

ASHLAND ACUPUNCTURE

• compassionate, wholistic health care for body, mind & spirit •



Suzanne E. Sky, L.Ac., MTOM
1605 Siskiyou Blvd. Ashland, OR 97520
phone 541.488.9696 fax 541.552.9684
www.ashlandacu.com

Welcome!

Thank you for entrusting me with your health care! Offering 30 years of experience, knowledge and continuing research to draw upon. I work with each person as an individual to determine a treatment plan, which will change over time according to your needs. We have time during each office visit to touch base and discuss your progress.

Please peruse my website for further information and articles.

I work to facilitate the healing process by activating and expanding each person's innate healing and regenerative capacity. With Chinese medicine as my framework, I integrate various aspects of wholistic healing, combining ancient Eastern modalities and modern knowledge. This includes acupuncture, herbal medicine, nutritional medicine, dietary and lifestyle considerations. I look forward to working with you!

Your Initial Visit Your first appointment will take around one to one and a half hours. I review and discuss your health history with you, answer your questions, and discuss treatment recommendations. You also receive a full treatment during your first visit.

Please bring the following to your initial visit:

Intake Form Please fill in the intake form as best you can. It is extensive, which allows me to be aware of your complete health history. I appreciate your taking the time to fill this out. I review this form before we meet and this also allows me to spend your first appointment talking with you in more depth and to begin formulating a treatment plan with you.

Insurance Please bring in your insurance card before or at your first visit. We will call your provider to confirm your insurance benefits. We encourage you to call as well, since GET WORDING FROM FORMS

Medical Reports Please bring any medical reports that are pertinent to your condition, such as blood tests, bone scan reports, pathology reports or other written reports that will help me understand your condition more completely. Please get these reports directly from your physician.

Clinic Hours Open Monday – Thursday – usually:
Monday 11am to 6:30 pm
Tuesday and Wednesday 2:30 pm to 6:30 pm
Thursday 10:30 am to 1:30 pm
Other times by appointment.

Scheduling Often I am booked out 1 to 2 weeks in advance. I recommend booking a few weeks in advance if you need appointments on a specific day or time. Afternoon hours are the most popular.

Cancellation Policy We have a 24-hour cancellation policy. We charge \$30 (half the regular appointment fee) for missed appointments or those cancelled with less than 24-hour notice.

Web site
ashlandacu.com My website offers many pages of articles on a variety of subjects. Please visit the site periodically, as I often update with new information.

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INITIAL HEALTH ASSESSMENT

Today's Date _____

Thank you for filling this out so we may be of service!

Name _____ Male Female Age _____ Birth Date _____
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different) _____

Home Phone _____ Work Phone _____

Fax _____ E- mail address _____

Employment Status: Full-time Part-time School Retired Unemployed Other _____

Occupation _____ Employer _____

Employer's Address _____

Relationship Status: Single Married Divorced Widowed

Name of Partner/Spouse/Parent _____ Occupation _____

EMERGENCY CONTACT: In Case of Emergency Contact _____ Phone # _____

Do you have insurance? Yes No Provider _____ Your SSN _____

Whom may we thank for referring you? _____

Main health issue(s) you wish to address _____

What was initial cause? _____

How long have you had this/these condition(s)? _____

Is it getting worse? Yes No Does it bother your: Sleep Work Other _____

What seems to make it better? _____ What seems to make it worse? _____

Other therapies you have tried or are trying to help this condition _____

Have you had acupuncture before? Yes No Chinese Medicine? Yes No

Please tell the story of this condition (s) (use the back side of this page if necessary):

Family History

Please include any of the following:

alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, other addiction or illness.

<u>Member</u>	<u>Living?</u>	<u>Age</u>	<u>Important Diseases</u>	<u>Cause of death</u>	<u>Age</u>
Mom					
Dad					
Sib(s)					
Grandparents					

Current /Recent Health Care Providers

<u>Name</u>	<u>Dates</u>	<u>Care Provided</u>

Allergies

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc. _____

Hospitalizations/Surgery

<u>Date</u>	<u>Hospital</u>	<u>Diagnosis/Operation</u>	<u>Doctor</u>

Accidents/Injuries - briefly describe

MORE than 5 years ago _____

LESS than 5 years ago _____

Have you ever been diagnosed with cancer, a mass or tumor? Yes No

Type _____ Location _____ Stage _____ Current Status _____

<u>Date</u>	<u>Chemotherapy/Radiation/Other Treatment</u>	<u>Duration</u>

Medications - Please list all prescription and over-the-counter medications you are currently using

<u>Medication Name</u>	<u>What it's for</u>	<u>For how long?</u>	<u>Strength</u>	<u>Dose</u>	<u>Frequency</u>

SUPPLEMENTS/HERBS **Were these recommended by:** a practitioner self both

<u>Supplement/Herb Name</u>	<u>Brand Name</u>	<u>Potency(mg or IU, etc)</u>	<u>Dose</u>	<u>Frequency</u>

Current Personal Information

In general, I feel my overall health is: Excellent Good Fair Poor

Mark the following: 1 - if current, 2 - if past

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> palpitations | <input type="checkbox"/> migraines |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> sciatica | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> frequent depression |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> dribbling urine | <input type="checkbox"/> heart problems | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> painful urination | <input type="checkbox"/> poor sleep | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> scanty urination | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> blood in urine | <input type="checkbox"/> severe mood swings | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> prostate problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> no/low sex drive | <input type="checkbox"/> overweight | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> allergies | <input type="checkbox"/> impotence/frigidity | <input type="checkbox"/> underweight | <input type="checkbox"/> stroke |
| <input type="checkbox"/> sinus congestion | <input type="checkbox"/> afternoon persp/fever | <input type="checkbox"/> eating disorder | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> colitis | <input type="checkbox"/> night sweats | <input type="checkbox"/> gum/teeth problems | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> Chron's | <input type="checkbox"/> hearing problem | <input type="checkbox"/> lots of fillings | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> memory difficulty | <input type="checkbox"/> TMJ | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> parasites | <input type="checkbox"/> concussion | <input type="checkbox"/> frequent anger | |
| <input type="checkbox"/> gas | <input type="checkbox"/> anxiety | <input type="checkbox"/> frequent frustration | |
| <input type="checkbox"/> bloating | <input type="checkbox"/> arthritis | <input type="checkbox"/> heartburn/acid indigestion | |

Height _____ Weight _____ Blood Type _____ Blood Pressure _____

Please rate the following on a scale of 1 to 10 (10 being the best) & write in any comments:

Sleep _____

Energy Level _____

Appetite _____

Digestion _____

Any gas, bloating or other discomfort after eating: Yes No Describe _____

Elimination regular? Yes No Bowels: Float Sink Bad odor No odor Blood present

Do you rely on any of the following for bowel elimination? Yes No How often? _____

enemas laxatives purgatives What type/brand? _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? _____

Any foreign residence or travel in last two years? _____

Physical exercise: Avid Regular Sporadic Rare Not now

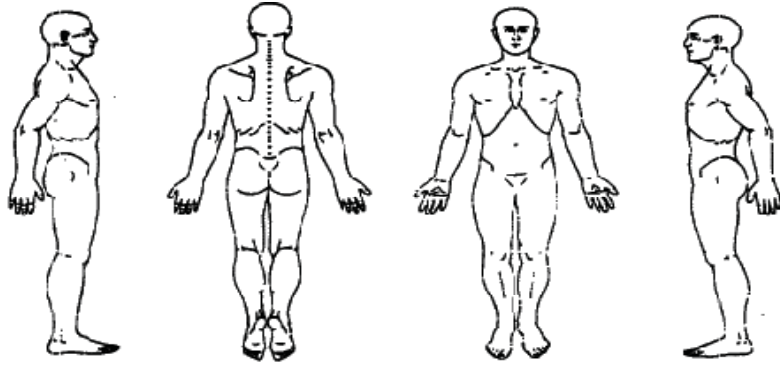
Type _____

Tobacco: how much? _____ (previously? _____ how much? _____ how long? _____)

Caffeine: how much? _____ Alcohol: how much? _____ how often? _____ Marijuana: _____

Other mood/mind altering substances (past/present) _____

Please circle or mark on the diagram any areas of pain or injury



Pain: dull sharp stabbing throbbing cramping burning limited range of motion limited use

<u>Area/Description of symptoms</u>	<u>Pain Level: 0 to 10 (10 as highest)</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diet, Exercise, Lifestyle

Dietary preferences/restrictions _____ Cravings? _____

What is your favorite food? _____ Favorite flavor? _____

Do you eat meals regularly? Yes No

Sample of day's menu (please also fill out 3-day food chart if you have been asked to do so)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Water and fluids _____

How do you feel about the following areas of your life?

Please check appropriate boxes & make any comments you would like to:

	GREAT	GOOD	FAIR	POOR	Comments
Self					
Work					
Spouse/Partner					
Sex					
Family					
Diet					
Spiritual Life					

Recent significant life events? (i.e. divorce, relocation, job change, death in family etc) _____

I commonly cope with stressful periods by _____

~FOR WOMEN ONLY!~

MENSTRUAL PERIODS

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

Since age _____ Regular? Yes No Flow lasts _____ days Length of cycle _____
Color of blood: light red dark red brownish other _____ Light Heavy Clots
Date of last menses _____ PMS Breast distention moodiness bloating other: _____
 Menstrual cramps (which days? _____)

HISTORY

Mark the following: 1 - if current, 2 - if past

___ hysterectomy	___ pain with intercourse	___ fibroids	___ breast reconstruction
___ D&C	___ dryness with intercourse	___ irregular bleeding	___ lumpectomy
___ tubular ligation	___ interstitial cystitis	___ breast implants	___ mastectomy
___ ablation	___ yeast infections	___ breast lumps (please describe _____)	
___ irregular PAP smear	___ pain during ovulation	___ fibrocystic breasts	___ endometriosis
___ vaginal discharge (color _____ frequency/when _____ amount _____)			

Date of last PAP smear _____ Results _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? Yes No Do you think you may be? Yes No

Number of pregnancies: _____ Number of children _____
Terminations? _____ Miscarriages? _____ Tubular pregnancies? _____

Difficulty in conceiving? _____

Birth control method(s): _____

MENOPAUSE

No menses since: _____

Experiences/symptoms you are currently feeling/having? _____

Experiences/symptoms you had in the past during menopause? _____

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INFORMED CONSENT STATEMENT

Suzanne E. Sky, L.Ac., MTOM is a Licensed Acupuncturist trained through two nationally accredited schools: the Tai Hsuan Foundation College of Acupuncture & Chinese Herbal Medicine in Hawaii and the Pacific College of Oriental Medicine in Southern California. She holds two Masters degrees; one in Acupuncture & Chinese Herbal Medicine and a second in Traditional Oriental Medicine. Licensed in the states of California and Oregon, she also holds national certification through the National Commission for Certification of Acupuncturists.

Under Oregon law, acupuncture means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by stimulation of specific points by insertion of needles, with scope of practice including traditional and modern Oriental medical and acupuncture techniques of diagnosis and evaluation, use of an extensive herbal pharmacopoeia, vitamins, minerals, dietary advice, as well as Oriental massage, exercise and related therapeutic methods.

Ms Sky is not a medical doctor. She does not claim to diagnose, treat or cure any medical conditions or pathologies nor prescribe medicine nor in any way represent herself as so doing. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not for your care is your right and Ms Sky assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made for acupuncture, herbal medicine, nutritional or dietary recommendations to treat or cure any medical condition (b) all information given is for educational purposes only (c) there is no implied or stated guarantee of success or effectiveness of any specific treatment plan or guidelines (d) I am free to act upon or disregard the recommendations of Suzanne E. Sky, L.Ac as I so choose.

I hereby release Suzanne E. Sky, L.Ac. and Ashland Acupuncture LLC from any and all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints.

I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of Ms Sky to participate in a professional relationship with her pursuant to the statements herein.

Client Name (Printed)	Client Signature	Date
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Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent or Guardian Signature	Date
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ASHLAND ACUPUNCTURE FEE POLICY

- If you are not an insurance client, charges for all services are due and payable at the time services are rendered. We extend a Time-of-Service Payment Discount for those paying at time of service.
- Returned checks are subject to a \$25 fee.
- We require a 24-hour notice for cancellation of appointments.
- For appointments cancelled or broken without 24 hour advance notice, we charge 50% of our normal visit fee.

*I have read the above, understand, and hereby agree to the terms as stated.
In the event it becomes necessary to place for collection an unpaid balance
due for services rendered, I agree to pay collection fees, and should legal
action be filled, I agree to pay reasonable attorneys fees and other costs the
court determines proper.*

Printed Name

Signature

Date

*We want everyone to be able to receive necessary treatment.
If unusual circumstances or hardship prevents you
from seeking or continuing treatment,
please speak with our Office Manager
at 541.488.9696.*

We look forward to working with you.
Please let us know any further questions you may have.
Thank you!

PRIVACY POLICY STATEMENT

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.

This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways.

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representation you choose to have your protected health information.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders, by telephone correspondence, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of your healthcare information that this office has disclosed.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. Upon written request you have the right to amend your Protected Health Information.
5. You have the right to receive all notices in writing.

If you have any questions, complaints or want more information contact this office:

Contact: Ashland Acupuncture Office Manager

Telephone: 541.488.9696

Address: 1605 Siskiyou Blvd. Ashland, OR 97520

You may submit a written complaint to the U.S.A. Department of Health and Human services.

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for Healthcare Services in this office. A copy of the Privacy Policies can be obtained upon request.

Patient or Legal Guardian Signature

Date

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WAIVER AND ACKNOWLEDGEMENT OF BENEFITS FOR INSURANCE CLIENTS

As a service to Ashland Acupuncture clients, Suzanne E. Sky, L.Ac., MTOM is a Provider with Insurance panels and can process insurance benefits.

We want everyone to be able to receive necessary treatment. Please note the following:

• Services not covered by insurance include:

- Herbal or Nutritional Consults,
- Facial Rejuvenation, nutritional supplements, herbs, ointments and other products.
- Payment for these services is due in full at the time of service.

• We are happy to accept your case on assignment when your insurance company verifies your coverage. We file your claim forms to assist you in reimbursement. **By accepting your insurance on assignment, we are extending you credit. This courtesy may be withdrawn if circumstances warrant.**

• We make eligibility calls and do our best to verify availability of insurance benefits for acupuncture, amount of

deductible and to give you our best estimate of the number of visits you may have available with us through your current coverage. **However - you are responsible for the accuracy of this information!**

There are many factors beyond our knowledge and control such as the amount of deductible, when/how the deductible is met and what other health practitioners you are seeing. We have no way of assessing these factors and each plan varies widely. It can sometimes take several months until we learn if the insurance company will, in fact, pay for your services received.

• **We highly recommend that you also make an eligibility call and keep track of your benefits.** It is common to receive different information from the same insurance company.

• **You are responsible to pay any amount not paid by your insurance company.** We bill on 30 day cycles. **Past due accounts are subject to a \$10 monthly fee.**

• If unusual circumstances or hardship prevent you from keeping your account in good standing, please speak with the office manager.

We invite you to call and speak directly with our billing service with any questions about your insurance eligibility, payments, or balance. Leslie Primus can be reached at 541.535.7135.

Waiver and Acknowledgement

Therefore, by signing below, I understand and agree to the above, and that acupuncture and evaluation services may not be considered eligible for benefits or may be determined to be not medically necessary, even after an initial phone call to determine benefits.

Actual benefits may also change if the deductible has or has not been met and what other services you receive from health practitioners. I understand that I am responsible for keeping track of this information. I understand that my health insurance coverage has certain restrictions and limitations and that Ashland Acupuncture, Suzanne Sky, L.Ac., MTOM and staff are not able to determine all these factors in advance.

Since I have chosen to obtain acupuncture and consultation services, I agree to be financially responsible for any and all related charges if they are not covered by my insurance.

In the event it is necessary to place an unpaid balance for collection, I agree to pay collection fees, and should legal action be filled, I agree to pay reasonable attorneys fees and other costs the court determines proper.

I have read the above, understand, and hereby agree to the terms as stated.

PRINT NAME

SIGNATURE

DATE

INSURANCE ELIGIBILITY FORM

Client's Name: _____

Primary Insurance

Ins. Co. Name: _____ Ins. Co. Phone #: _____

Insured's Name: _____ Client's Relationship to Insured: _____

Insured's ID Number: _____ Insured's Policy/Group #: _____

Insurance Co. Claim Address: _____

Client's Date of Birth: ___ / ___ / ___ Insured's Date of Birth: ___ / ___ / ___ Insured's Employer: _____

Secondary Insurance

Ins. Co. Name: _____ Ins. Co. Phone #: _____

Insured's Name: _____ Client's Relationship to Insured: _____

Insured's ID Number: _____ Insured's Policy/Group #: _____

Insurance Co. Claim Address: _____

Client's Date of Birth: ___ / ___ / ___ Insured's Date of Birth: ___ / ___ / ___ Insured's Employer: _____

Assignment of Benefits

I, the undersigned, do hereby authorize payment directly to this office for all the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance. I hereby authorize Suzanne E. Sky L.Ac., and Ashland Acupuncture LLC to release all information necessary to secure these benefits. I authorize the use of this signature on all my insurance submissions.

Client or Legal Guardian Printed Name

Signature

Date