Joyful Living Acupuncture & Chinese Medicine
| 500 Aloha Street Set C2, Seattle, WA 98109 | www.JoyfulLivingHealthCenter.com

Our Clinic Protects Your Health Information and Privacy

Dear Patient,
This notice describes our office policy for how medical information about you may be used and disclosed, how you can get access to this information and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, Worker's Compensation (and your employer as well in this instance) or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored. Medical files kept locked and secure.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including electronic medical files, telephone, and faxes sent) are kept on permanent file in a secure and protected manner according to HIPAA.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please let us know.

Sincerely,
Joyful Living Team

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Financial Policy

Welcome to our office! The following is basic financial policy for Joyful Living and is designed to allow us to offer affordable quality care for you and your family.

1. **Insurance Coverage**: Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Due to the variance from one insurance policy to another, we require that each patient is responsible for the understanding their benefits. Our listed rates apply to the majority of patients on most visits here at Joyful Living Health Center. Charges may be higher or lower depending on the complexity of the condition you are receiving treatments for, time evaluation and management for individual cases.
2. **Insurance Billing:** We use a third party insurance biller for all insurance claims. Claims will be submitted in a timely manner. All copays are due at time of service.
3. **Time of Service Discount**: We offer a discount to all patients that pay at the time of service.
4. **Payment Methods**: We accept cash, check, debit, and credit card.
5. **Products**: All supplies, nutritional supplements, herbs, essential oils or other products are to be paid in full on the day they are received.
6. **Receipt**: We will supply you with a receipt upon your request.
7. **Twenty-four hour cancellation policy: There is a 24 HOUR BUSINESS DAY CANCELLATION POLICY for all missed appointments.** Please notify us within 24 business hours to your reschedule appointment. There is a $65 charge for notification that is not made.

We are here to help you raise your levels of health. If you have any questions or concerns about this policy, please feel free to ask your practitioner.

By signing this form I agree to the above and am responsible to pay for the full treatment session that I have booked (even if arriving late). I understand that I am responsible for copays and all fees. I acknowledge the cancellation policy that I have twenty-fours business hours before my appointment to cancel without an assessed charge of $65 dollars. If I have to cancel my appointment and I do not do so by twenty-four business hours before my appointment time, then I will pay a $65 cancelation fee.

I have read and understand the above basic financial policy of Joyful Living Health Center.

Signature _____ Date_____

Print name_____

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Informed Consent

Welcome! This disclosure is to advise you of the credentials of the practitioner, the scope of practice for Acupuncture in the State of Washington, and to document your consent for services (WAC 246-802-120).

Credentials:
Ashley Schiavone received a Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in Kenmore, Washington in 2010. She is certified by the National Certification Commission for Acupuncturist and Oriental Medicine (NCCAOM) and was designated a Diplomat of Acupuncture and Chinese Herbs in 2010. She is currently an East Asian Medical Practitioner (EAMP) in the State of Washington, holding license number AC60201877 since 2011**.** Ashley Schiavone received her Massage Therapy training at Bellevue School of Massage, Bellevue, Washington in 2008. She is is a licensed massage practitioner (LMP) in the state of Washington since 2008. Her LMP number is MA60057809**.**

Nicole Eskandari received a Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in Kenmore, Washington in 2016. She is currently an East Asian Medical Practitioner (EAMP) in the State of Washington, holding license number AC60653216 since 2016.

Micheala Keehn received a Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in Kenmore, Washington in 2016. She is currently an East Asian Medical Practitioner (EAMP) in the State of Washington, holding license number AC 60720497 since 2016.

Scope of Practice: I hereby acknowledge and authorize Ashley Schiavone EAMP, Nicole Eskandari EAMP or Micheala Keehn, EAMP to perform the following treatments under the scope of practice of both EAMP and/or LMP if applicable in the state of Washington. This includes the following treatments below, but are not limited to:

- **Acupuncture, Moxibustion, Cupping, Infrared Heat, Dermal-friction Technique (Gwa-sha), Acupressure, Superficial Heat and Cold Therapy, Electrical, Mechanical or Magnetic Stimulation of Acupuncture Points, Sonopuncture, Laser puncture**
- **Dietary Advice and Health Education Based on East Asian Medical Theory**
- **Chinese Herbal Therapy**
- **Breathing, Relaxation, Qi Gong, and East Asian Exercise Techniques**
- **East Asian Massage and Tui Na:** this does not include spinal manipulation.
- **CranioSacral Therapy**

I recognize the potential benefits and risks of these procedures, which include but are not limited to:
Potential Benefits: Relief of presenting symptoms without the need of medication, relief from pain, improved circulation, improved immune system and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem. **Potential Risks:** Discomfort, pain, muscular tenderness, some pain following treatment in insertion area, minor bruising, burn, blistering, bleeding, infection, numbness or tingling at or near the site of the procedure, temporary discoloration or reddening of the skin, broken needle, needle sickness, possible aggravation of symptoms existing prior to the acupuncture treatment, allergic reaction to herbs, homeopathics or supplements. Dizziness, fainting or other bodily responses associated with general touch therapy. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). In the unlikely event of physical injury, immediate medical treatment will be obtained at the nearest health care facility. The costs of such emergency medical treatment will be the financial responsibility of the participant.

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Patients with bleeding disorders or pacemakers as well as pregnant patients must inform the practitioner prior to receiving treatment.

I acknowledge that all of the information that I provide is current and correct to the best of my knowledge. I understand it is my responsibility to inform my practitioner, if there are any changes to this information. I understand that if I experience any unusual discomfort and/or pain during my treatment session that it is my responsibility to inform my practitioner, so that she can adjust the pressure or technique being used. I acknowledge that I am responsible to show up for my appointment on time and that the therapist is not under obligation to extend my session.

I acknowledge that it is my responsibility to seek the advice of a medical doctor or other primary healthcare provider as I see fit to ensure that in the event of serious illness, I do not unknowingly delay necessary medical treatment.

Consent for Records Release: I understand that my practitioner will abide by the Notice of Privacy Practices in accordance with the Health Information Privacy Act, a copy of which I have been given or declined. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law and for insurance claim processing reasons. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my practitioner to the best of his/her ability. I also understand that my initials here authorizes this office to release the medical information necessary to process my insurance claims if applicable.
_____ **(initial)**

With this knowledge, I voluntarily consent to the above procedures, correspondences and releases, realizing that no guarantees have been given to me by Micheala Keehn EAMP or Ashley Schiavone EAMP ,regarding cure or improvement of my condition. I hereby release, Micheala Keehn or Ashley Schiavone, from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Signature: _____ Date: _____

Print Name: _____

Parent/Legal Guardian: _____Date: _____
(if under 18 years of age)

Practitioner Signature: _____Date: _____

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Insurance Verification

If you will be using insurance benefits, please call your insurance company and complete this form to help you understand what to expect from your insurance benefits.

Due to the variance from one insurance policy to another, we require that each patient is responsible for the understanding their insurance benefits.

Patient's Full Name:_____

Insurance Company:_____ Group Number: _____

Policy ID Number (with any letter prefix) :_____

Primary Insured (if different than self):_____

Primary Insured Date of Birth_____ Relationship to the patient:_____

Date of call:_____ Time:_____ Spoke to:_____

1. Is Acupuncture covered on my plan? Y / N

2. Is a referral or a pre-authorization required? Y / N

3. Is there a co-payment that I (the patient) am responsible for per treatment? Y / N
   If yes, what is it? $_____

4. Is there a co-insurance that I (the patient) am responsible for? Y /N
   If yes, what percentage of the visit is covered
   by insurance? _____%
   by patient? _____%

5. Is there a deductible? Y / N
   If yes, what is the deductible? $_____
   How much has been met? $_____

6. Is there a maximum yearly benefit for Acupuncture? Y / N

7. Do you currently have an open L&I claim or had one within the last 6 months? Y / N
   *If you checked yes, please be advised that L&I DOES NOT COVER ACUPUNCTURE.

8. Do you currently have an open PIP claim or had one within the last 6 months? Y / N

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WELCOME to our office! We are here to support and empower you in your journey and goals to improve health, well-being and your expression of living joyfully. Please complete the following questionnaire as thoroughly as possible in order for us to understand your health. This will become a part of your confidential records and will not be released unless you have authorized us to do so. Please let us know if you have questions.

Full Name: _____

Date of birth:_____ Age:_____Gender(sex):_____

Address:_____City:_____State:_____Zip:_____

Phone: (____)_____ Email*: _____

*Email will be used to contact you about upcoming appointments and will not be shared with anyone.

*We do not encrypt our emails. Do you agree to receive non encrypted emails? yes no

Emergency contact:_____Phone: (____)_____Relation:_____

How did you hear about us? _____

Present health concerns you would like to address (in order of importance):

Concern/Condition	Prior diagnosis? If so, what is it?

- **Vitamins/Herbs/Supplements** (current):

Name / type	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

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• **Medications** (current prescription and over-the-counter):

Name / type	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

• **Family History:** Using the following key to designate which family members have had the following. List specifics where parentheses are present.
S=Self, M=Mother, F=Father, Sib= Sibling, G=Grandparent C=Child

Condition	Who	Condition	Who	Condition	Who
Allergies		Cancer		Kidney Disease	
Addiction (alcoholism/ drug)		bleeding/clotting disorder		Mental/ emotional(anxiety/ depression, panic attacks, etc)	
Anemia		Epilepsy		Stroke	
Asthma		Heart Disease		Thyroid (low/high)	
Arthritis		High Blood Pressure		Tuberculosis	
Autoimmune Disease		High Cholesterol		Other_____	
Diabetes		Hepatitis (A,B,C, other)		Other_____	

• **Personal History:**

Tobacco use? _____How often_____
Alcohol?_____How often_____
Recreational drugs?_____ How often_____
Caffeine? _____ How often_____

Please circle
Single
Married
Partner
Widowed

•**Energy level:** (average per week, circle one):
(low energy) 1 2 3 4 5 6 7 8 9 1 0 (high energy)

•**Stress level:** (average per week, circle one):
(low stress) 1 2 3 4 5 6 7 8 9 1 0 (high stress)

- **How do you cope with stress?** _____
- **Occupation:** _____
- **Exercise:** Type(s)/frequency_____
- **Eliminations:** How many bowel movements per day(s)?_____

  Consistency(circle): hard, formed, soft, watery other_____

•Does stool pass easily (circle)? yes no *Laxative use (circle)? yes no
•Any mucus or blood on stool ? yes no *Any blood in urine? yes no
•Any pain, incontinence, frequency, other urinary symptoms (circle)?_____

•Are you sexually active? (circle one) Yes / No. History of STD_____

- **Digestion:** (circle or explain): Any stomach upset, pain, bloating, burping, reflux, flatulence (gas), nausea, or rectal itching after food?

  _____
- What do you do on a daily or weekly basis to improve your health?

  _____
- What do you feel is your biggest area for improving health?

  _____

- **Review of systems:** Please **circle the line item if you *currently*** have any of the following. Indicate ones of your past with a "P".

•daily fatigue	•anxiety	•arthritis
•frequent sinus infections	•high stress	•low back pain
•sinus congestion	•tension in body	•neck pain
•seasonal allergies	•depression	•joint pain
•asthma	•panic attacks	•(_____)
•chronic bronchitis	•emotional mental disorder	•whole body pain
•difficulty breathing	•(_____)	•hot or swollen joints
•tuberculosis		•numbness
•eczema	•Hepatitis (A,B, C, other)	•weakness in limbs
•psoriasis	•low libido	•nerve pain

•head trauma •whiplash •recurrent headaches	•autoimmune condition •(_____) •hyperthyroid •hypothyroid	•heart disease •chest pain •pace maker •irregular heart beats
•vertigo/dizziness •edema •high cholesterol •high blood pressure	•cancer •(_____) •Disease •(_____)	•prostate enlargement •testicular pain/swelling •erectile disfunction
•stomach ulcers •ulcerative colitis •diverticulitis •constipation •diarrhea •hemorrhoids •lasting nausea •recurrent vomiting	•dentures •mouth sores •brittle nails/dry skin •recent change in vision •skin rashes •loss of hearing •ringing in ears •TMJ, jaw pain	•irregular menses •excessive menstrual flow •no menstruation •painful menses/cramping •infertility •miscarriage •abortion •hot flashes •night sweats

If any of the above needs to be detailed or if there is anything else you would like your practitioner to know please do so here:

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form! It ensures that we will be able to look at your individual goals and needs according to your complete health picture.