SAGE

Office Use Only
Insurance Co:
Policy Number:
Co-Pay: # of Txs./MNR

Date_____

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely and clearly as possible. We confirm appointments via text and/or email and send occasional updates. You may unsubscribe from emails at any time.

Name _____ Date of Birth _____

SS#_____ Occupation _____

Home Address _____ City _____ State _____

Zip_____ Phone _____

E-mail: _____

Emergency Contact_____ Relationship_____ Phone_____

Whom should we thank for referring you to our office?_____

Have you had acupuncture therapy before? __ Yes __ No What was your experience? __ Good __ Bad __ No Change

General Health History

What are the health problems for which you are seeking treatment? _____

_____

WHEN and HOW did this condition originate? _____

What helps your condition? _____

What aggravates your condition? _____

If you are experiencing any pain, how would you rate it on a scale of 1-10 with 10 being the worst? _____

How would you characterize your pain: __ dull/achy __ sharp/stabbing __ burning __ tingling __ numbness __ electrical

What other forms of treatment have you sought? _____

How committed are you to correcting your problems?
__ I will *say* I will change but will quit if it is hard.
__ I will come in as long as insurance covers it.
__ I will give this 6-months and measure the results.
__ I will take the necessary steps to change my life!

What tools will you use to improve your life?
__ Meditation __ Stretching/Yoga __ Exercise __ Acupuncture __ Massage __ Diet/Nutrition
__ Herbal Remedies __ Other _____

Please list any surgeries, major health incidents, traumas, and/or mental or physical abuses you have experienced.

_____

How would you rate your overall health? __ Poor __ Good __ Great

What are your health goals? What do you want to be able to do? What do you want to improve? _____

_____

SAGE

General Health History (Continued)

Place a mark next to any of the following conditions that you have or have had:

__ Tuberculosis	__ Hepatitis	__Diabetes	__ Epilepsy/Seizures	__ Pregnancy
__ Heart Attack	__ Anemia	__ Eating Disorders	__ Blood Transfusions	__ Seizures
__ Jaundice	__ Parasites	__ HIV/AIDS	__ High Blood Pressure	__ Low Blood Pressure
__ Heart Disease	__ Cancer	__ Mental Illness	__ Thyroid	__ Multiple Sclerosis

Do you have any allergies?_____ Do you have any drug sensitivities?_____

List any medications you are taking and how often

_____

_____

_____

List any supplements you are taking and how often

_____

_____

_____

List three words to describe yourself _____ _____ _____

What are your hobbies? _____

How do you indulge yourself?_____

Please Check (in the column) any of the following that are regularly recurring symptoms

X		X		X		X		X	
	Bad breath		Insomnia		Sore throat		Low back pain		Eye problems
	Indigestion / heartburn		Mouth Sores		Shortness of Breath / Asthma		Knee Problems		Jaundice
	Diarrhea		Palpitations		Decreased sense of smell		Hearing Loss / Ear Aches		Itchy skin
	Vomiting		Cold hands and feet		Nasal congestion / nose bleeds		Toothaches		Gallstones
	Abdominal pain / distention		Numbness in hands		Skin problems / Rash		Change in sex drive		Bitter taste in mouth
	Excessive Phlegm		Chest pains		Allergies		Hair loss		Soft or brittle nails
	Blood in stool		Poor memory		Frequent colds / sinusitis		Urinary problems		Constipation
	Bruising		Nightmares		Mentally restless		Joint pain		Difficulty making decisions
	Dry throat / mouth		Night sweats		Sadness / Depression		Dizziness/Vertigo		Headaches
	Obsession with work, relationship		Fatigue / Low energy				Anxiety and Fear		Short Tempered / Irritability

SAGE

For Women Only

Menarche _____ Date of last period _____Number of days of flow_____Number of pregnancies _____

Number of days between periods (your cycle) _____Do you bleed after intercourse? _____

Color of flow

__ pale/light red
__ red
__ bright red
__ dark red
__ dark red/brown
__ clots

Amount of flow

__ spotting
__ light
__ even throughout
__ heavy

Other symptoms related to menses

__ Discharge
__ Constipation
__ Swollen Breasts
__ Changes in Appetite
__ Nausea
__ Headache
__ Diarrhea
__ Mood Swings
__ Insomnia

Any recent changes in your menstrual cycle? _____

Have you ever been diagnosed with any of the following (check all that apply):
__ Fibroids __ Fibrocystic breasts __ Endometriosis __ Ovarian cysts __ PID __ Polycystic Ovary Syndrome
__ STD _____ __ Other _____

Fertility Information

How long have you been trying to actively conceive? _____

Have you and your partner discussed your alternatives? _____ # of IVF procedures _____# of IUI procedures _____

Other: _____

Has a physician diagnosed a difficulty with fertility due to: __ Female Factor __ Male Factor __ Unexplained

Do you keep a regular BBT Chart? _____

Has your partner or donor had his sperm evaluated? _____

Have you had recent hormone lab work? _____

Have you ever been on Birth Control and if so how long did you use and when did you stop?_____

If you are currently Birth Control, what is it? _____

SAGE

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 indicated 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, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. 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 have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with their consumption.

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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. 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 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.

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

PATIENT SIGNATURE: _____Date_____

ACUPUNCTURIST NAME: _____Date_____

SAGE

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), the patient should initial here. _____. Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE: _____Date:_____
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE _____Date:_____

SAGE

Official Financial Policy & Authorization to Bill Insurance

Insurance Carrier_____ Phone _____ Date Contacted_____

Policy Number _____ Group Number _____

Co-Pay $_____ % Covered _____ Deductible Amount _____

Contact Name _____ Referral needed _____

Credit Card information

Card Type _____ Card Number _____ Exp Date _____

Billing Address _____ Billing Zip _____ CRV Code _____

Fees:
Our fees are determined by the complexity of each case and different services used. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service.

Insurance:
Your insurance coverage should be verified prior to treatment. We will file all claims as a courtesy to you. If for any reason you are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you provide all necessary insurance information. We are not a party to that contract. Any and all charges incurred at this office including co-payment, coinsurance, percentage due and/or deductibles or any other fees or services not covered by your insurance company are your responsibility. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Cancellation Policy:
Unless cancelled at least 24 hours in advance, our policy is to charge your credit card for missed appointments at the cash rate of a normal office visit. MISSED APPOINTMENTS ARE NOT COVERED BY INSURANCE. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping your scheduled appointments.

By signing below:
I authorize my insurance benefits to be paid directly to SAGE ACUPUNCTURE. I authorize SAGE ACUPUNCTURE to release any information and medical records required by my insurance company. I authorize SAGE ACUPUNCTURE to charge my credit card for services and/or missed appointments. I understand my information will be saved to file for future transactions on my account. I understand that I may revoke this consent by written request, at any time.

_____
Printed Name

_____ _____
Signature of Responsible Party Date

SAGE

COVID-19 Informed Consent To Treat

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to person contact, in which COVID-19 can be transmitted. _____

I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office. _____

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
*Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell _____

I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

_____ Date_____
Patient Signature

Temperature at visit _____°F Date_____ Temperature at visit _____°F Date_____

Temperature at visit _____°F Date_____ Temperature at visit _____°F Date_____

Temperature at visit _____°F Date_____ Temperature at visit _____°F Date_____