

Acu-Vision Therapy®
141 Kinderkamack Road
Park Ridge, N.J. 07656
201-690-6696

Name: _____ Phone: _____

SS No: _____ Date of Birth: _____

Marital Status: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____ Cell-Phone Provider: _____

Employed/Retired: _____ Occupation: _____

Employer Address: _____

Medical Information

What is your current Medical Ailment _____

Date Ailment first occurred: _____

Drugs/Medications: _____

Major Illnesses: _____

Patient Signature: _____ Date: _____

I irrevocably assign to Acu-Vision Therapy, LLC all my rights and benefits under any insurance contracts for payment for services rendered to me by Acu-Vision Therapy, LLC to be released to Acu-Vision Therapy, LLC. I irrevocably authorize Acu-Vision Therapy, LLC to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Acu-Vision Therapy, LLC. I irrevocably authorize Acu-Vision Therapy, LLC to act in my behalf and report any suspected violations of proper claims practices to proper regulatory agencies. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Signature of Patient / Guardian (If Minor)

Witness

Date

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Patient History(Confidential)

Name: _____ Date: _____
 Birth Date: _____ Age: _____ Sex: _____ Allergies: _____

Symptoms you are experiencing now or have experienced in the past 3 months

General

- Chills Fever
- Hot Flashes
- Night Sweating
- Day Sweating
- Irritability
- Easily Stressed
- Easily Angered
- Depression
- Anxiety
- Sadness/Grief

- Fatigue
- Cold Hands, Feet
- Tremors
- Poor Sleep
- Poor Memory
- Disorientation
- Fainting
- Headaches
- Migraines
- Bleeding Gums

- Earache
- Ear Ringing
- Loss of Hearing
- Sinus Problems
- Hay Fever
- Vision Problems
- Difficulty Swallowing
- Rash or Itching
- Bruises Easily
- Non-Healing Sores

Gastrointestinal

- Nausea
- Vomiting
- Indigestion
- Constipation
- Diarrhea
- Belching
- Abdominal Pain
- Abdominal Bloating
- Weight Gain Loss
- Ulcers
- Bad Breath
- Parasites
- Blood in Stools
- Hemorrhoids
- Poor Appetite
- Gas
- Excess Thirst
- Excess Hunger
- Hernia
- Others

Neuropsychological

- Seizures
- Concussion
- Dizziness
- Loss of Balance
- Areas of Numbness
- Lack of Coordination
- Disorientation

Respiratory

- Cough
- Asthma
- Bronchitis
- Painful Breathing
- Shortness of Breath
- Coughing Blood
- Excess Phlegm

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Irregular Heartbeat
- Chest Pain
- Palpitations
- Phlebitis
- Blood Clots
- Varicose Veins

Genito-Urinary

- Pain on Urination
- Urgent Urination
- Frequent Urination
- Inability to Hold Urine
- Decreased Urine Flow
- Blood in Urine
- Waking Up to Urinate
- Kidney or Urinary Stones

Musculoskeletal

- Muscle Weakness
- Muscle Cramps
- Muscle Atrophy
- Spasms
- General Aches
- Arthritis
- Joint Instability
- Injuries

Women Only

- Date of Last Menses _____
- Age of First Menses
- Bleeding Between Periods
- Unusual Color, Character
- Heavy or Light
- Irregular Periods
- Painful Periods
- Clots During Menses
- PMS
- Vaginal Discharge
- Vaginal Sores

- # of pregnancies
- # of Births
- Miscarriages
- Abortions
- Difficult Births
- Fertility Problems
- Birth Control? _____
- What type? _____
- Breast Lumps
- Painful Intercourse
- Low Sex Drive

Men Only

- Lump on Testicles
- Lump on Breasts
- Penis Discharge
- Penis Sores
- Erection Diffulty
- Impotence
- Low Sex Drive
- Other

List Major Diseases: _____

List Major Surgeries: _____

Current Medication(s): _____

Patient Signature or Guardian: _____ Date Signed: _____

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Acupuncture informed Consent

“Acupuncture” means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of Acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at the acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to Acupuncture treatment.

The potential benefits: Acupuncture may allow for the painless relief of one’s symptoms without the need for drugs, and improve the bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

Having read the above I give my consent for Acupuncture treatment.

Printed Name

Patient Signature

Witness

Date

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HEALTH INFORMATION PRIVACY ACT

It is necessary for us to explain to you the new Federal Health Insurance Portability and Accountability Act (HIPAA) Laws written to protect the confidentiality of your health information. We do not want you to be concerned that your personal information might be unnecessarily made available to others outside our office. We are committed to maintaining the complete confidentiality of our patient's health information. When we use the term "personal information," we mean financial, health, and other information about you that is nonpublic, which we obtain so that we can provide you with health care treatment. When we use "health information," we mean information that identifies you and relates to your medical history (i.e; the health care you receive or the amounts paid for that care). This notice will become effective on April 14, 2003.

Due to the use of the telephone answering machine, fax machines, computers and the Internet, the government has sought to standardize and protect the privacy of the electronic exchange of your health information. We are required by law to put in writing, the policies, and procedures we use to ensure the protection of your health information everywhere it is used. Copies of our privacy policy will be provided, free of charge, to any patient who requests a copy there of.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for, and been voluntarily given, your written permission.

Patient Signature: _____

Date: _____