Acupuncture Center of Santa Maria
Herb Kandel OMD, LAc
225 E. Mill St.
Santa Maria CA 93454
805-922-4490 fx 805-928-7194

CASE HISTORY FORM

Date: _____ Name: _____ DOB: _____

Address: _____

City/State/Zip: _____ E-mail: _____

Phone: _____ Work: _____ Age: _____

Cell: _____ Emergency Contact Person: _____

DL#: _____ Emergency Phone: _____

Occupation: _____ Number of Children: _____ Ages: _____

Circle one: **Married** **Single** **Divorced** **Partnered** **Widowed**

Referred By: _____

Current Health Providers (MD, DC etc.): _____

Medical Diagnosis for Current Complaints: _____

Current Complaint: (include symptoms, when/how problem started, things which increase or lessen the symptoms, and General Health Goals): _____

Current Prescribed Medications: (include dosage and duration - use back of sheet if needed): _____

Previously Prescribed Medications: (within 12 months, antibiotics, corticosteroids):

Current Nutritional Supplements: (vitamins, herbs, etc - use back if needed): _____

Vaccination History (please include any reactions): _____

Illnesses, injuries or surgeries from Birth to 20 years old: _____

from 21-40years old: _____

from 41 to present: _____

History of any emotional difficulties or traumas *(deaths, abuse, relationship difficulties, etc.)*

Briefly describe your Family's Medical History:(include any history of TB, cancer, skin disease, high blood pressure, nervous disorders, diabetes, arthritis, heart disease, stroke, seizures, colitis, asthma, allergies, alcoholism, etc:)

Father:

Mother:

Grandparents:

Siblings:

WOMEN:

Menstrual History

Age when periods began: Last PAP:

Difficulties with periods? (pain, flow, regularity, cramps etc.):

Current Mentrual problems: (pain, flow, regularity, PMS, discharge, etc.)

Birth Control History (methods used, duration, dosage):

Obstetric History (pregnancies, births, abortions, miscarriages, etc.):

Menopause (age of onset, duration, difficulties):

MEN:

Any history of impotence, premature ejaculation, fertility difficulties, discharge from penis, vasectomy:

MEN & WOMEN: Hisotry of Venereal disease, herpes, warts, etc.

DAILY HABITS: Check boxes that apply and indicate frequency

- ☐ Cigarettes, Tobacco _____
- ☐ Alcohol (Type) _____
- ☐ Coffee _____
- ☐ Tea _____
- ☐ Soda _____
- ☐ Recreational Drugs _____
- ☐ Exercise (type and frequency) _____

Describe your energy level: (circle one)
(low) 1 2 3 4 5 6 7 8 9 10 (high)

YESTERDAYS MENU

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack _____

DIET: Check boxes that apply and indicate frequency

- ☐ Dairy (milk, cheese, creams ice creams, yogurt, etc.): _____
- ☐ Meats, Fish, Poultry _____
- ☐ Bread Grains _____
- ☐ Sugar _____
- ☐ Salt _____
- ☐ Vegetables (raw, steamed?) _____
- ☐ Snacks (chips, sweets, etc.) _____

Fees, Insurance & Payment Agreement
Acupuncture & Oriental Medical Care
Acupuncture Center of Santa Maria

To all New Patients:

Welcome to our office. We hope that you find our office and staff pleasant. If you are an insurance patient our office provides courtesy insurance billing. Please provide us all necessary insurance information in order for us to bill your insurance. If your deductible has not been met, it is due on the first visit. If you are a private patient, payment is due at time of service.

Office Insurance Policy

All Initial visits need to be paid in full at the time of service, this gives us time to verify your insurance benefits by your second visit. Once we have verified your coverage we will review benefits with you at your next appointment. Although you may have insurance coverage please note that insurance companies tell us "Benefits quoted are not a guarantee of payment. Payment will be determined by the insurance company using all portions of the member's plan when a claim is received." **Although we do provide courtesy insurance billing from our office, if your insurance company fails to pay on your claims they are your responsibility in full.**

Please understand that we have no contracts or payment agreements with insurance companies. Insurance benefits are a matter between the patient i.e. the insured and their insurance company. **We must emphasize that should there be a dispute between you and your insurance company and/or your insurance company does not pay the full charge, you are directly liable for the bill in it's entirety or any remainder.

*If you are a patient that has sustained a personal injury, please furnish the name and information about your lawyer as well as the status of your case.

Cancellations

If you need to cancel or reschedule your scheduled appointment, please give us at least 24 hours notice. We have a $25.00 fee for all broken appointments and No Show appointments will be charged the full amount of visit.

Assignment of Benefits (for patients with insurance)

If you carry a private insurance you will be expected to assign benefits (tell your insurance company to forward insurance payments directly to the Acupuncture Center of Santa Maria for services provided here). We urge you to carefully review your insurance coverage and plan prior to your visit. Policies are confusing, misleading and rarely pay everything.

Fees

For your information, some of our fees are as follows. Once again, fees (deductibles and/or copays, coinsurance or other) for office services are payable at the time of visit.

- Office Visit New Patient (not incl. acupuncture).....$25-$65
- Re-evaluation Current Pt.....$20-$40
- Acupuncture.....$80-$110
- Massage (15 min).....$22.50
- Cupping.....$15

(Signature) (Date)

Informed Consent to Acupuncture and Oriental Medicine Treatment and Care

Acupuncture Center of Santa Maria Inc.
225 E. Mill St.
Santa Maria, CA 93454

Print Patient's Name: _____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, nutrition, acupuncture, moxabustion, cupping, electro-acupuncture, herbology, various modes of physiotherapy, on me (or the patient named above, for whom I am legally responsible) by the acupuncturist named above at the clinic or office listed above, or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and the purpose of acupuncture, moxabustion, cupping, electro-acupuncture, herbology, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, infection and blisters. There have been instances reported of fainting, infections and scarring. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any 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, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand that the office and clinic staff, have been fully trained in safe and effective needle removal. In case of an emergency a member of the staff may have to remove my needles. I understand that this will be at the acupuncturist's request and will only happen in case of emergency.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about it's content and 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(s) and for any future condition(s) for which I seek treatment.

_____ _____
Signature of Patient or Patient's Representative Print Name of Patient's representative

_____ _____
Witness to Patient's Signature Date Relationship or Authority of Representative

_____
Translated By Date

Herb Kandel, O.M.D. L.Ac.
Acupuncture Center of Santa Maria, Inc.
225 Mill St.
Santa Maria, CA 93454

Patient Name:_____

Acknowledgement of Receipt of Notice of Privacy Practices

As required by the Privacy Policy regulations, I hereby acknowledge that I have received a current copy of the **Acupuncture Center of Santa Maria, Inc.**'s "Notice of Privacy Practices".

As required by the Privacy Regulations, I am aware that **Acupuncture Center of Santa Maria, Inc.** has included a provision that it reserves the right to change the terms of its notice and to make the new notice of provisions effective for all protected health information that it maintains.

Requests: (If you accept the ~~NOPP~~ NPP in its entirety, Do NOT check a box below)

☐ I wish to file a "Request for Restriction" of my Protected Health Information

☐ I wish to object to the following practices in the "Notice of Privacy Practices"

_____

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

_____

Print Name

_____

Signature Date

_____

(Office Use Only)

Signed form received by:_____ Date_____

☐ Patient Refused to Sign Date_____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost:** $ 70 - 120.)

Medicare will not pay for: Acupuncture, Electro-Acupuncture, Moxa, Cupping, Hot/Cold packs, Exercises, Herbs and Supplements.;

☒ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

* **This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

/ /20
MM DD YYYY

(*) Please sign in box and date

This notice explaining exclusions from Medicare benefits is published by the Centers for Medicare & Medicaid Services.