Grace Acupuncture and Herbs, PLLC
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住所氏名などはローマ字、または英語でご記入ください。

姓:	名:	性別：男・女
住所:		
市:	州:	Zip:
電話番号:		
メールアドレス:		
生年月日:		年齢:
配偶者の有無:		
緊急時の連絡先:	御関係:	電話番号:
主治医:	電話番号:	
どのようにして当鍼灸院を知りましたか?		

あなたのプライバシーを守ることを約束しますが、時折 E メールやテキストメッセージ、郵便をお送りすることがございます。これらは大事なアップデートの場合もあります。
これらを送ることを許可しますか:

E メール: □ はい □ いいえ
テキスト: □ はい □ いいえ
郵便: □ はい □ いいえ

本日、当鍼灸院を訪れた主な理由:

_____

_____

日常生活にどれほどの支障がありますか:

_____

以下のうち当てはまる項目を☑してください：

- ❑ 心臓ペースメーカー
- ❑ 発作性疾患
- ❑ 出血性障害、又は抗凝血剤の服用
- ❑ 失神性疾患
- ❑ 高血圧
- ❑ 妊娠している、又はその可能性がある
- ❑ HIV/AIDS 陽性
- ❑ 肝炎
- ❑ 結核
- ❑ その他：_____

幼少期の主要な病気、成人後の主要な病気:

過去に大きな怪我、又は事故、手術などございましたか:

大病を患っている(た)肉親、その病名をリストしてください:

現在服用している薬、ハーブやサプリメントなどをリストしてください:

職業:

適度な運動はしていますか？
その内容と頻度:

食事制限はありますか？その内容は？

週に摂取する糖分(デザート・お菓子など)の量:

週に摂取する乳製品の量:

喫煙者ですか？たばこの一週間の摂取量:

週に摂取するカフェインの量(コーヒー、緑茶や紅茶、コーラなど含む):

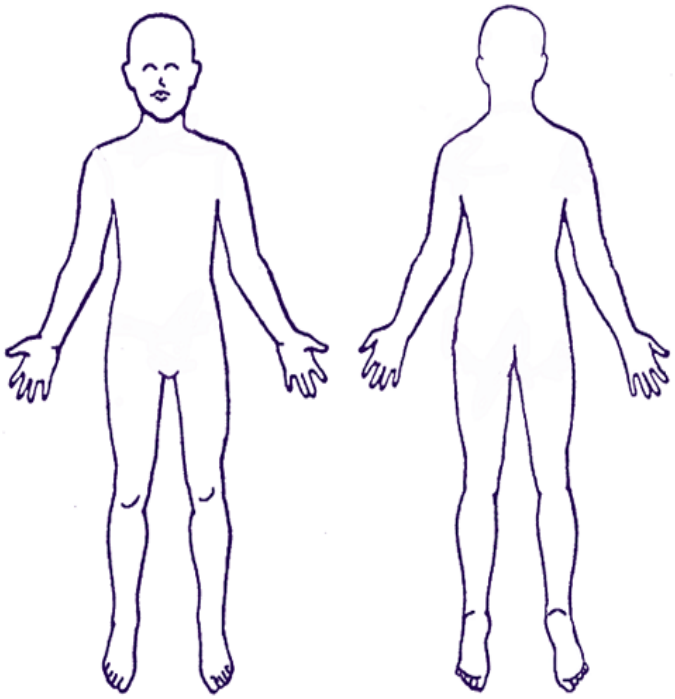
週にどれだけアルコール飲料を飲んでいますか？

脱法薬物、レクリエーションドラッグの有無と使用頻度:

アレルギー反応を起こす物質:

痛みや不快感のある場所を下記の記号を使って書き込んでください。痛みの度合い(1(ほとんど痛くない)～10(非常に痛い))を示してください。

XXX　鋭い、または刺すような痛み
PPP　ちくちくするような痺れ
NNN　麻痺したような痺れ
DDD　鈍い痛み



症状リスト
現在体験している症状に☑をいれてください。

□ 手足が冷たい
□ 疲労感
□ 午後に体がほてる、又は紅潮する
□ 手足又は胸がほてる
□ 寝汗をかく
□ よく風邪をひく
□ 日中に発汗しやすい
□ 眩暈がする
□ 飛蚊症

□ 動悸
□ 舌にできものがある
□ 気が休まらない
□ 不安症
□ 胸部痛
□ 不眠症

□ 咳
□ 鼻づまり
□ 口、喉、鼻、又は皮膚が乾燥している
□ 花粉症または食物アレルギー
□ 寒気や発熱
□ 首や肩こり
□ のどが痛い
□ 呼吸困難

□ 食欲がない
□ 軟便
□ 便秘
□ 食後に膨満感がある
□ 食後に眠くなる
□ (診断済の)臓器脱出症
□ あざができやすい
□ 体が全体的に重く感じる
□ 意識がぼうっとする、又は気が重い
□ 手足が腫れる
□ 食後に胸焼けがする
□ 口臭がひどい
□ 食欲が大きい
□ 口内炎
□ 歯茎が腫れる、又は出血する
□ げっぷが出る、又は胸焼けがする
□ 腹痛

□ 吐き気やおう吐
□ 下痢と便秘が交互にある
□ 胸が苦しい又は締め付ける感覚がある
□ 口の中で苦い味がする
□ 目が血走る、又は乾燥する
□ 怒りっぽい
□ 皮膚に発疹がある
□ 頭痛
□ 手足がしびれる
□ 筋肉が痙攣、又は硬直する
□ てんかん性発作や痙攣性発作がある
□ 膝が痛い、冷たい、または弱い
□ 腰痛
□ 頻尿
□ 夜に何度もトイレに行く
□ 尿を漏らすことがある
□ 記憶障害、または記憶力が悪い
□ 髪が抜ける
□ 耳鳴りがする

尿は:
□ ふつう　　□ 透明
□ 濃い黄色　　□ 赤っぽい
□ 曇っている　□ 少ない
□ 悪臭がする
□ 焼けるような感覚
□ 痛い
□ 出が悪い　　□ すぐに行きたくなる

リビドー(性欲)は:
□ ふつう　　□ 低い　　□ 高い

女性のみ:

❑ 現在妊娠していますか？
□ はい　　□ いいえ

❑ 子供の人数:_____

❑ 妊娠の回数:_____

❑ 初潮の年齢:_____

❑ 閉経の年齢:_____

❑ 月経リズムは規則的ですか？
□ はい　　□ いいえ

a. 平均的な月経日数:____

b. 月経血の量は:
□ ふつう　　□ 重い　　□ 軽い

c. 月経血の色は:
□ 赤　　□ 濃い　　□ 紫っぽい
□ 明るい茶色 □ 茶色

d. 生理中に以下の症状はありますか

□ 血餅(血の塊がある)
□ 生理痛
□ 吐き気
□ 乳房が腫れる
□ 感情的になる
□ 生理中でないときに出血する
□ 生理中でないときに膣分泌物が出る

e. 避妊薬:_____

男性のみ:

□ 陰茎分泌物がある

□ 睾丸の痛み、又は腫れ

□ 射精障害がある

□ 勃起障害がある

サイン _____

日付_____

OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay

Private Pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**

_____ Insurance Billing (Medical or Auto Insurance)

Regarding insurance:
We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Grace Acupuncture and Herbs will submit my claim for me to my insurance company. Although Grace Acupuncture and Herbs verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid.** I further understand that any unpaid balance **over 90 days**, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Grace Acupuncture and Herbs. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Person Authorized to Consent Date

NOTICE OF PRIVACY POLICIES

Grace Acupuncture and Herbs, PLLC

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law..

Patient Rights

Upon written request you have the right to access, review or receive copies of your healthcare records.

Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.

You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

You have the right to request that we amend your Protected Health Information; the request must be in writing.

You have a right to receive all notices in writing.

If you have questions, complaints or want more information please contact Lisa Megumi Boyle, L.Ac. at telephone: (425) 208-1972.

You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building
Washington, DC 20201

Kneady Body & Feet Association Privacy Notice

Clinic Policy—We are a cooperation of multiple businesses each with state licensing and insurance. We each operate a contracted business in cooperation with Kneady Body & Feet Massage LLC.

We are a HIPAA compliant office. Your privacy is important to us. Your personal information will be protected within our clinic and not shared with anyone outside of Kneady Body & Feet Association.

Patient Responsibility: You agree to communicate with your practitioner immediately about any conditions or techniques during your work together that do not enhance your well-being. Failure to communicate all of your medical conditions may further damage your health. Any actions that may be construed as sexual advances or unsafe behavior will be reported to the police station without discussion.

Cancellations and No Shows—In effort to provide all of our clients with outstanding service, 24 hours notice is required for all cancellation notices and rescheduling requests. Payments are due upon receipt of the invoice.

I have read and understand the privacy policies of Grace Acupuncture and Herbs and Kneady Body & Feet Wellness Center. I understand omitting any information could lead to further physical/emotional complications after receiving any type of bodywork. I acknowledge that my practitioner is not licensed to diagnose any condition and it is my sole responsibility to ensure the safety of my health.

_____ _____

Signature Date