American College of Traditional Chinese Medicine Community Clinic

PATIENT INFORMATION (Please Print and complete in full) New Patient ☐ Established Patient ☐

Name: ______________________________ Today's Date:______________________

Address:____

______________________________ ZIP ______________________________

Home Telephone # : ______________________________ Work Telephone #: ______________________

Cell# ______________________________

Would you like to be contacted by email with informational newsletters and special clinic offers?

If Yes ☐ Email Address: ______________________________ No ☐

Patient Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ______________________

Birth Date:____________________ Age: __________ Social Security # : ______________________________

Referred to our Clinic By: ____

Emergency Contact: ______________________________ Relationship: ______________________

Emergency Contact Telephone #: ____

Employment Status:
Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐

Occupation: ____

Employer's Name: ______________________________ Telephone #: ______________________

Employer's Address: ____

Primary Health care source

Physician's Name:______________________________ Telephone #: ______________________

Physician's Address: ______________________________ Date of last visit: ______________________

Date of Injury or Onset of Illness: ____

Medical Insurance status:
Self ☐ Private Insurance ☐ Medi -Cal ☐ Workmen's Comp ☐ Other ____________________

The ACTCM Community Clinic exists for the benefit of the community in our area and to support clinical instruction. To help maintain our small operating budget we ask that payment for services are made at the time of treatment. If your insurance covers acupuncture, we will bill them for you. We also accept Medi-Cal. .

We would like our patients to understand that this clinic provides treatments exclusive to traditional Chinese medicine and patients who seek other modalities of diagnosis and treatment must arrange to see other appropriate practitioners. We have no Medical Doctors on staff. As this is a teaching clinic, our students participate in both the diagnosis and treatment of patients under the supervision of licensed acupuncturists.

I understand the above statements and will comply with the stated needs and requests of the clinical personnel in order to retain this unique health care service in the city of San Francisco.

Patient Signature: ______________________________ Date: ______________

Parent or Guardian Signature:______________________________ Date: ______________

To allow us to see as many patients as possible as well as maintain our operating costs, we ask patients to provide us with **24 HOURS NOTICE WHEN CANCELLING** or rescheduling appointments. When shorter notice or a no-show occurs, the patient will be subject to a **$15 SERVICE CHARGE**, and may be put on a same day appointment basis or lose their sliding scale privileges.

Fees for treatment do not include the cost of herbs. If you do not have insurance, or if your insurance does not cover acupuncture, do you wish to be considered for the sliding scale rate? YES ☐ NO☐
If yes, what is your gross monthly income: $_______________

INSURANCE INFORMATION (Only some insurance companies will cover acupuncture)

Primary Insurance: ____ Telephone #: ________________________

Insurance Billing Address: ____

Policy Holders Name: _____________________________________ Relationship: ________________________

Policy # / ID #: ____ Group #: ____________________________

Secondary Insurance: ______________________________________ Telephone #: ________________________

Billing Address: ____

Policy Holders Name: ______________________________________ Relationship: _______________________

Policy #/ ID #: ____ Group #: ___________________________

Medi-Cal Information

Identification Number: ____

Issue Date : ____

Insurance Responsibility Statement:
Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release:
I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signed: ____ Date: ____________________________

American College of Traditional Chinese Medicine Community Clinic- Initial Health History Form

Patient Name:_______________________________________date:__________________________

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for a medical condition? Please describe

---

Please briefly describe any chronic pain:

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue?

Do you have other health concerns?

Please describe the type of foods you eat regularly:

Breakfast ____
Morning Snack____
Lunch____
Afternoon Snack____
Dinner____
Evening Snack____

Do you exercise regularly? Yes ☐ No ☐
What type of exercise do you do? ____

American College of Traditional Chinese Medicine Community Clinic- Initial Health History Form

Patient Name:__________________________________ date:______________________

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder							
Diabetes							
Cancers or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Stomach or intestinal disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at Death							

MAJOR HOSPITALIZATIONS - If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY & STATE

PREVIOUS PREGNANCIES:
Total Pregnancies____Living____Ectopic___Misscariages___Induced Abortions____

MEDICINES - Mark an X in the box next to any of the following that you are now taking:

☐ aspirin	☐ ibuprofen	☐ acetaminophen(Tylenol)	☐OTHER:
☐antacids	☐ laxatives	☐ cold tablets	_________________
☐oral contraceptives	☐ diet pills	☐ tranquilizers	_________________
☐ fiber supplements	☐sleeping pills	☐ hay fever tablets	_________________
☐ blood pressure pills	☐blood thinning pills	☐ insulin, diabetic pills	_________________

vitamins (please list)____
herbs (please list)____

DRUG ALLERGIES ____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Coffee	☐yes	☐no	cups per day/week____	age started ____	age quit _____
Tobacco	☐yes	☐no	# cigarettes per day___	age started ____	age quit _____
Marijuana	☐yes	☐no	use per day/week _____	age started ____	age quit _____
Alcohol	☐yes	☐no	use per day/week _____	age started ____	age quit _____
Crack/Coccaine	☐yes	☐no	use per day/week _____	age started ____	age quit _____
Heroin	☐yes	☐no	use per day/week _____	age started ____	age quit _____

Other ____

American College of Traditional Chinese Medicine Community Clinic – Initial Intake Form

Patient Name:_________________________Date:___________________________

GENERAL

past	current	
☐	☐	Appetite
☐	☐	Excessive Appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night Sweats
☐	☐	Sweat Easily
☐	☐	Chills
☐	☐	Localized Weakness
☐	☐	Poor Coordination
☐	☐	Change in Appetite
☐	☐	Strong Thirst
☐	☐	Other________

SKIN AND HAIR

past	current	
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, Lumps

HEAD AND NECK

past	current	
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck Stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other ______

EARS

past	current	
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other________

EYES

past	current	
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/Contacts
☐	☐	Eye inflammation
☐	☐	Other_______

NOSE, THROAT, AND MOUTH

past	current	
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing

CARDIOVASCULAR

past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Other_________

RESPIRATORY

past	current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other__________

GASTRO-INTESTINAL

past	current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black stools
☐	☐	Bad breadth
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Other_____________

GENITO-URINARY

past	current	
☐	☐	Kidney stones
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other________

MALE

past	current	
☐	☐	Pain /itching of genitalia
☐	☐	Genital lesions / discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other _________

FEMALE

past	current	
☐	☐	Frequent Urinary tract infections
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions / discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal Pap Smear
☐	☐	Irregular periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other___________

NEUROLOGICAL

past	current	
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness or tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other_____________

PSYCHOLOGICAL

past	current	
☐	☐	Depression
☐	☐	Anxiety / Stress
☐	☐	Irritability
☐	☐	Treated for emotional / psychological problems
☐	☐	Other__________

INFECTION SCREENING

Yes	No	
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphillis
☐	☐	Genital warts
☐	☐	Herpes: oral / genital

AMERICAN COLLEGE OF TRADITIONAL CHINESE MEDICINE COMMUNITY CLINIC

Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the member of the Clinic Medical Staff (Licensed Acupuncturist. Guest Acupuncturist, Student Intern, or Trainee) named below and/ or other member of the Clinic Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Medical Staff named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion. cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects,
Including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy.**

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the Clinic Medical Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Clinic Medical Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment, and 1 wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment which the Clinic Medical Staff thinks at the lime, based upon the facts then known, is in my best interests.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

To be completed by patient (or by patient's representative if the patient is A minor or is physically or legally incapacitated)

____
Print Name of Patient

____
Signature of Patient (or Representative)

____
(Print Name of Patient or Representative)

____
Date Consent Completed

To be completed by the member of the Clinic Medical Staff providing information and obtaining consent.

____
Print Name of Clinic Medical Staff

____
Signature of Clinic Medical Staff

____
(Print Name of Witness/Translator)

____
(Signature of Witness/Translator)

American College of Traditional Chinese Medicine

CONSENT TO USE AND PUBLICATION OF CLINICAL DATA AND CONTENTS OF PATIENT RECORDS FOR STATISTICAL PURPOSES, RESEARCH AND PUBLICATION

I, __________________(print patient's name) authorize The American College of Traditional Chinese Medicine and members of its Clinic Medical Staff, faculty and students to review my records for the purpose of collecting statistical data or pertinent clinical information for the purposes of research, publication, education and case review. I give my permission and consent to the publication of statistical and/or clinical data obtained from by records. I understand that all patient records are protected by clinic protocols and confidentiality agreements. I also understand that I will never be identified as the source of this information and that if any particulars of my case are used for the purposes of publication all possible clues to my identity will be disguised or altered. I understand that there is the remote possibility of being accidentally identified as the source of the clinical data but that the way this information is handled makes the risk very small.

____
Patient Signature

____
Date Signed

ACTCM Community Clinic

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, ____ Give

Consent to ACTCM Community Clinic the use and disclosure of my individual identifiable health information or Protected Health Information for the specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the services this office has rendered to me; and
C. The general administrative operation this practice provides to me

The purpose of this consent:
Protected Health Information is any information includes:

A. Demographic information
B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition.
C. Information gathered by this office for past, present or future payments for providing the healthcare services.
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my protected Health Information for the purposes of treatment; payment of healthcare operation of the Acupuncture practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to read and discuss the Notice of Privacy Polices and **Procedures form this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.**

I have the right to revoke this consent, in writing, at any time except to the extent that ACTCM Community Clinic has acted in reliance on this consent.

____________________________ Date___________________
Signature of Patient or Personal Representative

____________________________ Date___________________
Description of Personal Representative's Authority

ACTCM Community Clinic

Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office.

Contact: Anita Huang
Telephone 415-282-9603 Ext. 32
Address: 455 Arkansas Street San Francisco CA 94107
Send written complaints to the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.
This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature ____________________________ Date_________________________

American College of Traditional Chinese Medicine
New Patient Survey

Thank you for participating in the ACTCM New Patient Survey. The results from this survey will strengthen our services. Please answer all questions to the best of your ability. All answers will be kept anonymous.

1. **Today's date is:** Month __________ Day ________ Year _______

2. **Is this your first time as a patient at the ACTCM Clinic?**
O Yes, I am a New Patient O Yes, I am a Prospective Student O No, I have been seen at ACTCM in the past

3. **What is your age?**
O 0 – 19 O 20 – 29 O 30 – 39 O 40 – 49 O 50 – 59 O 60 – 69 O 70 +

4. **What is your gender?**
O Male O Female O Transgender O Other ________

5. **What is your racial/ethnic background?**
O Caucasian/White O African American/Black O Hispanic/Latino O Asian O Hawaiian/Pacific Islander
O American Indian/Alaskan Native O Middle Eastern O Indian O Mixed Race O Other ____________

6. **What is your primary language?**
O English O Spanish O Mandarin O Cantonese O Korean O Japanese O Vietnamese
O Thai O Hindi O Russian O Italian O French O German O Arabic O Other _____________

7. **What is the highest level of education you have completed?**
O No high school O Some high school O High school graduate/GED O Some college
O College degree O Some graduate school O Graduate degree

8. **What is your average personal monthly income?**
O No Income O $1 - $1,000 O $1,000 - $2,000 O $2,000 - $3,000 O $3,000 - $4,000 O $4,000+

9. **Where do you live?**

City: ____ State __________ Zip Code ________________________

10. **If you live in the city of San Francisco, what neighborhood? (i.e. Potrero Hill, SoMa, Richmond, etc)**

____

11. **How do you travel to our clinic?**
O Car O Motorcycle/Scooter O Bicycle O Walked O BART O MUNI/Bus O Cal Train
O Taxi Cab O Got a ride/Carpool O City Car Share/Zip Car O ParaTransit O Other ____________

12. **How are you paying for today's visit?**
O Cash/Check O Credit Card O Private Insurance O MediCal OWorker's Comp O Gift Certificate

13. **I prefer to be contacted in the following manner:**
O U.S. Mail O E-mail O Telephone O Please do not contact me

14. **Are you interested in receiving a FREE monthly email newsletter from our clinic that contains news, articles and health tips related to Traditional Chinese Medicine?** (We will not sell or share your email address).

O Yes, my email is: ____ O No, I am not interested.

OVER ---------- Continued on other side ---------- OVER

15) How did you hear about the ACTCM Clinic?

- ○ Advertisement
- ○ Internet Website
- ○ Search Engine
- ○ Recommendation
- ○ Word of Mouth
- ○ Nwspaper/Magazine
- ○ Health Fair
- ○ College Fair
- ○ ACTCM Admissions
- ○ Radio
- ○ Television
- ○ ACTCM Postcard
- ○ ACTCM CAP Site
- ○ ACTCM Ear Clinic
- ○ Other ____________

16) If you answered "Word of Mouth/Recommendation", please specify which source:

- ○ Doctor/Nurse
- ○ Massage Therapist
- ○ Chiropractor
- ○ Midwife/Doula
- ○ Lic. Acupuncturist
- ○ ACTCM Faculty
- ○ ACTCM Student
- ○ ACTCM Alumni
- ○ ACTCM Staff
- ○ Family
- ○ Friend
- ○ Other ___________________

17) If you answered "Internet or Search Engine", please specify which website.

- ○ City Search.com
- ○ Yelp.com
- ○ Craigslist.org
- ○ Tribe.net
- ○ AOL
- ○ Google
- ○ Yahoo
- ○ ACTCM Website
- ○ Yellowpages.com
- ○ SF Station.com
- ○ Insider Pages.com
- ○ Other ___________________

18) If you answered "Advertisement", please specify which publication:

- ○ Acupuncture Today
- ○ Acufinder Magazine
- ○ Catholic San Francisco
- ○ Chinese Yellow Pages
- ○ Common Ground
- ○ East Bay Express
- ○ Asian Film Festival
- ○ Potrero Hill Directory
- ○ Potrero View
- ○ SF Chamber of Commerce
- ○ SF Natural Pages
- ○ SF Bay Guardian
- ○ SF Weekly
- ○ SFSU Xpress Magazine
- ○ SFSU Xpress Newspaper
- ○ Share Guide
- ○ SF City College Guardsman
- ○ UCSF Synapse
- ○ USF Foghorn
- ○ Yoga Journal
- ○ Yellow Pages - SF
- ○ Yellow Pages - Oakland
- ○ Yellow Pages - Marin
- ○ Yellow Pages - San Jose
- ○ Yellow Pages - San Mateo
- ○ Other ___________________

19) If you answered "Magazine, Newspaper, Radio or Television", please specify which media outlet:

○ ____

20) If you answered "Health Fair", please specify which fair:

- ○ Ark of Refuge
- ○ Asian Art Museum
- ○ Asian Heritage St. Fr.
- ○ Chinatown Fair
- ○ Excelsior District
- ○ Harm Reduction
- ○ Homeless Prenatal
- ○ Mandarin Oriental
- ○ Marriott Hotel
- ○ Mills College
- ○ Mission District
- ○ Potrero Hill Fest.
- ○ Portola District
- ○ Richmond District
- ○ SF City College
- ○ SF MOMA
- ○ SFSU
- ○ Tenderloin District
- ○ USF Nursing Students
- ○ Other ___________________

21) If you answered "Community Lecture/Event", please specify which event:

- ○ Bioneers Conference
- ○ Canada College Lecture
- ○ Chamber of Commerce Expo
- ○ ACTCM Chinese New Year
- ○ Chinese New Yr Street Fair
- ○ Green Festival
- ○ Kabuki Hot Springs Lecture
- ○ New Living Expo
- ○ Nat'l Council On Alcoholism
- ○ North American AOM Day
- ○ Qi Gong Conference @ UCB
- ○ SF General Hospital
- ○ SFSU Integrative Medicine
- ○ SFSU Course on TCM
- ○ Stanford Students Lecture
- ○ UCB - SIM
- ○ UC Davis Pre-Med Lecture
- ○ USF Nurses Day
- ○ World Congress/Qi Gong
- ○ Yoga Journal Conference
- ○ Other