

GOLDEN LIGHT ACUPUNCTURE, P.C.

Health History Form

Dear Patient,

Welcome to our practice. We are delighted to work with you to meet your health goals. We are committed to supporting you as best we can.

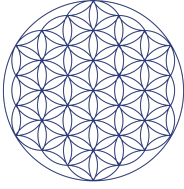
Please note our personal cell phone numbers and keep them in your phone. Please feel free to contact us via call or text with questions about appointments or to set up a phone call if any questions arise during your course of treatment - please do not send personal health information via text.

Michael: (516) 353-2412 | Marika: (845) 663-8853

Please complete the health history questionnaire and read the following information carefully, as it relates to the treatment that you may receive and our office policies. It is important to us that you are informed.

Thank you,

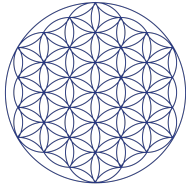
Golden Light Acupuncture, PC



GOLDEN LIGHT ACUPUNCTURE, P.C.

Health History Form

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GOLDEN LIGHT ACUPUNCTURE, P.C.

Health History Form

Patient Information

Patient Full Name _____ DOB _____

Mailing Address _____

Email Address _____ Cell Phone Number _____

Emergency Contact Name _____ Phone Number _____

Primary Care Doctor _____ Date of last visit _____

Occupation _____ Referred by _____
(May we say thank you? *please circle Y or N*)

Reason for Seeking Acupuncture

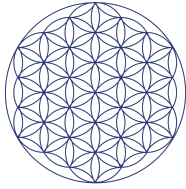
Please describe your primary reason for seeking acupuncture - is there a specific pain, injury, or illness?

If there is pain associated with this condition please rate it 1 (least) - 10 (most): _____

When did this begin? What makes it better/what makes it worse? Have you had a medical diagnosis or receive any treatments for this either in the past or currently?

Are there any other conditions or complaints? _____

Have you ever received acupuncture treatments before? If so, when and with whom? What was your experience?



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Lifestyle/Self Care

Please describe your usual sleep schedule and quality of sleep: _____

Do you keep any specific kinds of diet? _____

Any allergies? (food/environmental/medicines/etc) _____

Do you exercise regularly? Please describe: _____

Do you have a meditation, spiritual, or religious practice? _____

How is your work environment? Please describe: _____

How is your living environment? Please describe: _____

On average, how many times per week: Smoking _____ Alcohol _____ Coffee _____

Personal Health History *(use last page for additional info)*

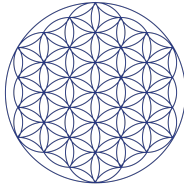
How would you describe your mental/emotional health? _____

Are you currently taking any medications, vitamins, supplements?

| <i>Name</i> | <i>Reason</i> | <i>Dosage</i> | <i>Prescribed by?</i> |
|-------------|---------------|---------------|-----------------------|
| | | | |
| | | | |
| | | | |

Any minor or major accidents, injuries, surgeries, or hospitalizations?

| <i>Date</i> | <i>Incident/Reason</i> | <i>Anything to report about the experience?</i> |
|-------------|------------------------|---|
| | | |
| | | |
| | | |



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Please circle all that apply

Digestive Health

| | | | |
|-------------|----------------|---------------|-------------|
| Bloating | Colitis | Constipation | Crohn's |
| Diarrhea | Diverticulitis | Gas | GERD/Reflux |
| IBS | Nausea | Poor Appetite | Ulcer |
| Other _____ | | | |

Cardiac/Respiratory

| | | | |
|----------------------|---------------------|--------------------|------------------|
| Allergies (Seasonal) | Asthma | Chronic Cough | Emphysema |
| Heart Disease | High Blood Pressure | Low Blood Pressure | Sinus Infections |
| Other _____ | | | |

Do you have any history of **Cancer** (if yes, please describe) _____

Neurological/Endocrine/Metabolic/Infectious

| | | | |
|--------------------|-------------------|----------------|---------------|
| Anemia | Chronic Fatigue | Chronic Pain | Diabetes |
| Dizziness | Headaches | Hearing Issues | Hyperglycemia |
| Hypoglycemia | Lyme Disease | Migraines | Night Sweats |
| Seizures or Stroke | Thyroid Imbalance | Vision Issues | |
| Other: _____ | | | |

Any **Dermatological** conditions _____

Urogenital & Reproductive

| | | | |
|---------------------|------------------|--|----------------|
| Bladder Infection | Impotence | Incontinence | Kidney Disease |
| Kidney Stones | Low Libido | Painful/burning urination or Intercourse | |
| Prostate Conditions | Urgent Urination | Other _____ | |

Any **Liver** and/or **Gallbladder** conditions? _____

Female Health

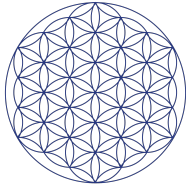
Age of onset of menses _____ Age of menopause? _____

Are you currently pregnant? _____ Trying to get pregnant? _____ Taking/have taken birth control _____

Please describe your menstrual cycles (frequency, duration, any pain, etc) _____

How many pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Any other ovarian, uterine, or vaginal conditions _____



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Musculoskeletal

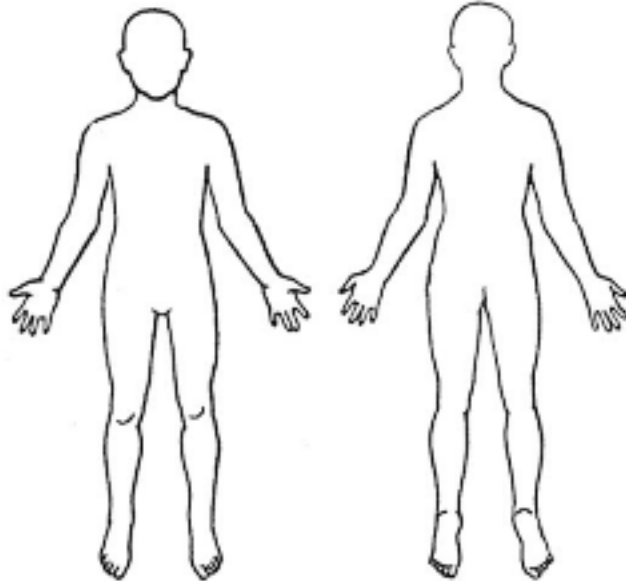
Arthritis

Broken Bones

Sprains

Other _____

Do you regularly experience pain anywhere in your body? Please describe or draw:

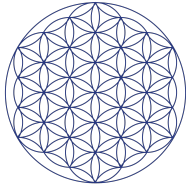


Any additional information to share?

I hereby declare that the information given in this intake is accurate to the best of my knowledge and recollection. If anything changes, I will notify Golden Light Acupuncture as soon as possible.

Patient Signature _____ Date _____

Practitioner Signature _____



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Please read the following pages carefully and initial at the conclusion of each paragraph to acknowledge that you have read and understood the information provided. Thank you.

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments (as described above) on me or the patient name listed below, for which I am legally responsible, by licensed acupuncturists who are employed or contracted by Golden Light Acupuncture.

Please Initial here: _____

I understand that acupuncture involves the insertion of sterilized, single-use filiform needles, sometimes with e-stim (electrical stimulation). I understand that, although very rare, acupuncture has the risk of causing unintentional bleeding, bruising, fainting, infection, pneumothorax, miscarriage, organ puncture, and nerve damage. I understand that certain acupuncture techniques may cause intentional bleeding, based on the theories of Chinese Medicine, and that I will be informed and my specific consent will be sought. I will notify my acupuncturist immediately if anything happens that is painful or unusual.

Please Initial here: _____

I understand that there are certain treatment procedures that are inappropriate for women who are pregnant & that **it is my responsibility to immediately tell my acupuncturist if I become pregnant**, so that proper precaution is taken.

Please Initial here: _____

I understand that massage, cupping, and Gua Sha might be performed. Cupping and GuaSha will result in visible marks that appear like bruises on the skin. These are healthy, physiological responses to the treatment.

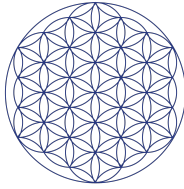
Please Initial here: _____

I understand that moxibustion and/or infrared therapy may be used and incurs the possibility of burns and/or scars and it is my responsibility to notify the practitioner in the event of any sensation of heat at the site of therapy.

Please Initial here: _____

I understand that the profession of acupuncture includes recommendation of dietary supplements and natural products including, but not limited to, the recommendation of diet, herbs and other natural products, and their preparation in accordance with traditional & modern practices of East Asian medical theory.

Please Initial here: _____



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Privacy

I acknowledge that I have read and understand the HIPAA privacy agreement provided to me by the Practice. They are available on GoldenLightAcupunctureNY.com

I understand that Golden Light Acupuncture will keep all communications and records confidential, unless I consent in writing to share this information with others. However, I consent to the Practice's use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me and for Golden Light Acupuncture's general healthcare operations purposes. PHI relates to any information created or received by Golden Light Acupuncture, that relate to my past, present or future physical and mental health or condition, that either identifies me or where there is a reasonable basis to believe the information can be used to identify me.

Cancellation Policy

Cancellation within 24 hours of an appointment will incur a charge of \$50.

Please Initial here: _____

I further agree to hold Golden Light Acupuncture harmless from any and all liabilities and claims which may arise as a result of my participation in the acupuncture sessions. I will not hold Golden Light Acupuncture responsible for the consequences of any decisions I may make, or any actions I may take, or may choose not to take, following any recommendation made by Golden Light Acupuncture.

While there have been no warranties, assurances, or guarantees made to me, I consent and freely agree to receive acupuncture treatment from Golden Light Acupuncture. I understand that while Golden Light Acupuncture may make certain recommendations to me during the sessions, it is entirely my own decision whether or not to accept and follow these recommendations. I have read and understood the information provided in this Consent Form, as well as all materials provided to me. I have asked any and all questions that I may have about the sessions and these questions have been answered to my full satisfaction.

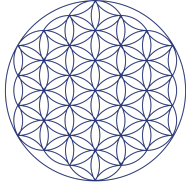
I, the undersigned, do affirm that I have been advised by Golden Light Acupuncture to consult a licensed physician regarding the condition or conditions for which I seek acupuncture treatment and under no circumstances should I forego any medical treatment recommend by a doctor. In signing, I am voluntarily agreeing to all the above descriptions, terms, and conditions.

Patient Name _____

Date _____

Patient or Guardian Signature (note relationship please)

Practitioner Signature



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FINANCIAL AGREEMENT & AUTHORIZATION

In-Network Acupuncture Benefits with NYSHIP | UHC’s Empire Plan

Golden Light Acupuncture, P.C. is an in-network provider with the NYSHIP Empire Plan. Members of this plan are required to provide payment of their copayment at each visit. Please provide the following information if you are insured under this Plan:

Policy Holder Name _____ Policy Holder DOB _____

Member ID _____

Fee-for Service

Payment in full is due at the time of service. We accept the following forms of payment:

- Cash
- Check
- Credit Card
- Venmo (@GoldenLightAcu)*

*Please note that Venmo is not a confidential or HIPAA (Health Insurance Portability and Accountability Act) compliant platform to pay for acupuncture. In signing below, you acknowledge that you are voluntarily choosing Venmo and are responsible for the privacy settings.

Out of Network Acupuncture

We will work to provide necessary documentation to you in order to submit a claim. Our office will not enter into a dispute with your insurance company over any claim. We will work to provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise, and will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. Our office does not guarantee that your insurance company will pay for treatment you receive from our office.

Authorization

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Golden Light Acupuncture, PC for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to be responsible for any balance due. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

Patient or Guardian Signature _____

Date _____