

Thanks for visiting our Clinic. Below are very Important questions for diagnosis condition. Please fill out the blank.

Patient Information										
Name			Date			Date of Birth				
Gender		M	F	Blood Type		Marital Status		Single	Married	Phone#
E-mail			Occupation			Cell#				
Address						State:		Zip:		
How do you know this clinic?				Referral (Doctor):			Google:			
				Friends:			Other:			
Medical History										
Medical Condition		<input type="checkbox"/>	Hypertention		<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	Hepatitis	
		<input type="checkbox"/>	Hyperlipidemia		<input type="checkbox"/>	Gastritis		<input type="checkbox"/>	esophagitis	
		<input type="checkbox"/>	Osteoporosis		<input type="checkbox"/>	Cirrhosis		<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	gout		<input type="checkbox"/>	Stomach Ulcer		<input type="checkbox"/>	Thyroid Disease		<input type="checkbox"/>	Other:
Do you have any allergy or get frequent colds?						<input type="checkbox"/>	Yes		<input type="checkbox"/>	No
Allergy		Yes () No () If yes :								
Family Medical History										
Medication										
Please list any medication being used:										
Complaints										
Please identify your major health concerns										
Have you been given a diagnosis for these problems?										
How long have you had this problem?										
General (Please check all that apply)					Head, Eyes, Ears, Nose, and Throat					
<input type="checkbox"/>	Poor Appetite		<input type="checkbox"/>	Weakness		<input type="checkbox"/>	Low Energy		<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Hearing Loss		<input type="checkbox"/>	Fever		<input type="checkbox"/>	Chills		<input type="checkbox"/>	Ear Ringing
<input type="checkbox"/>	Easy to Bruise		<input type="checkbox"/>	Sweat Easily		<input type="checkbox"/>	Poor Balance		<input type="checkbox"/>	Night Blindness
<input type="checkbox"/>	Strong Thirst		<input type="checkbox"/>	Poor Sleep		<input type="checkbox"/>	Tremors		<input type="checkbox"/>	Lurry Vision
<input type="checkbox"/>	Puffiness		<input type="checkbox"/>	Swelling		<input type="checkbox"/>	Weight Loss		<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Night Sweats		<input type="checkbox"/>	Cravings		<input type="checkbox"/>	Weight Gain		<input type="checkbox"/>	Poor Hearing
<input type="checkbox"/>	Poor Appetite		<input type="checkbox"/>	Fatigue		<input type="checkbox"/>	Other:		<input type="checkbox"/>	TMJ Pain
<input type="checkbox"/>	Cough		<input type="checkbox"/>	Bronchitis		<input type="checkbox"/>	Difficulty Breathing		<input type="checkbox"/>	Night Blindness
<input type="checkbox"/>	Skin Ulcers		<input type="checkbox"/>	Eczema		<input type="checkbox"/>	Hair Loss		<input type="checkbox"/>	Coughing Up Blood
<input type="checkbox"/>	Hives		<input type="checkbox"/>	Pimples		<input type="checkbox"/>	Recent Moles		<input type="checkbox"/>	Painful Breathing
Skin & Hair					Respiratory					
Cardiovascular					Gastro-Intestinal					
<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>	Lightheadedness		<input type="checkbox"/>	Palpitations		<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Low Blood Pressure		<input type="checkbox"/>	Phlebitis		<input type="checkbox"/>	Chest Pain		<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Cold Hands or Feet		<input type="checkbox"/>	Blood Clots		<input type="checkbox"/>	Fainting		<input type="checkbox"/>	Rectal Pain
<input type="checkbox"/>	Swelling of Hands		<input type="checkbox"/>	Swelling of Feet		<input type="checkbox"/>			<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Use		<input type="checkbox"/>	Vomiting		<input type="checkbox"/>	Intestinal Gas		<input type="checkbox"/>	Chronic Laxative
<input type="checkbox"/>	Bad Breath		<input type="checkbox"/>	Diarrhea		<input type="checkbox"/>	Belching		<input type="checkbox"/>	Blood in Stools
<input type="checkbox"/>	Indigestion		<input type="checkbox"/>	Ulcers		<input type="checkbox"/>			<input type="checkbox"/>	Abdominal Pain

Caution

If you are planning for a general check up, stop taking the herbal medicine at least 3 days prior to the checking date.

If you get any allergic response, stop the herbal medicine and get treatment first. It is usually ok to continue but some people can have continuous allergic response. If the symptoms does not get better, stop the herbal medicine completely. (In this cas, we will refund for the remaining herbal medicine)

If you get any abnormal vaginal bleeding, stop the herbal medicine and get treatment first. If the symptom is severe stop, the herbal medicine completely. (In this case, we will refund for the remaining herbal medicine)

Female Only		
Pregnant	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	do you have any plan for pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	You should not get pregnant nor take pills during pregnancy.	<input type="checkbox"/> Understood
Period	No Menstruation	<input type="checkbox"/> since:
	Cycle of Menstruation	<input type="checkbox"/> 26-30 Days <input type="checkbox"/> 31-40 Days <input type="checkbox"/> 41 Days <input type="checkbox"/> Every _____ Days
	Is it regular or irregular?	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular
	Any blood clots?	<input type="checkbox"/> No <input type="checkbox"/> Little <input type="checkbox"/> A lot
	What is the color of it?	<input type="checkbox"/> Bright Red <input type="checkbox"/> Brown <input type="checkbox"/> Dark Red
	How long does it last?	_____ Days
	Do you have any discharge?	<input type="checkbox"/> No <input type="checkbox"/> Little <input type="checkbox"/> A lot <input type="checkbox"/> All the time
	Do you have any abdominal cramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Last date of period	_____ / _____ / _____

Modu Acupuncture, P.C.

221 S. Middletown Road, Nanuet, NY 10954
Tel: 917-902-5995. Email: cs@moduacupuncture.com

Patient Advisory to Consult A Physician

Modu Acupuncture, P.C. is committed to your health and well-being. While Traditional Eastern Medicine has a great deal to offer as a health care system, it cannot entirely replace the services available from biomedical practitioners. Therefore, it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture or herbal treatment.

To comply with Article 160, Section 8211.1 (b) of New York State Education law, please read and sign the following statement:

I, _____ (print name) do affirm that I have been advised by Modu Acupuncture, P.C. and their licensed acupuncturists, to consult a physician regarding the condition or conditions for which I seek acupuncture treatment.

Patient's (or Guardian's) Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I, _____ (print name) do affirm that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also have read and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's (or Guardian's) Signature: _____ Date: _____

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na(Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, as, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the 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 results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: _____

PATIENT SIGNATURE _____
(Or Patient Representative) Date (Indicate relationship if signing for patient)

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Financial Agreement and Health Insurance

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:

Many insurance policies do cover acupuncture treatment but this office makes no representation that your does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture treatment. Because of the variance from on insurance policy to another, as well as any unpaid balance in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangement:

We require that you Co-pay \$ amount towards today’s charge. Your full portion of the bill is expected to be when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 1.5% of applied per month.

Assignment of Benefits:

By signing this form, you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full, the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information:

By signing this form, you are also authorizing this office upon request form your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request of government benefits either to myself or to the party who accept assignment, namely this office.

Voluntary Termination of Care:

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will be responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again, we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above

Initial: _____

Signature of Patient / Guardian: _____ Date: _____

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ASSIGNMENT OF BENEFITS

Date: _____

Patient's Name: _____

Patient's Address: _____

Insurance Company: _____

ID Number: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interest to Modu Acupuncture, P.C., hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New York.
2. I, the patient, do hereby acknowledge that I have an obligation to comply with reasonable requests of the insurance carrier. I, the patient, do further agree to cooperate with the attorney selected by the medical provider.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorized my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies due on my account, or, the same to be deducted from any settlement made on my behalf.
5. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.
6. The provider will comply with the decision point review requests as required by the plan.
7. The provider shall submit disputes to Personal Injury Protection dispute arbitration if the decision point review plan requires same.
8. In the event it is determined by an Arbitrator and/or Court of Law that the imposition of a co-payment penalty was as a result of the medical providers failure to pre-certify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such co-payment penalty.

Patient's Printed Name / Guardian: _____

Signature: _____

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Covid-19 Virus Screening

If you have been exposed to a communicable disease, you may spread the disease to staff or other patients, and clients in the office of Modu Acupuncture, P.C. Therefore, prior to each appointment, we will be asking the following question to reduce the chances of transmission. Thank you for your cooperation.

First Name: _____.

Last Name: _____.

Phone Number: _____.

Address: _____.

Date of Birth: _____.

Gender: Male () Female ()

Do you or anyone you have recently been in contact with have any of the following symptoms? Check all that apply.

- 1. Fever? (Defined as over 99.8 F degree or above ())
- 2. Cough or sore throat, congestion or runny nose? ()
- 3. Shortness of breath or trouble breathing? ()
- 4. Fatigue, muscle or body ache, headaches, or new loss of taste or smell? ()
- 5. Nausea or Vomiting? ()
- 6. None of the Above ()

Have you or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 virus or any other communicable disease? Yes () / No ()

I understand that if the answer to any of the question is yes, I may be asked to reschedule my appointment to a later date. Yes (), I understand.

I attest that I have answered all the above questions truthfully and to the best of my knowledge, by signing on this document.

Signature: _____ Date: _____.

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Cancellation Policy

If you do not give us a 24-hour notice to cancel your appointment,
There will be a \$20 (Twenty dollars) Charge.

You will be charged \$40 for not showing on your appointment.

I read and agree to the cancellation policy of this office of Modu Acupuncture, P.C.

Patient's (or guardian's) Name: _____.

Patient's (or guardian's) Signature: _____.

Date: _____.