Patient Information Sheet

12304 Santa Monica Blvd., #120 ☯ Los Angeles, CA 90025 ☯ Phone: 310-826-5288 ☯ Fax: 310-826-7178 ☯ www.TCMHealingCenter.com

Last Name:	First Name:	Preferred Name:	Occupation:	Referred By:
Gender M ◯ F ◯	Date of Birth:	Age:	Marital Status: Single ◯ Married ◯ Divorced ◯ Widow ◯	Tel:
Address:		City:	State:	Zip:
Home Phone:		Work Phone:	Cell Phone:	
Emergency Contact & Relationship:		Phone Numbers of Emergency Contact: Primary:	Alternate:	

Check Health Insurance Coverage:

None ☐ PPO ☐ POS ☐ HMO ☐ Work's Comp ☐ Auto Injury with Med Pay ☐ Military ☐ Other:_____

Email Address:

Please be assured that your e-mail address will only be used by our office for your needs and will not be sold to another company or individual.

Primary Care Doctor: Name: Tel:	Specialty:
Other Doctor You See: Name: Tel:	Specialty:

Major Complaints:

Please Answer the Following Questions:

	Yes	No		Yes	No
Do you have a tendency to faint?	◯	◯	Are you pregnant? (women)	◯	◯
Do you have a pacemaker?	◯	◯	Have you ever had Hepatitis?	◯	◯
Do you bleed for a long time?	◯	◯	Have you ever tested positive for COVID-19?	◯	◯
Are you HIV+?	◯	◯	Have you been vaccinated for COVID-19?	◯	◯

Medication: Please list all prescription medications you use. Include those which you may only use occasionally:

Prescription Name	Purpose:	How Long	Dose	How Often	Last Dose

OUR OFFICE POLICY

1) For most cases, we do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. We do not accept responsibility for collecting your insurance claim or for negotiating a settlement of a disputed claim. However, we will gladly prepare a doctor's statement of charges for you to submit to your insurance carrier for reimbursement.
2) If you need to cancel an appointment, *please inform us **at least 24 hours** in advance to avoid a full charge of service*. A missed appointment will also be charged at full fee.
3) There is a service charge of $35 for every returned check.
4) There is a service charge of $2 per bag for returned herbs. (Raw Herbs are not returnable)
5) I authorize the release of any medical records and/or any other necessary information to process a claim with my insurance.
6) TCM Healing Center is in compliance with HIPPA law and regulations.

Fees	Initial Consultation	Acupuncture	Electric Acupuncture	Follow-up Herbal Consultation
Dr. Shiaoting Jing	$ 220.00	$ 150.00	$ 165.00	$ 100.00
Dr. Biao Lu	$ 160.00	$ 145.00	$ 165.00	$ 85.00
Dr. Miao Miao	$ 130.00	$ 120.00	$ 135.00	$ 85.00

☐ I have read and agree to the terms of the preceding paragraphs. All information presented is true to the best of my knowledge. Checking this box and entering my full name below means this document is signed.

Patient's Signature _____ Date _____

Patient's Name: Date:

PATIENT MEDICAL HISTORY

The following list of symptoms you may or may not currently have.

- Individually rate each symptom's severity by marking 1-5 (5 being the worst).
- Leave blank if N/A.
- ✓ any symptoms you have had in the past.

Cardiovascular
(TCM: Heart/Small Intestine)

- [✓] Heart palpitations
- [ ] Chest pain or pressure
- [ ] Dizziness
- [ ] Irregular heart beat
- [ ] Shortness of breath
- [ ] High blood pressure
- [ ] Leg cramps
- [ ] Lack of joy in life
- [ ] Craving / aversion to bitter food
- [ ] Cold hands and feet
- [ ] Heaviness anywhere in the body
- [ ] Hard to wake up in the morning
- [ ] Edema / swelling
- [ ] Bad breath
- [ ] Tendency towards hypoglycemia
- [ ] Muscle fatigue
- [ ] Difficulty digesting oily food
- [ ] Tendency to become obsessive
- [ ] Craving / aversion to sweets

Respiratory (TCM: Lung/Large Intestine)

- [ ] Dry cough
- [ ] Cough with sputum
- [ ] Cough with blood
- [ ] Sore throat
- [ ] Nasal problems
- [ ] Nasal discharge
- [ ] Poor sense of smell
- [ ] Nose bleeds
- [ ] Asthma or wheezing
- [ ] Pneumonia
- [ ] Hay-fever
- [ ] Bronchitis
- [ ] Allergies
- [ ] Low resistance to colds or flu
- [ ] Low physical stamina
- [ ] Itchy skin
- [ ] Grief / Sadness
- [ ] Craving / Aversion to spicy foods

Genitourinary (TCM: Kidney/Urinary Bladder)

- [ ] Frequent urination
- [ ] Painful urination
- [ ] Bloody discharge from anis
- [ ] Incontinence
- [ ] Pain in the genital area
- [ ] Decreased sex drive / excessive sex drive
- [ ] Kidney stone
- [ ] Kidney failure
- [ ] Neuritis
- [ ] Weakness / low back pain
- [ ] Achy bones
- [ ] Poor memory
- [ ] Hair loss
- [ ] Hearing problems
- [ ] Ringing in ears
- [ ] Craving / aversion to salty foods

Gastrointestinal (TCM: Spleen/Stomach)

- [ ] Indigestion
- [ ] Bloating
- [ ] Gas / belching
- [ ] Abdominal pain or cramps
- [ ] Gall stones
- [ ] Constipation
- [ ] Diarrhea
- [ ] Black stool
- [ ] Hemorrhoids
- [ ] Excessive appetite
- [ ] Decreased appetite
- [ ] Anorexia
- [ ] Nausea and vomiting
- [ ] Colitis or Diverticulitis
- [ ] Heartburn
- [ ] Acid reflux
- [ ] Fatigue

TCM: Liver / Gallbladder

- [ ] Jaundice
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Cirrhosis
- [ ] Irritability
- [ ] Depression
- [ ] Headache / migraine
- [ ] Visual problems
- [ ] Red eyes
- [ ] Itchy eyes
- [ ] Clenching of teeth at night (TMJ)
- [ ] Muscle twitching
- [ ] Joint tightness / stiffness
- [ ] Soft / brittle nails
- [ ] Craving / aversion to sour food

Muscular-Skeletal

- [ ] Back pain
- [ ] Neck pain
- [ ] Arthritis
- [ ] Muscle pain or cramps
- [ ] Painful joints
- [ ] Disc problem
- [ ] Epilepsy
- [ ] Scoliosis

Males Only

- [ ] Prostate problems
- [ ] Pain in testicles
- [ ] Low sperm count

Females Only

- [ ] Menstrual pain
- [ ] Irregular menstrual cycle
- [ ] Lower back / sacrum ache
- [ ] Swelling or pain in the breast
- [ ] Heavy bleeding
- [ ] Vaginal discharge (excessive)
- [ ] Vaginal yeast infection
- [ ] Vaginal dryness
- [ ] Endometriosis
- [ ] Polycystic ovary syndrome
- [ ] Uterine Myoma
- [ ] HPV +
- [ ] Genital warts
- [ ] Breast cancer
- [ ] Ovarian cancer
- [ ] Osteoporosis
- [ ] Night sweats / hot flashes
- [ ] Menopause / perimenopause

Miscellaneous

- [ ] Psoriasis
- [ ] Eczema
- [ ] Skin rash
- [ ] Lupus
- [ ] Rheumatoid arthritis
- [ ] Parkinson's syndrome
- [ ] Reynard's syndrome
- [ ] Diabetes
- [ ] Multiple sclerosis
- [ ] Varicose veins
- [ ] Blood clotting
- [ ] Cancer
- [ ] Genital herpes
- [ ] HIV +

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Under the health Insurance Portability and Accountability Act (HIPAA) of July 1, 1997, it is our legal duty to safeguard your protected health information (PHI). If a person has been insured for the past 12 months, a new insurance company cannot refuse to cover the person and cannot impose pre-existing conditions or a waiting period before providing coverage.

Our office respects your right to privacy. Information regarding the reason you sought therapy with us is strictly confidential and is used to communicate with your doctor, case worker, and claims representative for payment from your insurer and the Dept. of Labor & Industrial Relation (for Worker's Comp. claims) or for pre-authorization. Should any other official party request information about you, we would need to see your signed authorization to release information.

All other uses of the protected health information will be made only with your authorization and you have the right to revoke such authorization at any time. If a claim is unpaid due to the unavailability of the requested information, then you will be responsible for payment to us.

Evaluation reports, treatment plans, copy of prescriptions for the therapy and progress notes are generally mailed to the insurer (case worker) to carry out treatment and receive payment for services.

In settlement cases, your attorney can request copies of your file with a written authorization from you. The other party's attorney will generally subpoena your records. A **subpoena** is a legal demand with which we must comply.

All therapies are on an appointment basis.

If you have questions regarding other alternatives, we can give you general information. Your primary care physician will determine what program for you to follow.

Marketing:
TCM Healing Center will not use or disclose your PHI for marketing communication without your written authorization. This office may send birthday cards, thank you cards, notice of clinic events, newsletters, and/or appointment reminders.

Disclosure:
TCM Healing Center may use or disclose your PHI without your consent or authorization when required by law.

Patient Rights Notice of Privacy Policy:

- A patient/client may request restrictions on certain uses and disclosure of the protected information.
- You have the right to receive confidential communication of protected health information.
- You have the right to inspect and request a copy of protected health information and medical records.
- You have the right to amend protected information (there is an appeals process).
- You have the right to an accounting of disclosures of protected health information.

TCM Healing Center reserves the right to change our privacy policy in accordance with HIPAA, and would send such notice to your last known address if your case is involved. This is in compliance with HIPAA following April 14, 2003 except in emergency treatment situations.

If you have questions about this notice or any complaints about our privacy practice please contact our office.

☐ I have read and understood my rights regarding privacy of information, and under which conditions this information is shared with others, so that I may receive therapy and claims can be made on my behalf (only for insurance purposes).

☐ I acknowledge that I have received the "Patient's Rights" and I will _____, will not _____ take a copy with me. ____initials

☐ By checking this box and entering my full name below means this document is signed.

Signature: _____ Date: _____
Patient or Patient's personal representative

Print Name: _____
Patient or Patient's personal representative

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PATIENT CARE FINANCIAL AGREEMENT

Thank you for choosing TCM Healing Center for your health care needs. We are committed to your improved health by providing appropriate, high quality, comprehensive family health care. While our intension is to assist you, it is your responsibility to ensure that all services rendered by TCM Healing Center on your behalf are paid in full. In order to understand our Financial Policies we have listed below our financial requirements.

1. Patient without Insurance Coverage:

Payment at the time of services is required. Cash, check, and credit cards are accepted payment methods.

2. Patient with Insurance Coverage:

We may be an out-of-network provider with your insurance carrier. You will be expected to pay at the time service is rendered.

- If you provide us with your insurance information, every 3 visits we will print out an insurance form that you must sign and submit yourself to your insurance company. Your insurance company will reimburse you directly for any amount that is covered by your plan.
- Any insurance checks that might be paid to our office in error will be credited to your account promptly or returned to your insurance company for reissue in your name.

3. Workers' Compensation Claims:

Treatment will be provided with a workers' compensation claim approval. If your employer or their insurance carrier denies your claim, you will be held financially responsible for all charges incurred for services rendered on your behalf. Any quotes given regarding treatment are cash rates – insurance may be billed differently.

4. Auto Injury Claims:

Treatment will be billed to the MedPay portion of your auto insurance policy. If your insurance carrier denies your claim due to exhausted benefits or any other reason, you will be held financially responsible for all charges incurred for services rendered on your behalf. No liens will be accepted. Any quotes given regarding treatment are cash rates – insurance may be billed differently.

I acknowledge that I have read an understood the above information. I understand I am financially responsible (regardless of insurance coverage) for any and all charges incurred from services provided. By checking this box and entering my full name below means this document is signed.

☐ Signature: _____ Print: _____ Date: _____

For our protection, we ask that you complete the following authorization, especially for Work's Comp claims, auto insurance claims, and direct billing cases. Please note that NO charges will be billed to this account unless we are unable to resolve outstanding balances with you directly. All credit card information is safeguarded and confidential. We appreciate your cooperation.

I hereby authorize T.C.M Healing Center, Inc. or his agents/employees to bill my credit card for amounts unpaid.
*Please note that there will be an additional $1.00 fee for authorizing credit card on file to be used after every visit.

Print name as it appears on credit card: _____

Card Number: _____ Expiration Date: _____

CVV: _____ Billing Zip Code: _____

Signature: _____ Date: _____