

Woman's Health History:

Date of last gynecological exam: _____

- Have you ever had an abnormal PAP: YES NO
- Is there a chance you are pregnant: YES NO
- Do you use oral contraceptives: YES NO
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- At what age did your menstrual cycle start: _____
- At what age did your menstrual cycle stop: _____
- What is the date of your most recent period: _____
- How many days does your period last: _____
- How many days pass from the start of one period to the start of the next: _____
- Does this time vary by more than two days per cycle: YES NO
- Do you consistently have spotting for 2 or 3 days before your menses: YES NO
- Do you have blood clots or tissue in your menses: YES NO
- In general, how would you describe the color of your menses:
- FRESH RED
 - BRIGHT RED
 - DARK RED
 - PURPLISH
 - PALE
 - WATERY
- Do you experience any of the following before, during, or after your menses:
- ABDOMINAL PAIN
 - CRAMPING
 - LOW BACK PAIN
 - GENERAL BODY ACHES
 - HEADACHES
 - DEPRESSION
 - BREAST TENDERNESS
 - BREAST SWELLING
 - WATER RETENTION
 - FATIGUE
 - IRRITABILITY
 - ANXIETY
- Do you have unusual discharge or lactation from your nipples:
-

- Have you ever had a diagnosis of endometriosis: YES NO
- Have you ever had a diagnosis of polycystic ovarian syndrome: YES NO
- Have you ever had a diagnosis of uterine fibroids (myoma): YES NO
- Have you ever had a diagnosis of pelvic inflammatory disease: YES NO
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- Number of pregnancies: _____
- Number of births: _____
- Number of miscarriages/abortions: _____
- Was conceptions difficult: YES NO
- Did any health issues arise during any pregnancy / labor / delivery: YES NO
-

If you are currently trying to conceive, answer the following questions:

- How long have you been trying: _____
- Have you seen a western fertility specialist: YES NO
- If so, who: _____
- Do you track your ovulation: YES NO
- by: URINARY LH STICK BASAL BODY TEMPERATURE CERVICAL MUCUS
- If so, do you ovulate on a regular basis each month: YES NO
- Do you have any blood relatives who have had a stroke, heart attack, or any other blood clotting related disorder before 50 years old: YES NO
- Do you have any blood relatives who have had a diagnosis of an autoimmune disease (multiple sclerosis, lupus, reynauds, rheumatoid arthritis, etc): YES NO
- Do you have a male partner: YES NO
- If yes, what is his age: _____
- Has he has a semen anyalysis: YES NO

— Informed Consent for Acupuncture Treatment —

The nature of acupuncture treatment: Some patients feel a bit light headed after a treatment. If this happens, please tell us. Even if you do not feel dizzy after a treatment, it is a good idea to take a few minutes to breathe deeply and regroup before heading out the door.

Herbal prescriptions and patent medicines are intended ONLY for the person for whom they are prescribed. Do NOT give your herbs to anyone else, even if it appears they have a condition similar to yours. State and local sales taxes are included in the price charged for herbs and herbal products.

Possible risks: Acupuncture needles may occasionally cause a small bruise. This is typically not cause for concern; however do call if you experience lingering discomfort or discoloration at the site of needle insertion. Only pre-sterilized, single use, disposable needles are used in this office.

. . .

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 office listed below, or any other office or clinic, whether signatories to this form or not.

I **have had an opportunity** to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I **have read, or have had read to me, the above consent.** I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. 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.

Alana Ramey-Bernardi, L. Ac., CMT • 831 . 325 . 9691

Neil Bernardi-Wright, L. Ac., FABORM • 408 . 402 . 1849

1011 Center St., Santa Cruz CA 95060 • 15251 National Ave, Ste. 106, San Jose CA 95035

Name: _____ Date: _____

Signature: _____

HIPAA Compliance Authorization

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice.

I acknowledge that I have received a HIPAA Compliance Assurance Notification.

Name: _____ Date: _____

Signature: _____

Compliance Assurance Notification

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

Cancellation Policy & No-Show Policy

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need for care.

Please be aware that a \$30.00 cancellation fee will be assessed if you are a no-show or fail to cancel with in 24 hours of your appointment.

Our acupuncture appointments generally take 50 + minutes. If you arrive more than 15 minutes late, this will count as a missed appointment. Unfortunately, we cannot guarantee that "late comers" will receive full time for their treatment.

In the case of an unavoidable emergency, this fee may be waived. If you have any questions, don't hesitate to ask.

Please accept below to acknowledge your understanding of our cancellation policy.

Name: _____ Date: _____

Signature: _____

Insurance Verification Form

Patient please fill in upper portion:

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ C: _____

Name of insured: _____ Relationship: self spouse child other

ID/Policy #: _____ Group#: _____

Insured persons address: _____

Insurance company name and phone #: _____

Insurance address: _____

Assignment of Benefits:

I hereby direct the above named Insurance Company to pay by check made out to and mailed directly to **Neil Bernardi-Wright, L.Ac** or **Alana Ramey-Bernardi, L.Ac** for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges 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 Neil Wright, L.Ac., and I agree to pay any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

I also hereby authorize the release of any medical records necessary for the processing of claims submitted by Neil Bernardi-Wright and Alana Ramey-Bernardi for services rendered to me. A photocopy of this form shall be considered as valid as the original.

Patient Signature: _____ **Date:** _____

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1011 Center St, Santa Cruz CA 95060 // 15251 National Ave, Ste.106, Los Gatos CA 95032

Office Use: Billing Addr.: _____

Contact: _____ Date and time called: _____ Diagnoses: _____

Deductible: _____ Co-pay: _____ Pay rate: _____ Visit limit: _____

Ref. By: _____ W/C PI MM Other Injury Date: _____

Notes: _____