醫 長
藥 城

Great Wall Chinese Medicine

3225 N 75th St. Scottsdale, Az 85251 | p.480.429.8881 - f.480.429.8882

New Patient Registration

Today's Date: Social Security Number:

Patient Information

***Patient's Name* - Last:** **First:** **Middle:**

****check one**** Mr Mrs Miss Ms ***Marital status:*** Si Mar Div Sep Wid

Is this your legal name? Yes No ***IF NO what is your legal name?***

Birth Date: ***Age:*** ***Sex:*** M F ***Phone Number:***

Street Address:

City: ***State:*** ***Zip:***

E-mail: ***May we contact you by phone?*** Yes No

Would you like to join our e-mail list for updates, specials, and more information about our clinic and work? Yes No

Occupation: ***Employer:*** ***Work Phone:***

Why did you choose our clinic?

How were you referred to our clinic?

What is/are the reason(s) of your visit today:

1. 2.

3. 4.

Please give your insurance card to the receptionist. Please note that we do not bill insurance companies, but you have the option to submit the bill directly to the insurance company if you request the 1500 Form.

In Case of Emergency

Emergency Contact's Name:

Relationship to contact: ***Emergency Contact's Number:***

Share Your Story

Are you interested in giving a testimonial upon feeling better? Yes ☐ No ☐

If yes, *check all that apply* Written Testimonial ☐ Online (yelp, google, yahoo) ☐ Video ☐

If yes, please request a copy of our release form from the front desk.

Personal Health History

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

List any and all medical problems that you have been diagnosed with *(i.e. diabetes, heart conditions, pace-makers, etc)*

Have you had any surgeries?

Year:	Reason for surgery:	Hospital:
Year:	Reason for surgery:	Hospital:
Year:	Reason for surgery:	Hospital:
Year:	Reason for surgery:	Hospital:

Other Hospitalizations?

Year:	Reason:	Hospital:
Year:	Reason:	Hospital:
Year:	Reason:	Hospital:
Year:	Reason:	Hospital:

Have you ever had a blood transfusion? Yes No *If yes, what was the date?*

List any medications, perscriptions, vitamins, or over the counter items you are taking:

Are you allergic to any medications?

Women Only

Menstruation Cycle: Always comes early ☐ Always comes late ☐ Irregular ☐

Menstruation Amount: Heavy ☐ Scanty ☐

Menstruation Color: Dark red or bright red ☐ Pale blood ☐ Purple or blackish ☐ Fresh red blood ☐

Menstruation Quality: Congeal blood with clots ☐ Water blood ☐ Turbid blood ☐

Menstruation Pain: Before the periods ☐ After the periods ☐ During the periods ☐

Leukorrhea Color: White ☐ Yellow ☐ Greenish ☐ Red & white ☐ Yellow/pus & blood ☐

Leukorrhea Consistency: Watery ☐ Thick ☐

Leukorrhea Smell: Fishy ☐ Leathery ☐

Pregnancy Vomiting: Morning Sickness ☐

Pregnancy Miscarriage: Before 3 months ☐ After 3 months ☐

Pregnancy Childbirth: Nausea/heavy bleeding after ☐ Sweating/fever after ☐ Post natal depression ☐

Health Habits and Personal Saftey

Exercise Level: How often do you exercise: Hrs/Day Days/Week Do you stretch Yes No

Intesity Level 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What do you do for exercise?

Diet: *Are you dieting?* Yes No *If yes are you on a physician perscribed medical diet?* Yes No

# of meals you eat a day? *Salt intake:* Hi☐ Med☐ Low☐ *Fat intake:* Hi☐ Med☐ Low☐

Caffeine: None Coffee Tea Cola *How many times in a day do you drink it?*

Alcohol: *Do you drink?* Yes No *If Yes, What kind?* *How many drink per week?*

Does your drinking concern you? Yes☐ No☐ *Have you considered stopping?* Yes☐ No☐

Have you ever blackout while drinking? Yes No *Are you prone to binge drinking?* Yes No

Do you drive after drinking? Yes☐ No☐

Tobacco: Yes No *How many:* Cigarettes/day Chew/day Pipe/day Cigar/day

# of years used: *If you quit, how long has it been:*

Drugs: *Do you currently use recreational or street drugs?* Yes☐ No☐

Have you ever used street drugs via injection with a needle? Yes☐ No☐

Sex: *Are you sexually active?* Yes☐ No☐ *If Yes, are you trying for pregnancy?* Yes☐ No☐

If not trying for pregnancy, list methods of contraceptive used:

Is there any discomfort during intercourse? Yes☐ No☐

Illness related to HIV and AIDS have become a major public health issue. Risk factors for this illness include intravenous drug use and unprotected sex. Would you like to speak with your provider about your risk of this illness? Yes☐ No☐

Personal Safety: *Do you live alone?* Yes☐ No☐ *Do you fall frequently?* Yes☐ No☐

Do you have vision or hearing loss? Yes No *Do you have a will or advance directive?* Yes No

Would you like information on the preperation of these? Yes☐ No☐

Physical and/or mental abuse have become major health issues in the U.S. This often takes the form of verbal, physical or sexual abuse that brings you harm physically or emotionally. Would you like to discuss this issue with your provider? Yes☐ No☐

Everyone Please Read & Sign Below

By signing below, I acknowledge the above information is true to the best of my knowledge.

I understand that GWCM does NOT participate with any insurance companies, and does not bill any insurance companies. If requested by patients, GWCM can provide a bill that patients may submit directly to the insurance company, which in turn might reimburse patients directly. I also authorize GWCM or insurance company to release any information required processing my claims. Patients should contact their insurance company to find out what types of acupuncture services are covered under their policy. GWCM will collect payment when services are rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of appropriate statement. I understand and agree that full payment, paid in cash or by credit cards, is required at time services are rendered.

Parent/Guardian Signature Print (Last. First) Date

Informed Consent & Disclosure

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by Great Wall Chinese Medicine. I understand that GWCM will explain all known risks and complications, and I wish to rely on GWCM to exercise judgment during the course of the procedure, which GWCM determines is in my best interests. I may request another person of my choice to be present in the treatment room during the treatment. GWCM has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to GWCM's use of this treatment (if indicated).

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation and minor bruising at the acupuncture site.

Acupressure/TuiNa involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.

Indirect Moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. Great Wall Chinese Medicine does not allow direct moxibustion where material contacts the skin.

Cupping involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.

GuaSha involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where GuaSha is performed.

Tapping, Plum Blossum, Bleeding, Pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

Electrical Stimulation/TENS uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.

Infrared involves utilizing infrared radiation. It is a safe and medically proven method of healing.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with GWCM. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results. **Authorization for Release of Medical Information:** I further understand that GWCM may need to contact my medical physician if and when they have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, Pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to GWCM to contact my medical physician if/when necessary. **Treatment of Pediatric Patients <3 years:** I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to GWCM to contact my child's medical doctor if/when necessary.

Parent/Guardian Signature **Print (Last. First)** **Date**

GREAT WALL CHINESE MEDICINE
3225 N 75th St. Scottsdale, Az 85251 | p.480.429.8881 - f.480.429.8882

H.I.P.P.A. - Patient Authorization Form

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed - ***The information covered by this authorization includes:***

Persons Authorized to Use or Disclose Information - ***Information listed above will be used or disclosed by:***

Name of Person/Organization:

Name of Person/Organization:

Name of Person/Organization:

Expiration Date - ***This authorization is effective through*** **write desired time frame**

Unless revoked or terminated by the patient or patient's personal representative.

Patient Rights - Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature **Date**

Print Patient's Full Name **Date**

Witness Signature **Date**

Cancellation Policy

***All appointments must be cancelled 24 hours in advance ***

1. A $60 charge will be added to patient account if cancelled within 24 hours of appointment.
2. If a patient consecutively sets & cancels 3 appointments without attending 1, a $90 charge will be incurred.
3. If a patient does not call or show up for their appointment a $120 charge will be incurred.

***All charges must be paid before treatment will be continued ***

***Great Wall reserves the right to amend these policies or make special considerations ***

Package Policy

Packages are purchased and discounted in sessions of 5 and 10. If a patient chooses to cancel an on- going, pre-paid package, they will be charged either the value of the closest matched package or full price for each session attended *(e.g. If a 10 holistic package is purchased at a discount of $130/visit and only 3 visits are attended before cancellation, the patient will be charged full price of $145 for 3 visits and refunded the remainder. If 5 visits were attended before cancellation, the patient will be charged the price of a 5 package for $135/visit with the remainder refunded).*

All packages must be used within 1 year of purchase ***special circumstances may be approved***

Packages are transferrable to another person upon approved request, however, treatment value must be matched *(e.g. If new patient receives treatment $180 above package cost $130 for the new patient visit, they must pay the remainder of the new patient visit cost $50.)*

All refunds will be given in the manner in which they are received. Cash will be refunded via check.

Great Wall Chinese Medicine reserves the right to refuse service and treatment to anyone at any time.
Additionally, Great Wall Chinese Medicine reserves the right to cancel on- going, pre-paid treatments & will only refund treatments not received. Great Wall Chinese Medicine will collect payment for all services rendered.

Printed Name Date

Signature