



Balance Acupuncture of L.I.
Patricia Gallo L.Ac

Patient Information Form:

Name: _____ SS#: _____/_____/_____

Gender: M____ F____ D.O.B _____/_____/_____ Relationship to you: _____

Home Address: _____
(Street, Apt #) (City) (State) (Zip)

Home Ph: (____) _____ Work: (____) _____ Cell: (____) _____

Phone number where we can leave a message: (____) _____

Email: _____

Employer: _____

Employers Address: _____
(Stree) (City) (State) (Zip)

Emergency Contact: _____ Phone: (____) _____

Relationship to you: _____

Who Referred you to us: _____

Insurance Information

The insurance information questions are necessary. Please provide your insurance ID card for Photocopying. Thank you.

Insurance Company: Name _____ Phone(____) _____

Insured's ID# _____ Group # _____ DOB ___/___/___

As a service to our patient, Patricia Gallo L.A.c will submit charges for medical treatment to the patient's insurance company. However, the patients is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patient's insurance company will pay for the specific medical procedures. Occasionally, even though coverage was verified before medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

I agree to be responsible for payment of services in the event my insurance company doesn't agree to pay for these services. Not signing this document does not release your responsibility of payment

Patient or Authorized Person's Signature

Date



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Medical History and Symptom/ Pain Information

Please identify your major health concerns: _____

1. How long have you had this problem? _____

2. How long have you had this problem? _____

3. How long have you had this problem? _____

Have you been given a diagnosis for these problems? _____

What other treatments have you tried and what were the outcomes? _____

Do you have a Pacemaker/Defibrillator? _____

Are you Pregnant? _____ How Many Months? _____

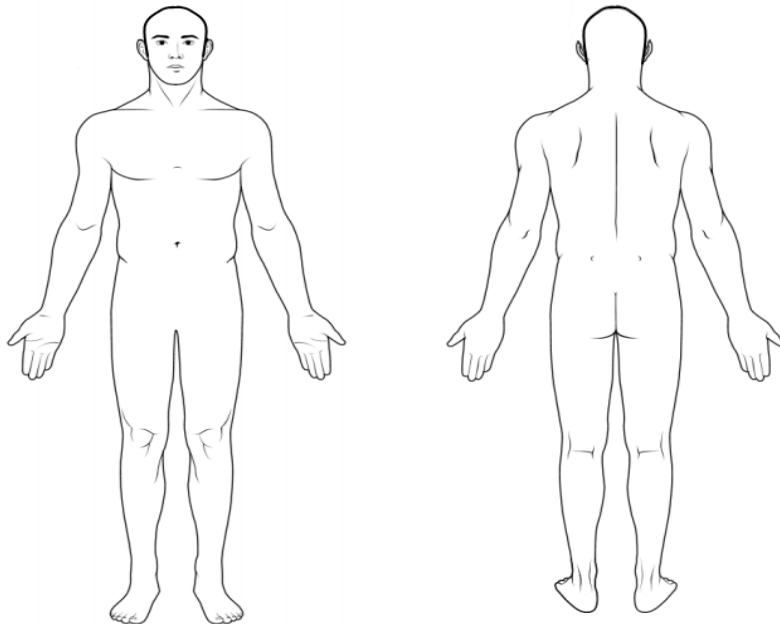
{ } New Injury { } Old Injury { } Chronic Pain { } Wellness

Are you in pain: Yes _____ No _____

Rate your pain with the following scale: (Circle one) None 1 2 3 4 5 6 7 8 9 10 Intense

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain

- [P.] Pain
- [T.] Tingling
- [N.] Numbness
- [B.] Burning
- [S.] Stiffness





Information and Consent to Services

I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risk and benefits of the service(s) to be performed have been explained to me. I have also received the Notice of Privacy Practice and the accompanying will be used and disclosed consistent with this notice, and that I have the right to request restrictions on certain questions regarding the proposed services and other pertinent information, including questions about him or her, and I have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

Disclosures For Acupuncture

Services to be provided

I understand that acupuncture services individuals with range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with insertion of needles and/or with application of heat to the skin.

Risks, Possible Side Effects and Healing Response

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Generally, the healing response will subside within 72 hours. It is the responsibility of the patient to inform the practitioner of any treatment reactions as soon as possible.

Other Professional Competencies

I am aware of other bodywork modalities and understand that I have consented to the specific service of acupuncture as noted above. I understand that should I need such additional care that my practitioner may offer referrals to a separately licensed professional.

NO Guarantees

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantee or promises as to the results or success that will be obtained from the services provided.

Infectious Disease Prevention

I know that infectious diseases are carried through the air, though physical contact, and through body fluids. I understand that me practitioner follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious diseases.

Patient responsibilities

I understand that it is my responsibility as a patient to inform my practitioner about all aspects of my health and that as the services progresses, to inform my practitioner of changes that occur. If I experience any pain or discomfort during the treatment, I will immediately inform the practitioner so that treatment may be adjusted to my level of comfort.

Patient or Authorized Person's Signature

Date



Information Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatment and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Patricia Gallo L.Ac

I understand that the methods of treatment may include, but not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counselling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriages and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plants, animals and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience and gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of procedure, which the acupuncturist feels at the time, based upon the facts then and known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I Have read, or have had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shredded only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named procedures. 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.

Patient's Name: _____

Patient's/ Patient Representative's Signature: _____

Date ____/____/____



Patients Follow Up

Date: ____/____/____

Pulse: _____

Tongue: _____

Notes: _____

Points: _____

Date: ____/____/____

Pulse: _____

Tongue: _____

Notes: _____

Points: _____

Date: ____/____/____

Pulse: _____

Tongue: _____

Notes: _____

Points: _____
