

PATIENT REGISTRATION FORM

(Please complete and sign all forms before your appointment)

patient name: _____
first middle last

address: _____
street city state zip

home phone: _____ age: _____ birth date: _____ sex: m f

work phone: _____ marital status: married single divorced widowed

mobile phone: _____ social security no: _____

employer: _____ referred by: _____

e-mail: _____ emergency contact: _____
(for appointment notification) name and phone number

billing information - I plan to pay by: cash/check/credit card health insurance other _____

primary insurance: _____
plan name address insured's ID no. group no.

secondary insurance: _____
plan name address insured's ID no. group no.

If my acupuncture benefits are not yet verified, I agree to one of the following:

- Pay my charges in full at time of service until verification is confirmed. My account will be credited upon verification.
- Place my credit card information on file, which will be charged for any outstanding portion of my balance.

Credit card: visa, m/c Name as it appears on card: _____

Credit card number: _____ exp date: _____

Personal Medical History (check all that apply):

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> artificial joints | <input type="checkbox"/> diabetes | <input type="checkbox"/> liver disease | <input type="checkbox"/> surgeries (list) _____ | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> addiction | <input type="checkbox"/> digestive problems | <input type="checkbox"/> menstrual problems _____ | <input type="checkbox"/> urinary problems | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> allergies | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> pacemaker _____ | <input type="checkbox"/> venereal disease | <input type="checkbox"/> other (specify) _____ |
| <input type="checkbox"/> angina | <input type="checkbox"/> fainting/dizziness | <input type="checkbox"/> prostate problems _____ | <input type="checkbox"/> thyroid disorder | |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> fatigue | <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> traumatic injury _____ | |
| <input type="checkbox"/> asthma | <input type="checkbox"/> headache | <input type="checkbox"/> hepatitis _____ | | |
| <input type="checkbox"/> anemia | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> easy bleeding/bruise _____ | | |
| <input type="checkbox"/> cancer/tumors | <input type="checkbox"/> heart disease | <input type="checkbox"/> rapid wt gain/loss _____ | | |
| <input type="checkbox"/> convulsion/seizures | <input type="checkbox"/> kidney disease | <input type="checkbox"/> stroke _____ | | |

medications w/dosages: _____

vitamins/supplements: _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

date: _____ patient's (or guardian) signature: _____

Patient Information Acknowledgement Form

I have read and fully understand Uchida Acupuncture's PATIENT INFORMATION ACKNOWLEDGEMENT FORM. I understand that Uchida Acupuncture may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Uchida Acupuncture will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes noted in Uchida Acupuncture's PATIENT INFORMATION ACKNOWLEDGEMENT FORM. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____

Signature: _____ Date: _____

Patient Care Financial Agreement

- 1) I agree that payment of all charges for treatment, including deductibles, co-pays and co-insurances, are due at time of service.
- 2) I agree that payment for herbal formulas, supplements and other therapeutic items that are generally not covered by insurance are due at time of service.
- 3) Until verification of insurance benefits is confirmed, I agree to pay all charges in full at time of service or else place my credit card information on file with Uchida Acupuncture. My credit card will only be accessed in the event of default on payments. Once my benefits are confirmed, and Uchida Acupuncture has received reimbursement from my insurance company, any balance remaining on my account will be credited toward future appointments, or a refund check will be disbursed to me, whichever is my preference.
- 4) PPO PATIENTS: In the event that my insurance does not have acupuncture benefits, I will be responsible for the timely payment of all outstanding charges, which I agree to pay within 30 days of notice.
- 5) KAISER PATIENTS: I understand that my usual Kaiser co-pay will be collected at time of service, but that in some cases the co-pay for acupuncture services may differ from my usual Kaiser co-pay. In such cases, I agree that I may either be due a reimbursement or pay a balance depending upon the actual co-pay for acupuncture services as determined by the Explanation of Benefits received from my insurance company.
- 6) I agree to notify Uchida Acupuncture of a cancellation at least 24 hours before my appointment date. I understand that I am allowed one late cancellation within any two-month period, after which I will be charged a **\$25.00 late fee** for subsequent late cancellations. A no-show without prior notification will result in an immediate **\$25.00 late fee**.

I have read and understand the above Patient Care Financial Agreement, and agree to abide by the stipulations herein.

Signature: _____ Date: _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOME MAKING TASKS –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSES –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

PATIENT NAME _____

DATE _____

SCORE _____ [60]

BENCHMARK - = 5 _____

