Alaina Edgemon L.Ap, D.O.M
1215 W Baker St | Plant City, FL, 33563 | 813-754-2273

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender: ( ) Male ( ) Female** **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

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Contact and Health Information

Patient Name:_____ **Date:**_____

_____

Home Address ***City*** ***State*** ***Zip***

Home Phone:_____ **Cell Phone:**_____

Age:_____ **DOB:**___/___/_____ **Marital Status (circle one):** M S W D

Occupation:_____ **Employer:**_____

Name of Nearest Relative:_____ **Phone:**_____

Family Medical Doctor:_____ **Phone:**_____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? (circle one) YES NO

Have you ever received acupuncture before? YES NO

If Yes, for what condition? _____Date of service:_____

Are you currently doing any other modalities such as:

Chiropractic Physical Therapy Pain Management Massage Other: _____

Do you have any implants such as:

Pacemaker Insulin Pump Breast Implants Spinal Stimulator Other: _____

How were you referred to our office?_____

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History of Present and Past Illness

Chief Complaint (purpose of this appointment):_____

Date symptoms appeared or accident happened: ____/____/_____

Cause (circle one): Auto Work Other **Describe:**_____

Have you ever had the same or similar condition? YES NO

If yes, when and describe:_____

Days lost from work:_____ **Date of last Physical Exam**____/____/_____

Do you have a history of stroke or hypertension? (select one) YES____ **NO**____

List major illnesses, injuries, falls, auto accidents, surgeries, or childbirths, including dates:_____

_____

Have you been treated for any health condition by a physician in the last year? YES____ **NO**____

If yes, describe:_____

Do you have allergies of any kind? YES____ **NO**____

If yes, describe:_____

Do you have any congenital (genetic) conditions? YES____ **NO**____

If yes, describe:_____

WOMEN: Are you pregnant? YES____ **No**____

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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(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effect 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. 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 in herbs are nausea, gas, 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.

I do not expect the clinical staff to be able to anticipate and explain all the possible risks and complications of treatment, and 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 patent records and lab reports, but all of 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.

PRINTED NAME_____

PATIENTSIGNATURE:_____DATE:_____
(Or Patient Representative)

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Notice of Privacy Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice are subject to change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information is used or released for treatment, payment or healthcare operations. We are not required to agree to the restrictions, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except if we have already made a release on your prior consent.

Patient Signature_____

Please Print Name_____

Date_____

Witness_____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Re:_____

Patient:_____

Employer:_____

Claim/Group #:_____

Insured SSN#/ID#_____

I hereby instruct and direct payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Dr. Alaina Edgemon L.Ap, D.O.M.
1215 W Baker St, Plant City, FL, 33563
813-756-8505

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and about this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Dr. Alaina Edgemon L.Ap, D.O.M.
1215 W Baker St, Plant City, FL, 33563
813-756-8505

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Alaina Edgemon L.Ap, D.O.M
1215 W Baker St | Plant City, FL, 33563 | 813-754-2273

_____ _____
Insured Date