MERULLI ACUPUNCTURE & WELLNESS

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509 Olive Way #1658 Seattle, WA 98101 206-388-3349

PERSONAL INFORMATION

Name_____Email_____

Address_____City/State/Zip_____

Phone_____Age_____Height_____Weight_____BloodType_____Birthdate_____

Occupation_____Employer_____

Physician_____Phone _____

Emergency Contact & Phone_____Relationship_____

How did you hear about my practice? Website/Referral/Friend/other_____

Appointment reminders: Email or Text Would you like to receive your statements by email? Y / N

PAYMENT & INSURANCE INFORMATION

Credit Card #_____Exp Date_____CCV_____

Please initial_____ *Being the authorized cardholder, by signing I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Merulli Acupuncture & Wellness to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.*

Insurance Plan_____Patient ID_____Group Number_____

Social Security Number_____Copayment Amount_____Deductible Amount_____

HEALTH HISTORY

Have you ever had a work related, L&I, or automobile accident injury? If yes, please list dates:_____

Have you been treated with Acupuncture, East Asian Medicine or Massage Therapy before?

Do you have fear of needles?

TREATMENT GOALS

What are your symptoms and health goals today? When did they begin?

To what extent do these concerns interfere with your daily activities (work, sleep, etc.)?

Have you been given a diagnosis?

What kinds of treatment have you tried?

Medical History: (Please Circle and indicate if family member or yourself)

Asthma	Diabetes	Stroke
Heart Disease	High Blood Pressure	Thyroid Disease
Cancer	Seizures	Other

Surgeries: medical and cosmetic (list type and date):

Significant Trauma (auto accidents, falls, emotional stress, etc.)

Allergies (drugs, chemicals, foods/result):

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):

Occupational Stress (chemical, physical, psychological, etc.):

Do you have an exercise program? Please describe:

List any dietary restrictions past or present:

What is your average daily diet?

Do you have a spiritual practice you'd like me to be aware of?

How many packs of cigarettes do you smoke per day?

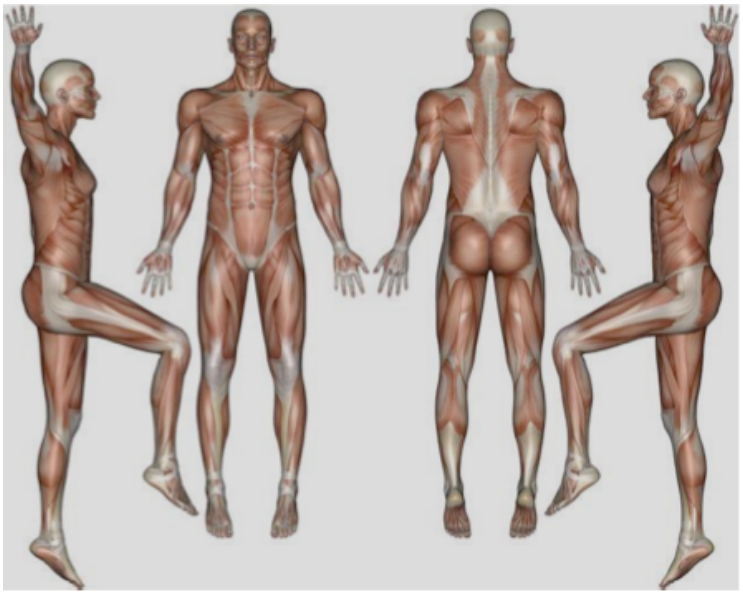
How much coffee, tea or cola do you drink per day?

How much alcohol do you consume per day?

How much water do you drink per day?

Is there anything I need to be aware of that I haven't asked?

Please indicate painful or affected areas in the drawings below: **Comments**



Please select any symptoms that you've had in the last 3 months

General
- ❑ Chills
- ❑ Fever
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Bleed or bruise easily
- ❑ Peculiar smells or tastes
- ❑ Strong thirst (cold or hot)
- ❑ Thirst, no desire to drink
- ❑ Fatigue
- ❑ Edema
- ❑ Poor sleep
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain/loss

Respiratory
- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Pain with a deep breath
- ❑ Phlegm production
- ❑ Coughing blood
- ❑ Pneumonia or Bronchitis

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Stroke
- ❑ Chest discomfort/pain
- ❑ Heart palpitations
- ❑ Cold hands or feet
- ❑ Swelling of hands/feet
- ❑ Blood clots
- ❑ Fainting
- ❑ Difficulty in breathing
- ❑ Unable to lie down
- ❑ Varicose or spider veins

Skin and Hair
- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or skin
- ❑ Eczema
- ❑ Oozing skin lesions
- ❑ Hives
- ❑ Acne
- ❑ Recent moles
- ❑ Hair loss

Eyes, Ears, Nose & Throat
- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
- ❑ Facial pain
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Eye pain/dryness
- ❑ Excessive tears
- ❑ Discharge from ear
- ❑ Nose bleeds
- ❑ Sinus congestion/Nasal drainage
- ❑ Grinding teeth
- ❑ Tooth problems
- ❑ Jaw clicks
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Snoring

Urinary
- ❑ Painful urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Decrease in flow
- ❑ Peculiar color/odor
- ❑ Incontinence
- ❑ Dribbling
- ❑ Kidney stones
- ❑ Impotency
- ❑ Change of sexual drive
- ❑ Wake up to urinate

Gynecology
- ❑ Length of cycle: _____
- ❑ # of bleeding days: _____
- ❑ Heavy periods
- ❑ Light periods
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Birth control
- ❑ Miscarriages
- ❑ Menopause
- ❑ Breast lumps
- ❑ PMS
- ❑ Children

Gastrointestinal
- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Blood in stools
- ❑ Abdominal pain or cramps
- ❑ Gas
- ❑ Bloating
- ❑ Hemorrhoids

Musculoskeletal
- ❑ Neck pain
- ❑ Jaw pain
- ❑ Shoulder pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Spinal pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Muscle pain
- ❑ Muscle weakness

Neuropsychological
- ❑ Seizures
- ❑ Areas of numbness
- ❑ Weakness
- ❑ Sleep disorder
- ❑ Concussion
- ❑ Emotional outbursts
- ❑ Vertigo
- ❑ Depression
- ❑ Focus issues
- ❑ Susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse
- ❑ Suicide attempts
- ❑ Treatment for emotional problems

PATIENT FINANCIAL AGREEMENT

Payment is due at time of service unless other arrangements have been made in advance.

CANCELLATION POLICY AND CHARGE

Please provide a minimum of 24 hours notice to cancel or change your appointment time.

- **Please initial: ____ I acknowledge a $75 fee will be charged for less than 24 hours notice & for no-shows.**
- No charge if cancelled with a minimum of 24-hour notice.

PAYMENT TERMS

- Payment for visit, co-payment and/or supplies is due at time of service and can be made by cash, check, credit card or debit card.
- Interest accrues at 1% monthly, 12% annually on all unpaid balances and a $10 fee will be charged for each month payment is late.
- A $40 NSF fee is charged on all returned checks.
- Merulli Acupuncture & Wellness participates in a variety of insurance plans. It is your responsibility to contact your insurance plan regarding provider participation, co-pays, deductibles and referral requirements.
- Patients are responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 60 days will be billed to the patient. Outstanding balances greater than 90 days will be turned over to a collection agency unless prior arrangements have been made in writing.
- If I have insurance, I understand that I am responsible for understanding my medical benefits. When applicable, I am responsible to pay a co-payment for my visit at the time of treatment. Co-payment and deductibles are a contract responsibility between the patient and their insurance. These amounts are non-negotiable. I understand that I am fully responsible for the total payment of all procedures performed in this office, including any treatment that is not a benefit of my medical insurance.

I, _____ agree to the above defined financial policies of Merulli Acupuncture & Wellness. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account.

I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

_____

Patient Signature Print Name Date

CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, herbal therapy, massage, Qi Gong, Yoga, point injection, laserpuncture, sonopuncture, and nutritional counseling. I understand that these modalities are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol

and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise their judgment in my best interest during the course of treatment, based upon the facts then known.

I understand that booking an appointment involves the reservation of time specifically for me, and that **24 hours notice is required to reschedule or cancel an appointment, and that a $75 fee will be charged for sessions missed without advance notification.** I understand that insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient Signature Date

COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Desiree Merulli, L.Ac., EAMP, LMP, RYT there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices.
- Your employer, if you use your work email to communicate with Desiree Merulli, L.Ac., EAMP, LMP, RYT
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If there are people in your life that you don't want accessing these communications, please talk with us about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Desiree Merulli, L.Ac., EAMP, LMP, RYT, to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes your health data use and sharing and how you can get access to this data

I. How we may use and share health data about you:
- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
- a) Patient directories - You can decide what health data, if any, you want listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Patient Signature _____Date_____

Print patient name _____Patient Birth Date_____