



Acupuncture & Wellness

Center Of Florida

10139 NW 31 Street #101, Coral Springs, FL 33065

Suzanne Swearingen, DOM, A.P.

First Name: _____ Middle Initial: _____ Last Name: _____ Today's Date: _____

Height: ____' ____" Weight: _____ lbs. Male Female Birth Date: ___/___/____ Age: _____

Last 4 digits of your SS#: _____ Guardian (if under 18): _____

Marital Status: Single Married Separated/Divorced Widowed

Referred By: _____ Occupation: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone #: _____

Home Phone #: _____ Work Phone #: _____

We WILL use contact information that you provide, such as email addresses & phone numbers for messages and / or texts, to leave confidential messages (including but not limited to appointment reminders, scheduling changes, or messages asking for a return call). Please be sure that you are providing numbers where messages of this nature are acceptable. If you require special arrangements, please SPEAK TO OUR STAFF, and indicate here: _____

Health Concern/Reason for Visit: _____

What symptoms are you having: _____

Does anything limit you from Care? Yes No If YES, explain: _____

Other physicians/ therapists seen for this condition: _____

Medications/Supplements/ Vitamins: _____

Allergies: _____

Is this visit related to an Automobile Accident? Yes No If YES, what was the date of the accident? _____

Is this visit related to a Worker's Comp Injury? Yes No

Please List Past Surgeries: _____

Do you smoke? Yes No If YES, how much? _____

Do you drink coffee/black tea? Yes No If YES, how much? _____

Do you use alcohol? Yes No If YES, how much? _____

Questionnaire Continues On Next Page

Do you exercise? Yes No If YES, how often? _____

In Case of Emergency:

Contact: _____ Relationship: _____

Phone #: _____ Can medical information be shared with this person? Yes No

Secondary Contact: _____ Relationship: _____

Phone #: _____ Can medical information be shared with this person? Yes No

Check Any You Have Had In The Past:

- | | | | |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | | |

Please check ANY of the following that pertain to you:

Overall Temperature (Kidney Function):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold hands | <input type="checkbox"/> cold feet | <input type="checkbox"/> sweaty hands | <input type="checkbox"/> sweaty feet |
| <input type="checkbox"/> hot body temperature (sensation) | <input type="checkbox"/> cold body temperature (sensation) | <input type="checkbox"/> perspire easily | |
| <input type="checkbox"/> afternoon flushes | <input type="checkbox"/> night sweats | <input type="checkbox"/> lack of perspiration | <input type="checkbox"/> take water to bed |
| <input type="checkbox"/> heat in hands, feet and chest | <input type="checkbox"/> hot flashes any time of the day | <input type="checkbox"/> thirsty | |

Overall Energy (Lung, Kidney Function):

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> general weakness | <input type="checkbox"/> easily catch colds | <input type="checkbox"/> low energy |
| <input type="checkbox"/> feel worse after exercise | | | |

Blood (Liver, Spleen, Heat function):

- | | |
|------------------------------------|---|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> see floating black spots |
|------------------------------------|---|

Heart Function:

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> palpitations | <input type="checkbox"/> anxiety | <input type="checkbox"/> sores on the tip of the tongue | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> frequent dreams | <input type="checkbox"/> restlessness | <input type="checkbox"/> mental confusion | <input type="checkbox"/> wake un-refreshed |

Lung Function:

- | | | | |
|--|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> nasal discharge | <input type="checkbox"/> cough | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> sinus congestion |
| <input type="checkbox"/> sneezing | <input type="checkbox"/> dry mouth | <input type="checkbox"/> dry throat | <input type="checkbox"/> dry skin |

...Continued From Page Two

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> stiff neck | <input type="checkbox"/> alternating fever & chills | <input type="checkbox"/> stiff shoulders |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> headache
(location: _____) | <input type="checkbox"/> smoke cigarettes
(# per day _____) |
| <input type="checkbox"/> achy body | <input type="checkbox"/> sadness | | |
| <input type="checkbox"/> melancholy | | | |
-

Spleen Function:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> low appetite | <input type="checkbox"/> abrupt weight gain | <input type="checkbox"/> abrupt weight loss | <input type="checkbox"/> abdominal bloating |
| <input type="checkbox"/> abdominal gas | <input type="checkbox"/> gurgling in the stomach | <input type="checkbox"/> fatigue after eating | <input type="checkbox"/> prolapsed organs |
| <input type="checkbox"/> easily bruised | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> pensive | <input type="checkbox"/> over-thinking |
| <input type="checkbox"/> worry | | | |
-

Spleen, Stomach, Large Intestine, Small Intestine Function:

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> loose stools | <input type="checkbox"/> constipated | <input type="checkbox"/> incomplete | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> blood in stools | <input type="checkbox"/> mucous in stools | <input type="checkbox"/> undigested food in stools | |
-

Dampness Trapped in the body:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> general sensation of heaviness in the body | <input type="checkbox"/> mental sluggishness | <input type="checkbox"/> snoring | |
| <input type="checkbox"/> mental heaviness | <input type="checkbox"/> mental fogginess | <input type="checkbox"/> nausea | <input type="checkbox"/> chest congestion |
| <input type="checkbox"/> swollen hands | <input type="checkbox"/> swollen feet | <input type="checkbox"/> swollen joints | |
-

Stomach Function:

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> large appetite | <input type="checkbox"/> bad breath | <input type="checkbox"/> canker sores | <input type="checkbox"/> bleeding gums |
| <input type="checkbox"/> heartburn | <input type="checkbox"/> acid reflux | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> belching |
| <input type="checkbox"/> hiccoughs | <input type="checkbox"/> stomach pain | <input type="checkbox"/> vomiting | <input type="checkbox"/> pain after eating |
-

Liver, Gall Bladder Function:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> bitter taste in mouth | <input type="checkbox"/> tingling sensation |
| <input type="checkbox"/> anger easily | <input type="checkbox"/> frustration | <input type="checkbox"/> depression | <input type="checkbox"/> numbness |
| <input type="checkbox"/> irritability | <input type="checkbox"/> muscle twitching | <input type="checkbox"/> convulsions | <input type="checkbox"/> unable to adapt to stress |
| <input type="checkbox"/> alternating diarrhea and constipation | <input type="checkbox"/> lump in the throat | <input type="checkbox"/> headache at the top of the head | |
| <input type="checkbox"/> skin rashes | <input type="checkbox"/> muscle spasms | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> seizures |
| <input type="checkbox"/> neck tension | <input type="checkbox"/> shoulder tension | <input type="checkbox"/> drink alcohol | <input type="checkbox"/> gall stones |
-

Eyes (liver function):

- | | | | |
|---|---|---------------------------------|---------------------------------|
| <input type="checkbox"/> itchy | <input type="checkbox"/> bloodshot | <input type="checkbox"/> hot | <input type="checkbox"/> dry |
| <input type="checkbox"/> far-sighted | <input type="checkbox"/> near-sighted | <input type="checkbox"/> watery | <input type="checkbox"/> gritty |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> decreased night vision | | |

Kidney, Urinary Bladder Function:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> frequent cavities | <input type="checkbox"/> easily broken bones | <input type="checkbox"/> sore knees | <input type="checkbox"/> weak knees |
| <input type="checkbox"/> cold sensation (knees) | <input type="checkbox"/> low back pain | <input type="checkbox"/> memory problems | <input type="checkbox"/> excessive hair loss |
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> fear | <input type="checkbox"/> easily startled | <input type="checkbox"/> bladder infections |
| <input type="checkbox"/> lack of bladder control | <input type="checkbox"/> wake twice or more during the night to urinate | | |
-

Patient's Signature:



Acupuncture & Wellness

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients complete our Patient Consultation Information/History Sheet before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMEX AND DISCOVER.

Regarding Insurance:

We will verify coverage prior to the first treatment. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for each treatment until verification is obtained. We cannot bill your insurance company unless you provide all insurance information. You insurance policy is a contract between you and your insurance company. We are not part of that contract. In the event that your insurance company will not assign benefits to our office, any balance due on your account is your responsibility whether your insurance company pays or not. Our fees are determined by the complexity of the particular case and the different modalities used during treatment. In signing this document, you are agreeing to turn over, or reimburse the complete amount of any and all insurance checks which may be given to you, the patient. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Regarding Payments on Date of Service

In an effort to minimize costs and create the best possible atmosphere for healing, payments are due at the time services are rendered. If you are on a payment plan, payments are due as specified in your specific plan.

Missed Appointments

By signing this document you agree to give 24 hours notice if you need to cancel or change an appointment, otherwise you will incur a \$30 fee. Please keep in mind that your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. We are best able to serve you when you keep your scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. By signing this document you agree that you have read and understand the terms of our Financial Policy.

A photocopy of this document shall be considered as effective as the original.

X _____
(Signature of Patient or Responsible Party)

Date: _____

X _____
Print Name



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Patient Consent Form HIPPA

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 Form. The terms of our office 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 and 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 not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands:

- 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.

This Consent was signed by: _____

Date: _____

Print Name: _____

Relationship to Patient _____
(if other than patient):

Witness: _____
(Sign and Print Name)

Date: _____



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Consent Form

I, _____ voluntarily consent to be treated at The Acupuncture & Wellness Center of Florida. Treatments may include (but are not limited to) Acupuncture, Homeopathic or Chinese Herbal Medicine, Massage / Manual Therapy, Injection Therapy, Laser Therapy, Hypnosis, etc.

I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture or Chinese Herbal Medicine treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that No guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop treatment at any time.

I agree that I will give at least 24 hours notice if I need to change or cancel an appointment and I will be charged for the appointment \$30 if such notice is not given.

Sign Name: _____

Date: _____

Print Name: _____

Witness: _____



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Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

You will be responsible for the office visit portion for your appointments. The bill will show the office visit and the fee. However, there are several procedures that may occur during your visit, which will be modified, any of these procedures used during your treatment will be reduced to \$0.00, and you will be responsible for the office visit fee only.

97810-52	Acupuncture 1 st unit	97813-52	Acupuncture w/Elec. Stim. 1 st unit
97811-52	Acupuncture add'l units	97814-52	Acupuncture w/Elec. Stim. add'l units
97010-52	Heat Therapy	97140-52	Manual Therapy
97014-52	Elec. Stim. (Unattended)	97530-52	Kinetic Activities
97032-52	Elec. Stim. (Attended)	97110-52	Therapeutic Exercises
97112-52	Neuromuscular Re-educ.	96372-52	Injection Therapy

The fee for an office visit ranges from \$75.00 (99211) to \$180.00 (99203)

As part of your treatment plan, we inform you prior to treatment of anticipated costs and fees associated with your particular healthcare needs.

I have read and understand the information contained therein.

(Patient's Signature)

Date: _____