BEAM*

Beacon East Asian Medicine

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206) 914-6797
beamacupunctureclinic.com

Today's date:_____

Legal name:_____ Preferred name:_____

Phone (primary)_____ OK to leave a message? Y N

Address:_____ City/Zip_____

Email:_____ OK to communicate via email? Y N

Preferred pronoun:_____ Gender:_____

Age:_____ Date of Birth:_____ Place of Birth:_____

Height:_____ Weight:_____ Relationship status:_____

Employer:_____

Family Physician:_____ Referred by:_____

Emergency Contact:_____ Phone:_____

Have you been treated by acupuncture or East Asian medicine before? Y N

Main concern(s) bringing you in today:

How long ago did this problem begin (please be specific)?

To what extent does this problem interfere with your daily activities (work/sleep/etc)?

Have you been given a diagnosis for this problem? If so, what?

What treatments have you tried?

Past Medical History (please include date): Cancer_____ Diabetes_____
Hepatitis_____ High Blood Pressure_____ Heart Disease_____
Rheumatic Fever_____ Thyroid Disease_____ Seizures_____
STI_____ HIV/AIDS_____ Other_____
Surgeries (type & date):_____
_____
Significant Trauma (auto accidents/falls/etc):_____
_____
Significant Dental Work (type & date):_____
_____
Allergies (drugs/chemicals/foods + result):_____

Family Medical History (check): Diabetes ❑ Cancer ❑ High Blood Pressure ❑
Heart Disease ❑ Stroke ❑ Seizures ❑ Asthma ❑ Allergies ❑
Other ❑_____

Medicines taken within the last two months (vitamins/drugs/herbs/etc)

Name of medication/supplement:	Reason for taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical/chemical/psychological/etc):_____
_____

Do you have a **regular exercise program?** Y N Please describe:

Have you ever been on a **restricted diet?** Y N Please describe:

Please describe you **average daily diet:**

Morning:

Afternoon:

Evening:

Tobacco: how many packs/day?_____

Caffeine (coffee/tea/cola/etc): how many cups/day?_____

Alcohol: how many drinks/week?_____

Please describe any use of recreational drugs:_____

Please check any you have had in the last three months:

General
❑ Poor appetite
❑ Fevers
❑ Sweat easily
❑ Localized weakness
❑ Bleed or bruise easily
❑ Peculiar tastes or smells
❑ Strong thirst (cold or hot)
❑ Thirst, no desire to drink
❑ Sudden energy drop—what time? _____
❑ Poor sleep
❑ Chills
❑ Tremors
❑ Poor balance
❑ Fatigue
❑ Night sweats
❑ Cravings
❑ Change in appetite
❑ Weight gain
❑ Weight loss

Skin and Hair
❑ Rashes
❑ Itching
❑ Dandruff
❑ Change in hair or skin
❑ Ulcerations
❑ Eczema
❑ Loss of Hair
❑ Hives
❑ Pimples
❑ Recent moles
❑ Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat
❑ Dizziness
❑ Glasses
❑ Poor vision
❑ Cataracts
❑ Ringing in ears
❑ Sinus problems
❑ Grinding teeth
❑ Teeth problems
❑ Concussions
❑ Eye strain
❑ Night blindness
❑ Blurry vision
❑ Poor hearing
❑ Nose bleeds
❑ Facial pain
❑ Jaw clicks
❑ Migraines
❑ Eye pain
❑ Color blindness
❑ Earaches
❑ Spots in front of eyes
❑ Recurrent sore throats
❑ Sores on lips or tongue
❑ Headaches – where and when_____
_____
❑ Other head or neck problems_____
_____

Cardiovascular
❑ High blood pressure
❑ Irregular heartbeat
❑ Cold hands or feet
❑ Blood clots
❑ Low blood pressure
❑ Dizziness
❑ Swelling of hands
❑ Phlebitis
❑ Chest pain
❑ Fainting
❑ Swelling of feet
❑ Difficulty in breathing
❑ Other heart or blood vessel problems _____
_____

Respiratory
❑ Cough
❑ Bronchitis
❑ Difficulty in breathing when lying down
❑ Production of phlegm what color?_____
❑ Coughing blood
❑ Pneumonia
❑ Asthma
❑ Pain with a deep breath
❑ Other lung problems:
_____
Approximately when was your last cold or flu?
_____

Gastrointestinal
❏ Nausea
❏ Constipation
❏ Black stools
❏ Bad breath
❏ Abdominal pain or cramps
❏ Chronic laxative use
❏ Vomiting
❏ Gas
❏ Blood in stools
❏ Rectal pain
❏ Diarrhea
❏ Belching
❏ Indigestion
❏ Hemorrhoids
❏ Other stomach or intestinal problems
_____
_____

Genito-urinary
❏ Pain on urination
❏ Urgency to urinate
❏ Frequent urination
❏ Unable to hold urine
❏ Impotency
❏ Blood in urine
❏ Kidney stones
❏ Sores on genitals
❏ Other genital or urinary system problems
_____
_____
❏ Do you wake up to urinate?
❏ Yes ❏ No.
How often?
_____

Any particular color to your urine?
_____

Pregnancy & Gynecology
# of pregnancies_____
# of births_____
Premature births_____
Miscarriages _____
Abortions _____
Age at first menses_____
Days between menses____
Duration _____
First day of last menses
_____
_____
❏ Unusual character (heavy or light)
❏ Painful periods
❏ Vaginal discharge
What color?
_____
❏ Changes in body/psyche prior to menstruation
❏ Clots
❏ Vaginal sores
❏ Irregular periods
❏ Last Pap _____
❏ Breast lumps
Are you sexually active?
_____
Do you practice birth control?
❏ Yes ❏ No ❏ N/A
What type and for how long?_____
_____

Musculoskeletal
❏ Neck pain
❏ Back pain
❏ Hand/wrist pain
❏ Muscle pain
❏ Muscle weakness
❏ Shoulder pain
❏ Knee pain
❏ Foot/ankle pain
❏ Hip pain

Neuropsychological
❏ Seizures
❏ Areas of numbness
❏ Concussion
❏ Bad temper
❏ Dizziness
❏ Lack of coordination
❏ Depression
❏ Easily susceptible to stress
❏ Loss of balance
❏ Poor memory
❏ Anxiety
❏ Other neurological or psychological problems
_____
_____

Please note the severity of your problem now:

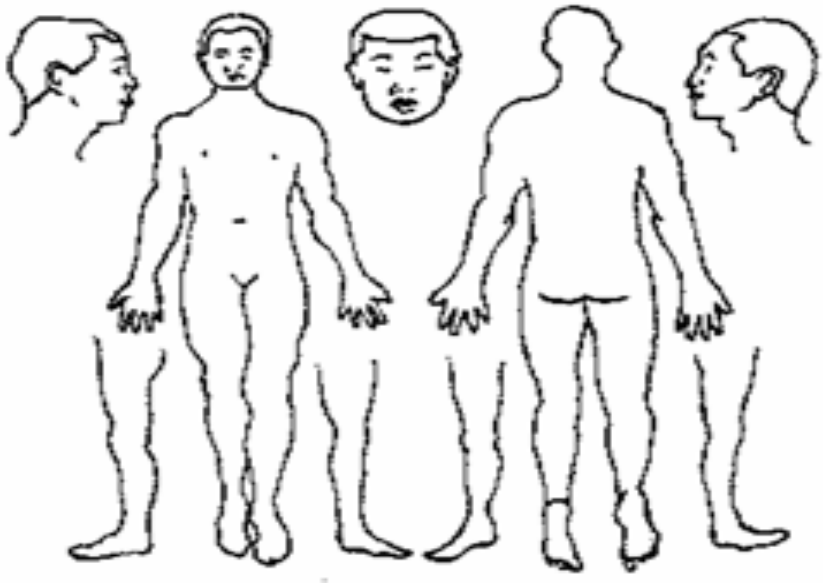
No Problem Worst Imaginable

Please note the severity of your problem within the last week:

No Problem Worst Imaginable

Comments (please mention any other problems you would like to discuss):

Indicate **painful or distressed areas:**



BEAM Acupuncture/Mariko Fujita, EAMP
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Patient Health Insurance Verification Form

(Reference above information, if prompted by insurance representative.)
******Complete only if you plan on using your insurance for acupuncture services.******

Patient Name:_____ DOB:_____
Insurance Plan Name:_____ Phone:_____
ID # (include prefix):_____ Group #:_____
Effective Date:_____

	(circle one)	
Is provider in-network?	Yes	No
Does plan cover acupuncture (CPT codes 97810, 97811)?	Yes	No
Does plan cover manual therapy (CPT codes 97140, 97026)?	Yes	No
Is there an additional copay for office visits (E&M code 99212)?	Yes	No
If yes, copay is _____		
Does plan require a referral? If yes, from whom?_____	Yes	No
Does plan require preauthorization for acupuncture (97810/97811)	Yes	No

Is acupuncture benefit subject to deductible? Yes No
Individual deductible:_____ Met:_____
Family deductible:_____ Met:_____

In-network: Paid at:_____% Copay:_____
What is annual acupuncture limit ($ amt./# of treatments)? _____

Are there "out-of-network" benefits for acupuncture?
If yes: Paid at:_____% Copay:_____
What is annual acupuncture limit ($ amt./# of treatments)? _____

Are there any exclusions or restrictions for acupuncture? _____
_____

Date:_____ Person you spoke with:_____

_____
(Patient Signature)

Notice of Privacy Policy

The information provided below is the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of the acupuncturist: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, the acupuncturist is required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration during the course of practice and will be in effect until it is replaced. The acupuncturist reserves the right to modify privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. The acupuncturist reserves the right to make the modifications effective for all protected health information that the acupuncturist maintain, including protected health information the acupuncturist created or received before the changes were made. Changing the notice will precede all significant modifications.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations.

Treatment: Use and disclosure of your protected health information may be provided to a healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services provided to you.

Healthcare Processes: The acupuncturist may use and disclose your protected healthcare information in relation to our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected healthcare information may be disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, the acupuncturist will disclose protected health information using her professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. The acupuncturist will use professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled herbal prescriptions.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if the acupuncturist has reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If the acupuncturist has reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, the acupuncturist may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, emails, or letters. The acupuncturist may also write a thank you card to whomever referred you.

Patient Rights Access: With limited exception, you have the right to review your protected health information.

Disclose Accounting: Your may choose to request a review of every time the acupuncturist discloses your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years.

Restrictions: You may request the acupuncturist apply additional restrictions to any disclosure of your healthcare information. The acupuncturist is not required to respond to the application of these additional restrictions. If the acupuncturist agrees to follow your request regarding additional restrictions, the acupuncturist will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your may request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

_____ _____

Signature Date

EAST ASIAN MEDICINE INFORMED CONSENT TO TREAT & FINANCIAL POLICY
BEAM* Acupuncture PLLC
Seattle Institute of Oriental Medicine, Seattle, 2012-2015, MAcOM
Licensed in Washington State as Mariko Fujita, LAc, EAMP, #AC60599982 (9/22/2015)

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of East Asian/Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment within the scope of East Asian/Chinese medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridian, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies. I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and 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 disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effect 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist named below if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. ****I will notify an acupuncturist member who is caring for me if I am or become pregnant. Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema must inform practitioners prior to any treatment.****

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I understand that the acupuncturist may review my patient records and lab reports.

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above named provider. In the even that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

I will provide my acupuncturist with at least 24 hours notice if I need to cancel or reschedule an appointment and I understand that I will be charged a fee for any appointment broken with less than 24 hours notice.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Signed _____ Dated_____

Printed name _____