Reveal Wellness

Date: / /

Name:_____
Date of Birth_____Sex M/F
Address:_____
_____
Phone:_____
Email:_____
Soc Sec #_____
Occupation:_____
Employer:_____
Emergency Contact:_____
#:_____Relation:_____
Do you have children? Y/N
How many?
Referred by: _____
When was your last physical?
What is your blood type? A, B, AB, O
Do you have mercury filings?
Allergies (drug, chemical, food and the result):
_____
_____
_____
Is your immune system compromised by any condition at this time? Y/N
Explain:_____
_____

What are the main problems you would like to address today?_____
___ _____
When did this begin?_____
What makes it better?_____
What makes it worse?_____
Have you been given a diagnosis for this problem? Y/N
What was it?_____
What kinds of treatment have you tried?
_____
List all surgeries:_____
_____
_____
Significant trauma:_____
_____
_____

Medicines taken within the last 3 months (vitamins, drugs, herbs, etc.)
_____
_____
_____
_____

Please check any symptoms that have been persistent in the last three months.

General
○Chills
○Fever
○Sweat easily
○Night sweats
○Bleed or bruise easily
○Odd tastes or smells
○Strong thirst
○Sudden energy drop- time:_____
○Poor sleep
○Edema
○Tremors
○Cravings
○Change in appetite
○Weight loss
○Weight gain

Muscu-Skeletal
Pain in :
○Neck
○LShoulder
○RShoulder
○Back
○Elbow
○Wrist/Hand
○Hip
○Knee
○Ankle/Foot
○Muscle Pain
○Muscle
Weakness
Other_____

Skin and Hair
○Rashes
○Itching
○Change in skin or hair
○Ulcerations
○Eczema
○Lesions
○Hives
○Pimples
○Recent moles
○Loss of hair

Head,Eyes,ENT
○Dizziness
○Migraines
○Headaches
○Facial pain
○Glasses
○Contacts
○Poor vision
○Night blindness
○Seeing spots
○Eye pain
○Cataracts
○Eye dryness
○Extra tearing or discharge
○Lasik

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ENT Cont.
○Poor hearing
○Ringing in ears
○Ear aches
○Discharge from ear
○Nose bleeds
○Nasal drainage
○Teeth grinding
○Jaw clenching
○Concussion
○Sores on lips or tongue

Cardiovascular
○High BP
○Low BP
○Phlebitis
○Chest pain
○Palpitations
○Cold hands
○Cold feet
○Blood clots
○Fainting
○Difficulty Breathing
Other_____

Respiratory
○Asthma
○Cough
○Coughing Blood
○Wheezing
○Pain with breath
○Difficulty breathing when lying down
○Production of phlegm
○Color_____
○Pneumonia
○Bronchitis
Other_____

Gastro- Intestinal
○Bad Breath
○Nausea
○Vomiting
○Heartburn
○Belching
○Indigestion
○Diarrhea
○Constipation
○Blood in stools
○Abdominal
○Cramps
○Upper Gas
○Lower Gas
○Rectal pain
○Hemorrhoids
Other_____

Sleep
○Fall asleep too easily
○Trouble falling asleep
○Wake repeatedly
○Wake often to urinate
○Vivid dreams
○Wake not rested
○Supplements needed to sleep

NeuroPsych
○Seizures
○Areas of numbness
○Weakness
○Sleep disorder
○Concussion
○Short temper
○Violent
○Behavior
○Lack of coordination
○Depression
○Easily stressed
○Loss of balance
○Poor memory
○Anxious
○Substance abuse
Other_____

Uro-Genital
○Pain upon urination
○Frequent urination
○Blood in the urine
○Decrease in flow
○Unable to urinate
○Unable to hold urine
○Kidney stones
○Change in sex drive
○Sores on genitals
Other_____

Male
○Impotence
○Lumps in testicles
○Epididymitis
○Testicular torsion
○Prostatitis
○Varicocele
○Hernia
Other_____

Female
Pregnancies
Births
Days between periods_____
Days of flow_____
Flow is:
○Heavy
○Light
○Irregular
○Clots
○Painful
○Vaginal sores
○Breast lumps
○STD's
○Fibroids
○Change in bowels
○Emotional
○Change
○Odor
○Discharge
○Yeast
○Birth Control
Other_____
_____
_____

Height:
Weight:
BP:
Heart Rate:

Internal Medicine Examination

Please answer the following questions as accurately as possible. In Oriental Medicine, we look at the whole body so your diagnosis depends on each answer. If there is something you are not sure about, please ask during the session.

Do you often feel fatigue or lethargic? Y/N

What time of day in particular?

Rate your energy level (1-10)

Do you have a healthy appetite? Y/N

Are you thirsty throughout the day? Y/N

Do you generally prefer hot or cold drinks?

Do you experience generalized muscle pain? Y/N

Do you experience stiffness in the morning or with weather changes? Y/N

Do you often have stomach gurgling after a meal? Y/N

How often do you have a bowel movement?

What is the consistency (circle one) firm, tooth-paste-like, watery, hard and difficult to pass

Do they feel complete? Y/N

What is the color?

Do you ever have ulcers or cold sores in the mouth, on the tongue? Y/N

What do your stools resemble: long and thin, marble-like, fibrous and broken, normal

Do your gums bleed? Y/N

Do you bruise easily? Y/N

What is the overall condition of your skin? dry, oily, clammy, sweaty, itchy, normal

Do you experience shortness of breath? Y/N

Is your throat often dry? Y/N

Do you have a tendency to clear your throat?

Do you get headaches? Y/ N How often?

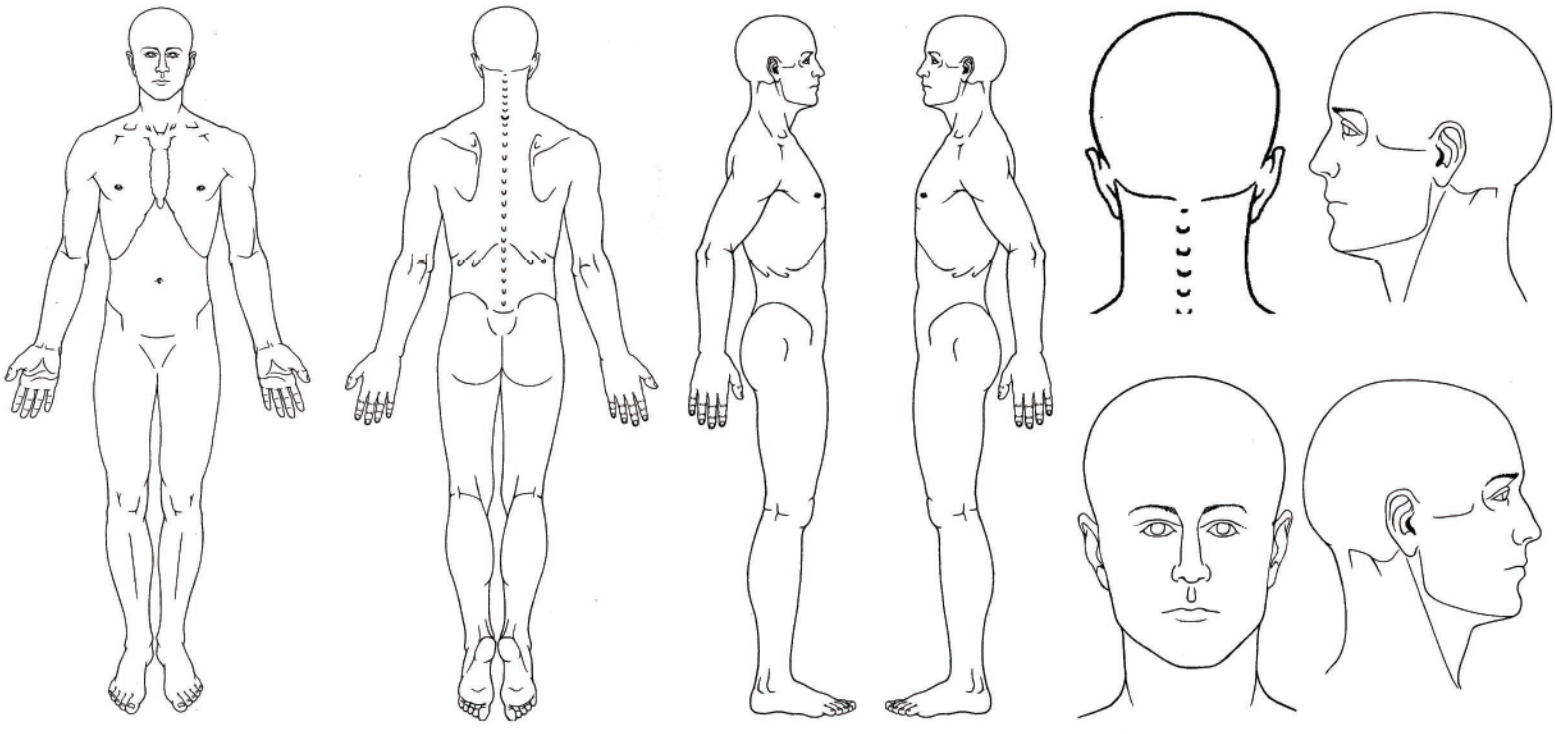
Where are they located?

Do you experience knee weakness or pain? Y/N

How often do you urinate?

Please indicate the location and sensation of your body pain using the following symbols:

^ ^ ^ ^ ^ ^ Numbness
o o o o o o o Pins and Needles
x x x x x x Burning
* * * * * * Aching/Dull
/ / / / / / Stabbing/Sharp
EEEEE Electrical



Effective Date: February 11, 2009

Notice of Patient Privacy

Health Insurance Portability and Accountability Act (HIPAA)

At Reveal Wellness, we respect 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.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

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. You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact L.A. Wellness at (310) 335-0073. You may also send a written complaint to the US Department of Health and Human Services.

Printed Name: _____

Signature: _____ Date: _____

Payment and Cancellation Policy

We thank you for choosing Reveal Wellness. We offer a few different payment options for your services received at our clinic. If you have insurance benefits that cover our services, you may pay for your service in full on the day of your visit and then we can provide you with a "Super Bill" which you can submit to your insurance company. Or, if you prefer for us to bill your insurance company, you acknowledge that the Invoiced Rates are higher than the Standard Pay Rates. You agree that you will be responsible for any portion of the Invoiced Rates that are not reimbursed by your insurance company, even though such amounts may be in excess of the Standard Pay Rates; be advised that your insurance company is likely to send a check directly to you for the allowed amount(s) that is / are invoiced in excess of your co-payment(s); as such, you agree to promptly pay Reveal Wellness the amount of money you receive from your insurance company promptly upon receipt; you acknowledge and agree that any dispute between your insurance company and you regarding the amount of your benefits and/or allowed amounts is strictly between you and your insurance company and that Reveal Wellness is not responsible for what your insurance company may decide to pay; in the event that your insurance company informs Reveal Wellness that you are eligible for reimbursement for acupuncture services rendered at our office, you agree that Reveal Wellness is not responsible for any action that it takes in good faith on your behalf based on such information; for example, Reveal Wellness shall have no responsibility if the claims submitted are subsequently denied for any reason, including, without limitation: the treatment is deemed medical unnecessary; your deductible has not been met; you have exceeded your benefit limit; a subrogation of claims; medical notes requested are not received and / or deemed insufficient; service is required to be performed by a specific doctor to qualify for coverage; and/or any other reason. You are solely responsible to be aware of your benefits and to contact your carrier directly when any issues arise regarding timely payment of claims, denials, rebilling, and other similar issues. Be advised that many insurance plans have limitations on benefits, especially when it comes to holistic health care. Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions.

All products and services received here at Reveal Wellness are the financial responsibility of the patient or their representative. Opened containers are NON-REFUNDABLE. Although we often provide samples of certain products, we do NOT consider a purchase an opportunity to sample a product. Understand that your purchase is considered final and, therefore, non-refundable. Unused service packages may be refunded according to the standard rate of service.

We accept Visa, MasterCard, American Express, FSA, Checks and Cash.

If you need to reschedule, we request that you do so 24 hours, or more, before the scheduled appointment time. A standard appointment rate is charged for a late, same day cancellation, or a missed appointment. We often have a waiting list of people to get in so a missed appointment is a loss for everyone. Please be sure to arrange accordingly.

Running Late? If you arrive 15 minutes or more after your scheduled appointment time, we will unfortunately have to reschedule and you will be charged for the appointment as, again, another person could have used that time slot. Thank you for understanding.

YOU MUST CALL 24 HOURS OR MORE PRIOR TO THE APPOINTMENT TIME TO AVOID THIS CHARGE.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____

Reveal Wellness/ ABC Acupuncture
28645 S Western Ave Rancho Palos Verdes, CA 90275
(310) 241-0947

Insurance Verification

Health Insurance:

Insurance Company: _____

Billing Address: _____

Patient Name:_____

Insured Name:_____

Social Security#:_____Date of Birth:_____

Policy #:_____Group #_____

Effective Date:_____Employed by:_____

Acupuncture Verification: Out of Network

Total Deductible $_____ Amount met $ _____ # visits per year_____

Maximum Limit $_____ Amount per visit $_____

Combined with Chiro? Y/N Exclusions: _____

Codes: 97810,97811,97813,97814,97110,97140,97026

Chiropractic Verification In/ Out of Network

Total Deductible $_____ Amount met $ _____ # visits per year_____

Maximum Limit $_____ Amount per visit $_____

Combined with Chiro? Y/N Exclusions: _____

Spoke with: _____ Date: _____

I authorize my insurance company to pay directly to Staysea Sumner, L.Ac., ABC Acupuncture or Reveal Wellness for all dates of service rendered in this office.

Patient Signature:_____