Great Wall Chinese Medicine and Acupuncture
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NEW PATIENT REGISTRATION FORM

Patient Information

Patient's Name: (Last)	(First)	(Middle)	Today's Date:
Is this your legal name? Yes No *If not, what is your legal name?*			Sex: M F
Social Security Number (optional):		Marital Status: Si Mar Div Sep Wid	
Birth Date: Age:	Personal Phone:		Work Phone:
Street Address:		Email Address:	
City:	State:	Zip Code:	Occupation:
How were you referred to our clinic?			Employer:
Why did you choose our clinic?			Full-time Part-time Retired Unemployed

Emergency Contact

Emergency Contact's Name:	Relationship:	Phone Number:

Share Your Story

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

If yes, check all that applies: Written Testimonial Online (Yelp, Google, Yahoo, Facebook) Video

Personal Health History

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio Other:

List any and all medical problems and the year that you were diagnosed with:

Communicable Disease________________________________ Bleeding Disorder ________________________________

Cancer ________________________________ Depression ________________________________

Diabetes ________________________________ Heart Problems ________________________________

High Blood Pressure ________________________________ Thyroid Problems ________________________________

Others: ____

Have you had any surgeries (pace-maker, replacement, plastic surgery, etc.)?

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

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

Other hospitalizations?

Year: Reason: Year: Reason:

Year: Reason: Year: Reason:

List any medications, prescriptions, vitamins, or over-the-counter items you are taking or had taken in the past 3 months and their purpose:

Are you allergic to any medications? Yes No

If yes, please list them.

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Women Only

Menstruation Cycle: Always comes early Always comes late Irregular On time

Menstruation Amount: Heavy Spotty Normal

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

Menstruation Quality: Congealed blood with clots Water blood Turbid blood/Cloudy

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

Discharge Color: White Yellow Greenish Red & White Yellow/pus & blood

Discharge Consistency: Watery Thick Normal **Discharge Smell:** Fishy Leathery No smell

Family Health History

Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? If yes, who?

Allergy ____ Bleeding Disorder ____________________________________

Cancer ____ Depression ____

Diabetes ______________________________________ Heart Problems ______________________________________

High Blood Pressure _____________________________ Other ____

Health Habits and Personal Safety

Exercise Level: How often do you exercise: ____hrs/day, ____days/week. Do you stretch? Yes No

Intensity Level: ______ (1-low to 10-high) What do you do for exercise? ______________________________________

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

# of meals you eat a day: _____ Salt intake: Low Med Hi Fat intake: low Med Hi

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 drinks per week? _____

Tobacco: Yes No How many: ____cigarettes/day; ____chew/day; ____pipe/day; ____Cigar/day.

# of years used: _______ *If you have quit, how long has it been?* ___________ Smoke exposure? Yes No

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: ____

Living Situation: Do you live alone? Yes No Do you fall frequently? Yes No

Are there pets at home? Yes No *If yes, what type?* __________________________________

Read and Sign

By signing below, I acknowledge the above information is true to the best of my knowledge.
I understand that Great Wall Chinese Medicine (GWCM) does not participate with any insurance companies. Insurance claims will only be submitted by GWCM if prior arrangements have been made and patient has signed the Insurance Payment Policy and Agreement. I also authorize GWCM or insurance company to release any information required for processing of claims. Patients should contact their insurance company to find out what types of acupuncture services are covered under their policy.

I understand that fees are due and payable on the date that services are rendered. I further understand and agree to pay all such charges incurred, in cash or by credit card, immediately upon presentation of appropriate statement.

____

Patient (parent/guardian) Signature Print Name Date

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Informed Consent and 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 (GWCM). 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 interest. 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).

**Please read and initial each of the following items.*

_____**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/Manual Therapy** 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. GWCM 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.

_____**Scraping/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 Blossom, 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 Heat** 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.

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Patient (parent/guardian) Signature   Print Name   Date

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H.I.P.A.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:

☐ Medical Records ☐ Billing ☐ Appointments

☐ Other: ____

Persons Authorized to Disclose Information - Information listed above will be disclosed by:

☐ Spouse: ________________________ ☐ Children: ______________________________

☐ Parents: ________________________ ☐ Doctors: _______________________________

☐ Other people or 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.

____

Patient or Legally Authorized Individual Signature Date

____

Print Patient's Full Name Date

____

Witness Signature Date

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Cancellation Policy

All appointments must be canceled 24 hours in advance.

1. A $60 charge will be added to patient account if canceled within 24 hours of appointment.
2. If a patient consecutively sets & cancels 3 appointment 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 transferable 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.

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Patient (parent/guardian) Signature | Print Name | Date

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