

# Welcome to Ling's Acupuncture!

*Our Purpose is to help as many people as possible.  
We are compassionate about the unique quality of care we offer.*

Thank You for choosing Ling's Acupuncture for your healthcare needs. We would like to take a moment to implement a few office policies that are fair and simple, revolving around the care of our patients.

Please read each section and initial and then sign at the bottom.

**Cancellations:** If you need to reschedule or cancel an appointment, please call our office at least 24 hours in advance. Cancellations 24 hours before your appointment are accepted. Cancellations on the day of the appointment will be billed a cancellation fee of **\$20**. Exceptions can be made for certain circumstances. As a courtesy to us and other patients, please call our office.

\_\_\_\_\_ I acknowledge and accept the cancellation policy.

**Patient Education:** Our practice is unique because we educate our patients on natural medicine. The purpose of this education is to help you understand how Acupuncture works and answer any questions or concerns you may have. Patient Education will also help the doctor move the initial visit along, confident that you understand the basics of Chinese medicine. Patient Education is recommended for all of our patients, especially for those who have never experienced Acupuncture.

\_\_\_\_\_ Yes, I am interested in the patient education that you offer. I understand that this will not cost extra or be counted as my time with the doctor.

\_\_\_\_\_ No thank you, I am not interested in patient education. I had received acupuncture before or understand the general concept.

**Payment:** Payment for services is due in full at the time services are rendered. We accept cash, check, visa, and master card. Please note that if you wish to file a claim with your health insurance, this is the patient's responsibility. We will provide any necessary paperwork to enable you to file your claim. However, you are still responsible to Ling's Acupuncture for the full payment of services.

\_\_\_\_\_ I have read and understand the payment policy.

Please sign and print your name with today's date stating you have read and acknowledge our policies.

X \_\_\_\_\_  
(Signature)

\_\_\_\_\_ Date: \_\_\_\_\_

# LING'S ACUPUNCTURE

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a significant role in your diagnosis and treatment.

## General Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Emergency Contact/Relation \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? Referred by \_\_\_\_\_

Yellow pages \_\_\_\_\_ Web-site \_\_\_\_\_ Drive-by \_\_\_\_\_ Other \_\_\_\_\_

Medications (if any): \_\_\_\_\_

Supplements (if any vitamins, herbs, etc.): \_\_\_\_\_

Major Complaint(s), in order of significance to you:

1. Major Complaint: \_\_\_\_\_

2. Secondary Complaint: \_\_\_\_\_

3. Other Complaint: \_\_\_\_\_

4. Other Complaint: \_\_\_\_\_

How do these conditions impair your daily activities? \_\_\_\_\_

## Patient Medical History

How was your childhood health? \_\_\_\_\_

Hospital visits/stays: \_\_\_\_\_

Recent tests: (please indicate test results and date on following page)

Physical    Cholesterol    Blood    Prostate    HIV    STD    Pap Smear

Mammography    Other \_\_\_\_\_

Test Results and Date: \_\_\_\_\_

Check any you have had in the past:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> CVA (stroke)   | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Gonorrhoea       | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> HIV            | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Epilepsy         |  |

Other: \_\_\_\_\_

Surgeries: \_\_\_\_\_

### Family Medical History

Check the following that have occurred in your blood relatives:

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Bleeding Tendency   |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental Illness      |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Other _____  |  |  |

### Patient Profile

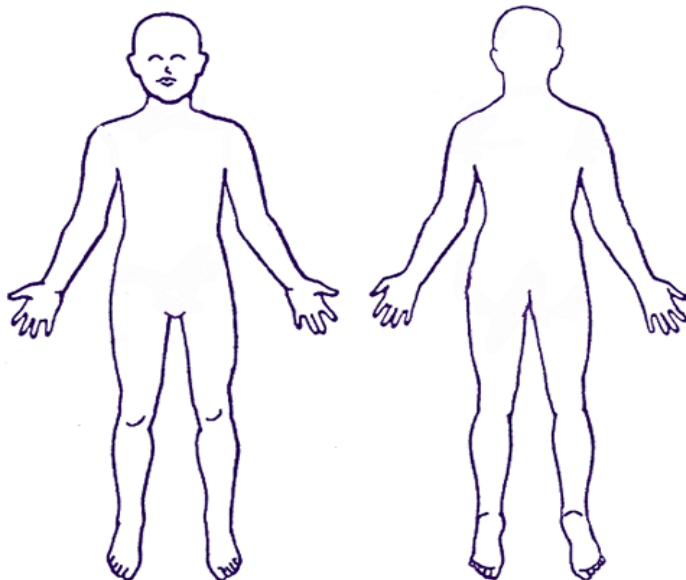
Please clearly mark any areas of pain on the diagram below:

Is the pain:

- Sharp  Burning  Aching  Cramping  Dull  Moving  Fixed  Other: \_\_\_\_\_

Do the following lessen the pain:

- Pressure  Cold  Heat  Exercise  Other: \_\_\_\_\_



Do the following worsen the pain:

- Pressure  Cold  Heat  Exercise  
 Other: \_\_\_\_\_

**Overall Temperature (Kidney function):**

- cold hands & feet
- afternoon flushes
- cold sensation
- sweaty hands & feet
- hot flushes
- perspire easily
- night sweats
- lack of perspiration
- thirsty
- hot sensation
- vaginal dryness
- low energy

**Heart function:**

- palpitations
- mental confusion
- mental fogginess
- anxiety
- vivid dreams
- mental sluggishness
- restlessness
- chest pain
- wake unrefreshed
- memory problem
- insomnia

**Lung function:**

- cough
  - dry throat
  - difficult breathing
  - nasal discharge /color:\_\_\_\_\_
  - allergies/to what:\_\_\_\_\_
  - sinus congestion
  - dry nose
  - chills & fever
  - nose bleeds
  - dry skin
  - stiff neck
  - cough with sputum/color:\_\_\_\_\_
  - dry mouth
  - sneezing
  - sore throat
- 

**Spleen function:**

- low appetite
- gurgling stomach
- diarrhea
- loose stools
- swollen hands
- bloating
- gas
- constipation
- hemorrhoids
- swollen feet
- abrupt weight change
- fatigue after eating
- undigested food in stools
- alternating diarrhea & constipation
- heavy body sensation
- mucous in stools
- blood in stools
- incomplete stools
- nausea

**Stomach function:**

- burning
- acid reflux
- bad breath
- belching
- very large appetite
- stomach pain
- bleeding or swollen gums
- canker sores
- vomiting

**Liver/Gallbladder function:**

- over thinking
- frustration
- tingling
- drink alcohol
- anger easily
- depression
- numbness
- lump in throat
- tightness in chest
- frequent headaches
- muscles spasms
- muscle tension
- bitter taste
- irritability
- ringing in ears

**Kidney/Bladder function:**

- sore/weak knees
- excessive hair loss
- low back pain
- fearful
- high libido
- low libido
- normal libido
- lack of bladder control

**Urination:**

- frequent
- scanty
- urgent
- burning
- dark yellow color
- painful
- strong odor
- difficult
- cloudy



**Ling's Acupuncture and Chinese Medicine**

120 Gatlin Ave. Orlando, FL 32806 407-851-2533

5931 Brick Ct. Ste. 160 Winter Park, FL 32792 407-681-3800

**Notice of Privacy Practices**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

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Patient or Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if other than patient):\_\_\_\_\_Date:\_\_\_\_\_

Witness\_\_\_\_\_Date:\_\_\_\_\_

(Printed Name Ling's Acupuncture Representative)

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**Patient Consent to Treatment**

I hereby consent to the following:

Patient's Name (Please Print):\_\_\_\_\_

A. Treatment: Any and all health care treatment, which may include acupuncture, herbal formulas, TuiNa, \_\_\_\_\_ cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.

B. Financial Information: All professional fees are due in full at the time services are rendered, unless prior arrangements have been made with the patient's health insurance company. I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to LING'S ACUPUNCTURE for the amount due after services have been rendered. Payment can be made by major credit cards, cash, or check.

C. Authorization to Use and Disclose Health Information: I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care.

Patient or Representative Signature:\_\_\_\_\_Date:\_\_\_\_\_

**Patient Questionnaire**

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation) :

\_\_\_\_\_

2. Please list the family members or significant others, if any, whom we may inform about your Medical condition ONLY IN AN EMERGENCY \_\_\_\_\_

3. Please print the **telephone number(s) where you want to receive calls** about your appointments, lab and x-ray results, or other information: \_\_\_\_\_

(Check one)

Okay to leave message with detailed information  Leave message with callback number only

**It is the responsibility of the patient to notify Ling's Acupuncture if this information should change**