elemental medicine
Chiropractic, Acupuncture & Massage

2915 SE Belmont St., # 1
Portland, OR 97214
503.505.9677
elementalmedicinepdx.com

Confidential Patient Health Questionnaire

Name_____ Date of Birth _____ Today's Date_____
Address_____
Phone (home)_____ (cell)_____
Email_____

Is it all right to leave a message about your care at these numbers? Yes / No

Would you like to receive our newsletter/special offers by email? Yes / No

Emergency Contact _____
Relationship & Phone # _____

Physician _____ Phone # _____

How did you hear about Elemental Medicine? _____

Please list the health concerns you would like to address in order of importance:

1. _____Date of onset:_____
2. _____Date of onset:_____
3. _____Date of onset:_____

LIFESTYLE

	None	A little	Some	A lot		None	A little	Some	A lot
Fruits & veggies					Soda				
Meat					Caffeine				
Dairy					Sweets				
Fast Food					Alcohol				
Water					Tobacco				

What is your current level of stress? ☐ Little to none ☐ Minimal ☐ Moderate ☐ Severe

What is your current level of exercise? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

Please describe your exercise_____

What is your current occupation?_____How many hours/week:_____

Do you enjoy your work? Y / N Why? _____

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Please list all medications/supplements/vitamins you are currently taking:

Name / Dosage Reason For How Long

Please list all surgeries, hospitalizations, illnesses and major accidents and when they occurred:

Please list all Diseases or Conditions that you are currently diagnosed with(and the date of diagnosis) or believe you may have:

Please list any allergies you have and your response to them (medications, foods, animals, environmental substances, etc.):

Family health history: ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Stroke ☐ Mental Health Issues ☐ Cancer (type)

Are you or might you currently be pregnant? Y / N
Do you have a pacemaker? Y / N Heart Murmur? Y / N
Do you have a history of seizures? Y / N Fainting? Y/ N

Chronic Infections, Please check all that apply:
☐ Tuberculosis ☐ Hepatitis A/B/C ☐ STD _____
☐ HIV ☐ AIDS ☐ Other _____

In the event that you need to cancel or re-schedule an appointment, kindly give 24 hours notice. A $30 fee will be assessed with less than 24 hours notice.

Patient Signature: Date:

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Privacy Policy

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.

We care about our patient's privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations

We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers compensation, and law enforcement. You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. *You have the right to request a restriction of your protected health information.* The physician is not required to agree to a restriction that you request. *You have the right to request that we communicate with you about your medical information by different means or to a different location.* This request must be made in writing. *You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.* We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. *You may request a copy of this notice.*

Questions or Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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Consent to Treat

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Elemental Medicine. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion/Cupping: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that acupuncture is a generally safe treatment; however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks include spontaneous miscarriage, nerve damage and organ puncture, including that of the lung (pneumothorax). Bruising is a common side effect of cupping. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician and I have carefully read or have had read to me and understand all of the above information, have had an opportunity to ask questions, and am fully aware of what I am signing. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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Acknowledgement and Understanding of Financial Policy

Please initial each item below. If you have questions, do not hesitate to ask.

_____ I hereby authorize Courtney Giordano, LAc to provide Acupuncture Services for me.

_____ I understand that full payment is due at time services are rendered unless prior arrangements have been made.

_____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Courtney Giordano at Elemental Medicine.

_____ After verification of insurance benefits, Elemental Medicine will accept payment directly from your carrier. **Your insurance is an agreement between you and your insurance company. Elemental Medicine does not promise that your insurance company will pay all charges relative to your care even after verification has been made. Therefore, all charges disputed by your carrier will be your personal responsibility, to be paid in full by you no more than 90 days from date of notification from your carrier.**

_____ I agree to pay all Uncovered Services at the time of the visit (i.e. deductible, co-Payment, co-insurance etc.)

_____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_____ I hereby assign all Acupuncture benefits, including major medical benefits to which I am entitled, Medicare, Private insurance, and all other health plans to Elemental Medicine, 2915 SE Belmont St, Suite 1, Portland, OR 97214.

_____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

_____ A $15 returned check fee will be assessed for any personal checks that are denied for insufficient funds. This fee will be due at the time of the next visit or 10 days after denial of the check, whichever comes first.

_____ _____
Patient Name / Patient Signature Date

_____ _____
Guarantor Signature Relationship to Patient

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