SAN FRANCISCO
INTEGRATIVE MEDICINE

Welcome to the office of San Francisco Integrative Medicine & Acupuncture, Inc. We know that you have many choices when looking for a health care practitioner, and we are quite happy you have chosen us. You can be sure that your treatments here will be given with the utmost care, with your comfort and safety foremost on our minds.

While many practitioners like to keep you coming back indefinitely, we here at San Francisco Integrative Medicine wellness center are of the philosophy that we'd like to get you healthy and back on your feet in as little time as possible. We welcome any and all questions you may have about your treatments, as well as questions or comments related to our atmosphere or billing practices. At a time when healthcare has taken a backseat to profits, we hope to singlehandedly change this trend by providing caring, affordable care to each and every patient we see.

Please note that price for acupuncture visits where payment is collected same day (non-insurance) are as follows:

Initial Visit - $135

Follow-Up Visit(s) - $90

(Herbal formulas are not included in this. You can purchase herbal formulas from our office or from a health food store, etc. – when purchasing herbs, make sure that the company is GMP (Good Manufacturing Process) certified. We have a full herbal pharmacy here using only companies with the highest quality controls.)

Please allow up to an hour and a half for your first visit and up to an hour for follow-ups. Thanks again for allowing us to be a part of your health care team!

Sincerely,

Elanita Korian, L.Ac., M.S.
Dawna Ara, L.Ac., M.S.
Laurie Terzo, DAOM, L.Ac., FABORM

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Welcome and thank you for choosing San Francisco Integrative Medicine.
Our goal is to help you achieve your optimum health and wellness. This is a **confidential** questionnaire to help me determine the best treatment plan for you. If you have any questions please ask. Thank you.

Personal Information

Name_____ Date_____

Home Address_____

City_____ State_____ Zip_____

Primary Phone_____ Email_____

Occupation_____ Work Phone_____

Person responsible for your account_____

Emergency Contact: Name_____ Phone_____

Sex: ☐ Male ☐ Female ☐ Trans (__MTF __FTM) ☐ Gender Queer Birthdate_____ Age_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered Number of Children _____

Have you received acupuncture therapy before? ☐ Yes ☐ No

When?_____ With whom?_____

Who should we thank for referring you? _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

Illness	You	Relative	Approx. Date	Illness	You	Relative	Approx. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Press	☐	☐	_____	Seizure	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Disease	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Diseases: ☐ Gonorrhea, ☐ Syphilis, ☐ HIV, ☐ HPV, ☐ Chlamydia, ☐ Herpes, Other_____

List any medications and supplements you are currently taking. Continue on back if necessary.

Medicine	Dose	Reason	How Long	Prescribed By	Date of Last Checkup

Check box if any of the following statements are true:

☐ I have known allergies ☐ I am taking Coumadin/Warfarin
☐ I have a pacemaker ☐ I am taking Lithium

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/ Black tea	☐	☐	_____	Alcohol	☐	☐	_____
Non-Medicinal Drugs	☐	☐	_____	Soda	☐	☐	_____
Tobacco	☐	☐	_____	Water Intake	☐	☐	_____

OB/GYN History

Age of 1st period (menarche)_____ Are you pregnant ☐ Yes ☐ No # of pregnancies_____

Age of Last period (menopause)_____ # of live births_____ # of abortions_____ # of miscarriages_____

# of days between periods_____ Date of last gynecologic exam_____ Pap smear_____

# of days of flow_____ Mammogram_____ Bone Density Scan_____

Color of Flow_____ Results_____

Clots ☐Yes ☐ No Color:_____ Avg. # of Pads/tampons per days 1st___ 2nd___ 3rd___ 4th___ 5th___ + _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian ☐ Cysts ☐ PID

Other_____

Birth Control: ☐ None ☐ Barriers ☐ Birth Control Pills ☐ IUD ☐ Spermicides ☐ Condoms

Location of Menstrual Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other_____

Nature of Pain (indicate before, during, after)

Cramping	_____	Stabbing	_____
Burning	_____	Aching	_____
Dull	_____	Bloating	_____
Consistent	_____	Intermittent	_____
Bearing Down Sensation	_____		

Other symptoms related to menses:

☐ Ravenous Appetite	☐ Vaginal Dryness	☐ Headache
☐ Poor Appetite	☐ Constipation	☐ Mood Swings
☐ Insomnia	☐ Swollen Breasts	☐ Diarrhea
☐ Increased Libido	☐ Hot Flashes	☐ Night Sweats
☐ Decreased Libido	☐ Nausea	☐ Discharge

Urogenital History

Date of last prostate checkup_____ PSA Results_____

Manual prostate exam results_____ Lab Results_____

Frequency of Urination: Daytime_____ Nighttime_____ Color of urine ☐ Clear ☐ Murky Odor_____

Symptoms Related to Prostate:

☐ Prostate Problems	☐ Delayed Stream	☐ Post Void Dribbling	☐ Incontinence
☐ Retention of Urine	☐ Decreased Force of Stream	☐ Increased Libido	☐ Decreased Libido
☐ Premature Ejaculation	☐ Impotence	☐ Back Pain	☐ Groin Pain
☐ Testicular Pain	☐ Erectile Dysfunction	☐ BPH/Enlarged Prostate	

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows in the space to the left.

No mark ( ) = never experience, Check Mark (√) = sometimes experience, Plus Sign (+) = frequently experience

☐ Lack of Appetite	☐ Abdominal pain	☐ Eye issues	☐ Fatigue
☐ Excessive appetite	☐ Chest pains	☐ Jaundice (yellowish skin/eyes)	☐ Edema
☐ Loose stool or diarrhea	☐ Sciatic Pain	☐ Difficulty digesting oily foods	☐ Blood in stool
☐ Digestive problems	☐ Headaches	☐ Gall stones	☐ Black tarry stool
☐ Vomiting	☐ Pain or coldness in genital area	☐ Light Colored Stools	☐ Easily bruised
☐ Belching	☐ Cough	☐ Soft or brittle nails	☐ Difficult to stop bleeding
☐ Heartburn/reflux	☐ Shortness of Breath	☐ Easily angered or agitated	☐ Asthma
☐ Feeling of food retention in stomach	☐ Decreased sense of smell	☐ Difficulty in making plans or decisions	☐ Tendency to catch colds easily
☐ Tendency to become obsessive in work/relationship	☐ Nasal problems	☐ Spasms or twitching muscles	☐ Intolerance to weather changes
☐ Insomnia, difficulty sleeping	☐ Skin problems	☐ Low back pain	☐ Allergies
☐ Heart palpitations	☐ Feeling of claustrophobia	☐ Knee problems	☐ Hay fever
☐ Cold hands/feet	☐ Bronchitis	☐ Hearing impairment	☐ Dizziness
☐ Nightmares	☐ Colitis or diverticulitis	☐ Ear ringing	☐ Tendency to faint easily
☐ Mentally restless	☐ Constipation	☐ Kidney stones	☐ High cholesterol levels
☐ Laughing for no apparent reason	☐ Hemorrhoids	☐ Hair loss	☐ Sudden weight loss
☐ Angina pains	☐ Recent antibiotic use	☐ Decreased sex drive	☐ Other_____
		☐ Urinary problems	

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

_____
_____
_____
_____

What other forms of treatment have you sought?

_____
_____
_____
_____

List any other health problems you now have.

_____
_____
_____
_____

List any allergies, food sensitivities or food cravings that you have.

_____
_____
_____

List any accidents, surgeries or hospitalizations (include date).

_____
_____
_____
_____

Clinical Notes
HPI:
For Office Use

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicates any problems you may be experiencing.

	Great	**Good**	**Fair**	**Poor**	**Bad**	**Your Comments**
Significant Other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

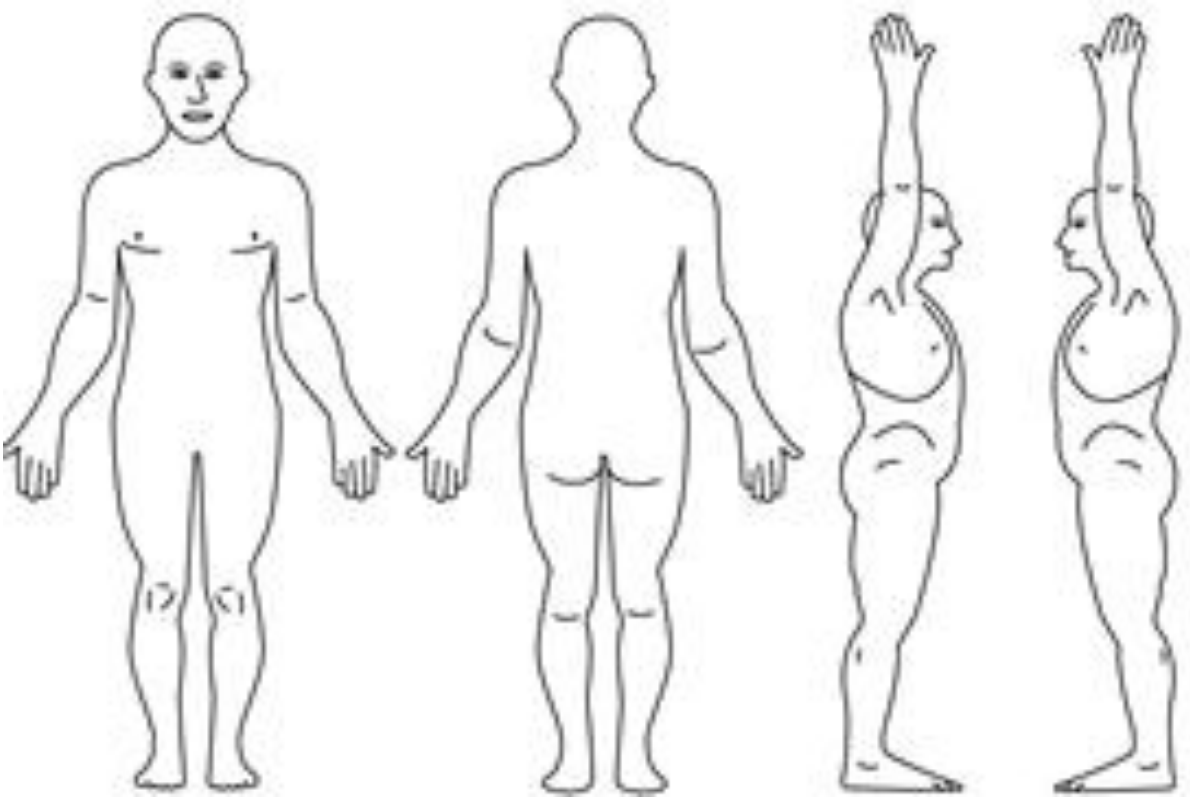
Which of the follow is most important to you? (choose one)
__ Unconditional love
__ Feeling understood
__ Feeling respected and appreciated
__ Feeling that everything is going to be okay
__ Having a sense of direction

Other information you would like to report/may be relevant to your medical history?

_____
_____

Pain Scale

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing



Sharp and Stabbing	= +++++
Dull and Achy	= VVVVV
Pins and Needles	= 00000
Numbness	= //////
Heat	= HHHH
Cold	= CCCCC

Please check the appropriate # to describe your present pain level with 0 being Normal/or no pain; and 10 being sever pain

Area of Pain	Normal	Mildly in Pain	Moderate Pain	Severe Pain		
Neck	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Middle Back	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Lower Back	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Hip(s) L R	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Shoulder(s) L R	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Arm (s) L R	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Leg(s) L R	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Headaches	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Other:	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Other:	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**
Other:	0 1	2 3 4	5 6 7	8 9 10	**C**	**I**

INSURANCE AND CANCELATION POLICY

Great news! More and more insurance companies are now covering acupuncture.
Do you have one of these policies?

San Francisco Integrative Medicine accepts many major insurance plans, worker's compensation and personal injury claims. We are happy to help you verify your level of insurance coverage. Once verified, we will submit your claims for reimbursement

{ To find out more about your insurance policy, you can either speak to your HR representative, your insurance broker, or insurance company directly }

In-Network / Out of Network Insurance – Billing

Patients who elect to have SFIM bill for them are accountable for any deductibles or out-of-pocket expensense, such as co-insurance/co-pays associated with each clinic visit. In addition, patients are responsible for all non-covered services, including herbs and supplements. Please note: our insurance rates differ from our "payment at the time of service" rates.

Out of Network Insurance – Reimbursement

Some plans will cover acupuncture treatments but for whatever reason, we cannot bill them directly. In these cases, after paying out "payment at the time of service" rates, as a courtesy will submit all the required documentation on your behalf and your insurance company will then reimburse you.

Worker's Compensation

We must have your authorization letter and referral before we schedule you for your first appointment.

Auto Insurance

At this time, we do not accept third party claims or liens.

Insurance is very complicated and we, along with our insurance billing company, work very hard to do everything we can to ensure that you receive all the benefits of you plan. **However, please note that you are ultimately responsible for any unpaid charges that may occur due to unforeseen complications that can sometimes happen when using insurance.**

Cancelations

We understand that unexpected things happen but please know your session time is reserved exclusively for you. We require advanced notice for appointment cancellations, and charge a fee for cancelations with less than 24 hours' notice.

By signing below, you acknowledge receiving and understanding SFIM insurance and cancelation policy, and authorize the release of any information necessary to process a claim with your insurance company.

Print Name:_____

Signature:_____ Date:_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I _____ hereby agree and consent to the performance of acupuncture and other Oriental medicine procedures. I understand that such procedures may include, but are not limited to, acupuncture, moxibustion, cupping and gua-sha (dermal friction technique), Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

- Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.
- Moxibustion is the application of indirect heat by burning a stick of compressed *Folium Artimesiae vulgaris*, commonly known as Mugwort, over acupuncture points and channels.
- Cupping utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.
- Tui-na is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the site of treatments on the day of, or the day following the treatment.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, or hematoma which may occur at the site of insertion and may last a few days. A sensation of light-headedness after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained or removed.

By voluntarily signing below, I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions, and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present conditions and for any future condition(s) for which I seek treatment.

_____	_____	_____
Date	Print Name	Signature of Patient

ACKNOWLEDGEMENT OF PRIVACY POLICIES

San Francisco Integrative Medicine is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

If you have questions, complaints or want more information, please contact this office. Contact: Office Manager at (415) 362 – 4600, 870 Market St #1117, San Francisco CA, 94102.

_____	_____	_____
Date	Print Name	Signature of Patient

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to our office.

- Legal Responsibilities of San Francisco Integrative Medicine & Acupuncture, Inc.: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.
- We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.
- Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.
- Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.
- Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.
- Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.
- Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.
- Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.
- Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.
- Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization. Required By Law: Your protected health information may be used or disclosed if required by law.
- Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.
- National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected

healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

- Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

- Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request. Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.
- Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.
- Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.
- Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.
- Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.
- Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name: Office Manager
Telephone: (415) 362-4600
Address: 870 Market St., Suite 1117 City, State, Zip: San Francisco, CA 94102