Meng's Acupuncture Medical Center Inc

4060 PGA Blvd., Suite 202, Palm Beach Gardens, FL 33410
561-656-0717
www.mengsacupunture.com, drmengweightloss@yahoo.com

Personal Information

Name (Last, First, Middle)_____Date_____

Home Address_____

City_____State_____Zip_____

Telephone_____(O)_____(C)_____

Birth date (M/D/Y)_____Age_____Gender M F

Emergency Contact: Name:_____Contact Phone:_____

Occupation_____Employer_____Phone_____

Email_____

Please Circle Martial Status: Single Married Divorced Widowed Children

Please circle if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):
Hepatitis HIV High Blood Pressure Seizures Pacemaker

Blood-Thinning Meds Pregnancy

Main reason(s) for seeking Acupuncture_____

Life style (please circle) Tobacco Alcohol Recreational Drugs Caffeinated Drinks

Current Medication, reason for:_____

Past Medical history and surgeries:_____

Allergies:_____

Does any member of your family have Diabetes, High Blood Pressure, Cancer, Heart Condition, Asthma, Hay Fever, Excessive Bleeding or any Contagious Disease?

_____

Are there any factors in your physical condition not already covered that you have questions about?

_____

NO REFUNDS / RETURNS ON HERBS

_____

Signature: (Patient or Guardian of Minor) **Date**

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How did you hear about Meng's Acupuncture Medical Center?

- My Doctor_____
- Family Member_____
- Friend_____
- Mass Media (TV, radio)
- Around the Gardens
- Other_____
- SF Health & Wellness
- Internet/Website
- Money Saver (PBG)
- Money Saver (Jupiter)
- Natural Awakening

Thank you!

Patient Acknowledgement $ Agreement

The undersigned Patient hereby agrees and acknowledges the following practice and policies of Meng's Acupuncture Medical Center:

1. Meng's Acupuncture Medical Center accepts many, but not all, forms of Insurance. If the Patient chooses to have charges for treatments directly submitted to their insurance company by Meng's Acupuncture Medical Center then they understand that the charges will be detailed and coded per the contract with the insurance company. We are contracted with certain insurance companies and the fees are non-negotiable. These charges will be listed as individual services and will be detailed according to standard practices. It should be noted that self-pay individuals are not subject to this pricing structure.
2. Meng's Acupuncture Medical center will make every effort to provide complete information about the Insurance company benefits; however, it is ultimately the Patient's responsibility to know and understand their insurance company benefits. Any fees for treatments and services rendered that are not covered by the insurance company will be the financial responsibility of the patient.
3. It is further understood and agreed that in the event any insurance payments intended for Meng's Acupuncture Medical Center are sent to the Patient, that the patient will immediately without delay forward those payments to Meng's Acupuncture Medical Center, as these payments are due to Meng's Acupuncture Medical center. Any failure by the Patient to forward these payments to Meng's Acupuncture Medical Center may result in collection activity including a notification to the credit bureaus as an outstanding debt for services rendered.

_____ _____

PATIENT SUGNATURE DATE

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Acupuncture and Herbs originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and medical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment. Payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Patient Signature _____ Date_____

Payment Policy

Fees: see fee schedule on the office wall
The patient is responsible for payment at time of service. It is the patient's responsibility to verify coverage of insurance benefits prior to your visit. Medicare, Medicaid, HMOs, and many insurance companies do not pay for the services of an acupuncturist. We do not bill directly to insurance companies for new patient. Itemized super-bills are available upon request for you to submit to your insurance company for reimbursement.

All supplements and supplies must be paid for in full at the time they are dispensed. Your insurance company will not pay for natural medicines.

Assignment is not accepted for personal injury cases for new patients. You are expected to pay your fees and collect reimbursement from your settlement. If you are an existing patient, we will be glad to review your case and determine what course of action would be best.

Patient Signature_____Date_____

Patient Informed Consent

In-compliance with section 468.326 Florida statures

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 named 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, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling, infra-red therapy. 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 be 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. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment; other side effect 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, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring from me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all 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 treatment 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.

I understand acupuncture treatment is a complement to and not substitute for western medical care. Certain conditions may best be addressed in partnership with my medical doctor or other health care provider. I understand that there is a worsening of my ailment or condition, or if a new ailment or condition arises that I should consult my medical doctor.

By voluntarily signing below, I show that the effect and nature of the procedure of acupuncture has been fully explained to me. I understand that in the practice of acupuncture, as well as in any other medical practice, no reputable practitioner can properly guarantee no risks or cure of a disease. I acknowledge that no guarantee or assurance has been made by anyone regarding the acupuncture procedure which I have herein requested and authorized an to which I hereby consent. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that I am free to withdraw this consent and discontinue participation of these procedures at any time.

I, _____, certify that I have read and understood
(Print Name)
the statements above. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any charges.

Signature (Patient or Guardian of Minor):_____Date:_____

Office signature:_____Date:_____

PLEASE MARK "X" IF YOU HAVE ANY OF THE FOLLOWING MEDICAL SYMPTOMS

RESPIRATORY & CIRULATORY SYMPTOMS

__Problem in Blood Vessels	__Chest Pain	__Asthma	__Hypertension
__Running Nose	__Buergers Disease	__Palpitation	__Hypotension
__Shortness of Breath	__Coughing	__Irregular Heart Beat	__Cold
__Excessive Sputum	__Bronchitis	__Coronary Heart Disease	__Influenza

DIGESTIVE & HEMOPOIETIC

__Nausea	__Stomachache	__Gastric Neurosis	__Jaundice
__Vomiting	__Abdominal Pain	__Chronic Gastritis	__Hepatitis
__Gas Distention	__Diarrhea	__Gastric ulcer	__Cirrhosis
__Hyperacidity	__Constipation	__Cholecystitis	__Anemia
__Excessive Hiccup	__Blood in Feces	__Gallstones	__Leukocytopenia
__Thrombocytopenic Purpura			

UNINARY AND REPRODUCTIVE SYSTEMS

__Frequent Urination	__Urinary Retention	__Polyuria	__Kidney Stone
__Urgent Micturition	__Dysuria	__Urethritis	__Emission
__Incontinent Urination	__Blood in urine	__Bladder Infection	__Impotence
__Enuresis	__Nocturia	__Chronic Nephritis	__Sexual Dysfunction
__Venereal Disease			

NERVOUS SYSTEM

__Dizziness	__Numbness of Limbs	__Stroke	__Anxiety
__Excessive Sweating	__Facial Spasm	__Hemiplegia	__Tension
__Insomnia	__Intercostal Neuralgia	__Palsy	__Depression
__Headache	__Trigeminal Neuralgia	__Sciatica	__Alcoholism
__Migraine	__Epilepsy	__Loss of Equilibrium	
__Use of Narcotics	__Schizophrenia	__Nervousness	__Stress Syndrome

MUSCULOSKELETAL SYSTEM

__Pain in Fingers __Pain in Ribs __Shoulder Arthritis __Leg Pain
__Wrist Pain __Pain in Spine __Tennis Elbow __Leg Cramps
__Arm and Hand Pain __Carpal Tunnel Syndrome __Neck Pain __Shoulder Pain
__Acute Lumbar Sprain __Neck Syndrome __Knee Arthritis __Ankle Sprain
__Chronic Lumbar Muscle Strain

SURGICAL AND SKIN DISEASES

__Hemorrhoid __Urticarial __Wart __Rashes
__Acute or Chronic Eczema __Acne __Psoriasis __Cutaneous Pruritus
__Acute or Chronic mastitis __Neurodermatitis __Erysipelas __Allergic Skin
__Thrombotic Phlegmasia __Loss of Hair __Shingles __Varicosis
__Herpes __ Anaphytactoid Purpura __Tuberculosis Lymphadenitis

GYNOCOLOGY

__Dysmenorrhea __Pelvic inflammation __Uterus Fibroid __Gravid Skin
__Amenorrhea __Vulvovaginitis __Ovarian Cyst __Infertility
__Irregular Menstruation __P.M.S. __Breast Cyst __Leucorrhea
__Menopause Syndrome __Vomiting During Pregnancy

METABOLISM, ENDOCRINE AND IMMUNE SYSTEMS

__Diabetes __Hyperglycemia __Hypothyroidism __Rheumatic Arthritis
__Gout __Hyperthyroidism __Arthritis __Obesity

EYE, EAR, NOSE and THROAT

__Myopia __Glaucoma __Sinusitis __T.M.J.
__Conjunctivitis __Acute/Chronic Pharyngitis __Hay Fever __Vertigo
__Cataract __Tonsillitis __Epiphora Tinnitus __Sore Throat
__Hordeolum __Allergic Rhinitis __Deficient Visual Ability

What kind of medications are you currently taking?

_____

Are you allergic? If so, what are you allergic to?

_____

Do you carry a cardiac pacemaker?

_____

Do you bleed or have blue marks on your skin? Easily?

_____

Have you been hospitalized in the past year? For what condition?

_____

(Females only): How often are your periods?

_____

How long does each one last?

_____

Color:	Dark	Light
Quantity:	Heavy	Light