Zoe *aka Amy* Darling
Acupuncturist, Herbalist, Health Educator

Your Name *+preferred pronoun(s)*_____

What are your primary concerns? _____

How do these impact your daily life? _____

How would you like these to change? _____

What have you already tried? _____

What are major sources of stress in your life? _____

_____

Have you been treated with Acupuncture before? Yes ☐ No ☐
with Chinese Herbal Medicine? Yes ☐ No ☐

How did you learn about my clinic? _____

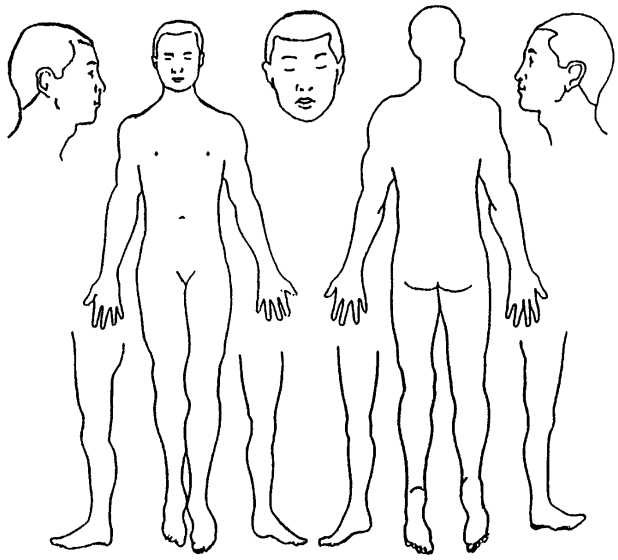
Show list/areas of concern

_____

_____

_____

_____



CURRENT SUPPLEMENTS & MEDICATIONS

(Please note vitamins and supplements, separate page or listed on back okay)

item for what condition prescribed by

_____

_____

Blood Thinning Medication? Yes ☐ No ☐

Do you consider yourself an active person? Yes ☐ No ☐

How do you move your body on a regular basis ? _____

Allergies (drugs, chemicals, foods)? _____

Please note if you have quit any of the following? If so, how long ago?
Alcohol Tobacco Marijuana Other substances _____

IF YOU FEEL COMFORTABLE, please some personal and family MEDICAL HISTORY

	SELF	FAMILY		SELF	FAMILY
Anemia	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Allergies	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Depression/Mental Illness	☐	☐
Bleeding Disorders	☐	☐	Sexually Transmitted Disease	☐	
Diabetes	☐	☐	Stomach & Intestinal Disorders	☐	☐
Eating Disorder	☐	☐	Drug or Alcohol Abuse	☐	☐

Surgery (type & date)?_____

Other _____

CONSENT FOR TREATMENT

Acupuncture is one of a *many-fingered hand* of East Asian Medicine. Zoe's tool bag includes:

- Acupuncture
- Electric stimulation
- Chinese herbal medicine
- Tuina and Sotai massage
- Cupping
- Gua Sha
- Heat Lamp, moxa and other warming techniques.
- Mindfulness and Awareness practices.
- Qi Gong and other movement exercise.
- Dietary counsel and recommendations.

I recognize that as a part of this healing relationship, it is my right and responsibility to ask questions at any time. I also understand Zoe will explain every technique she uses in real time. I remain in choice throughout our sessions. By signing below, I release Zoe *aka Amy* Darling from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and discontinue treatment at any time. I recognize it is my responsibility to communicate if I am experiencing discomfort in any way during treatment.

_____ _____

Signature of patient (or guardian) Date

Zoe *aka Amy* Darling ~ Seattle, WA
Acupuncturist, Herbalist, Health Educator

PATIENT'S FIRST Name: _____ MI: _____ LAST: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ SSN (last 4 digits) _____ PRIMARY ph: ( ) _____

Employer: _____ Alternate phone ----------

Date of Birth: / Age: _____ Height: _____ Weight _____

Place of Birth _____ Gender _____

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Relationship Status, please circle : Solo Married Partnered Divorced Widowed Dependent Other

Referred by: _____ Primary Care Provider: _____

In case of emergency contact: _____ Relationship: _____ Phone: ( ) _____

Primary Insurance:

If you will be paying out of pocket, simply sign below.

Insurance Company Name: _____ Phone: ( ) _____

Subscribers Name: _____ Date of Birth: / / _____

Relationship to you: ( )Self ( )Spouse ( )Dependent ( )Other _____

I.D. # as shown on card: _____ ( )Group #: _____

Secondary Insurance:

Is this visit injury related? ( ) Y ( ) N Auto accident ( ) Y ( ) N * Please note at this time L & I DOES NOT pay for acupuncture

Insurance Company Name: _____ Phone: ( ) _____

Claims Address: _____

City, State, Zip: _____

Subscribers Name: _____ Date of Birth: / / _____

Relationship to you : ( )Self ( )Spouse ( )Dependent ( )Other

I.D. Claim # as shown on card: _____ Policy # _____

Employer if applicable: _____ Effective / Date of Injury: / / _____

Please read the following statement carefully before signing:

I, the undersigned, understand and agree that I am financially responsible for all charges and agree to pay for services. If I cancel an appointment with less than 24 hour notice, I understand I will be charged up to the full cash rate depending on the circumstances. I authorize Zoe (aka Amy) Darling,c to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize payment to be directly made to Amy (Zoe) Darling, LAc.

Signature: _____ Date: _____

INSURANCE VERIFICATION FORM

COMPLETING THIS FORM WILL HELP YOU UNDERSTAND WHAT YOUR INSURANCE COVERS, AND WHAT IS YOUR FINANCIAL RESPONSIBILITY. YOU WILL NEED TO CALL THEM.

Patient name: _____

Date of call:_____ Time: _____ Name of person you talked to _____

CIRCLE or FILL IN AS APPROPRIATE

1. Is Acupuncture covered on this plan? YES or NO
2. Is Amy Darling a preferred provider with my plan? If not, are there out of network benefits?
3. Is pre-authorization required? YES or NO
4. Is referral required? YES or NO If so, who can make a referral?
5. Am I limited to specific diagnosis codes? YES or NO

   Please note, some Insurance companies limit diagnosis codes for which they allow a patient to access their acupuncture benefit. Some allow only specific kinds of pain and deny other claims. If you are seeking treatment for things others than physical pain, we will need to discuss how to access your benefit while honoring the Insurance company's restrictions/limitations.
6. Is there a deductible? YES or NO What is the deductible? $_____
   How much have I met this year? $_____
7. Is there a maximum yearly benefit for Acupuncture? YES or NO
   Per _____ Calendar Year OR _____ Fiscal year Renewal Date? _____

   #_____ of visits
   #_____ of visits used year to date
8. What percentage is covered? _____% or if it is a $ amount per year, how much $_____
9. Is there a co-payment or percentage that I am responsible for? YES or NO
   If yes, what is it? $_____
10. When my acupuncturist bills for an "Office Visit", time spent in interview, is my copay different?
    YES or NO
11. Are benefits for other forms of care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture? YES or NO
12. If my acupuncturist bills for manual modalities (massage or cupping) during acupuncture treatment, will these take away from my benefits for massage or physical therapy?
    YES or NO
13. If my acupuncturist bills using mental health codes (ex. anxiety, insomnia, depression, will these be drawn from my acupuncture benefit or my mental health benefit? YES or NO
    If drawn from mental health, what are my benefit limits?

Please note, benefits stated by a representative cannot be guaranteed.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situations, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONSENT

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities such as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosures relating to worker's compensation programs.

- We may share your protected health information with a third party "business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between a business associate and us involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc.). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices form this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about my privacy practices:

Privacy Officer
Zoe (aka Amy) Darling
509 Olive Way Suite 1358
Seattle, WA 98101
(206) 920-9929

For more information on HIPAA or to file a complaint:

The US Dept. of Health &
Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
877-696-6775

This notice has been issued and considered effective as of the date signed. This copy shall be retained by the department for a minimum of six (6) years.

In the interest of convenience for my patients, I make myself available to communicate by email. While my own email is encrypted,I cannot assure the privacy of this communication medium. If you prefer NOT to communicate by email, in the interest of assured privacy of your personal information, you must sign in the box to the right.

PLEASE DO NOT COMMUNICATE WITH ME BY EMAIL

_____
Signature

_____ _____
Signature of Patient or Legal Representative Date
I have thoroughly reviewed these privacy policies.