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Skin rashes (redness, itching)
- ☐ Headache at the top & sides of the head, migraines
- ☐ Numbness / tingling sensation
- ☐ Muscle twitching / cramping / spasms
- ☐ Seizures / convulsions, tremors, tics
- ☐ Lump in the throat
- ☐ Neck & shoulder tension / tightness / pain
- ☐ Joint pain
- ☐ TMJ pain
- ☐ High-pitched ringing in ears
- ☐ Difficulty adapting to stress
- ☐ Dizziness / poor balance / vertigo
- ☐ Itchy eyes / burning eyes / dry eyes
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Sore achy/ weak knees
- ☐ Profuse or frequent urination
- ☐ Scanty urination
- ☐ Low back pain
- ☐ Muscle tightness
- ☐ Urinary incontinence
- ☐ Abnormal urination (blood, painful, cloudy)
- ☐ General weakness, low energy, chronic fatigue
- ☐ Low / no libido
- ☐ Excessively high libido

WOMEN ONLY

- ☐ Menstrual cramps
- ☐ Irregular cycle
- ☐ Premenstrual syndrome
- ☐ Headaches - premenstrually or menstrual