

ASHLAND ACUPUNCTURE

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



Suzanne E. Sky, L.Ac., MTOM
545 A Street, Suite 1. 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 changes over time according to your needs. We have time during each office visit to touch base and discuss your progress.

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!

PLEASE READ BEFORE YOUR FIRST VISIT

Your Initial Visit Allow 1 to 1.5 hours for your first appointment.
We will review and discuss your health history, 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.
I appreciate your taking the time to fill this out. This 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.
- Medical Reports** Please bring any medical reports pertinent to your condition, such as blood tests, bone scan reports, pathology reports or other written reports.

ASHLAND ACUPUNCTURE CLINIC INFORMATION

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

Cancellation Policy We have a 24-hour cancellation policy.
We charge \$35 for missed appointments or those cancelled with less than 24-hour notice.

Web site
www.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 _____ E-mail _____

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

Occupation _____ Employer _____

Employer's Address _____

Health insurance? Yes No Provider _____ Your SSN _____

Relationship Status: Single Married Divorced Widowed Number of Children: _____

Name of Partner/Spouse/Parent _____ Occupation _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone # _____

Whom may we thank for referring you? _____

Main health concern(s) you wish to address, in your order of importance:

1. _____
2. _____
3. _____

What was initial cause? _____

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

Is it getting worse? Yes No Does it bother you: 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 _____

Please write any other information regarding the above: (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.

| Member | Living? | Age | Important Diseases | Cause of death | Age |
|--------|---------|-----|--------------------|----------------|-----|
| Mom | | | | | |
| Dad | | | | | |
| Sib(s) | | | | | |

Current /Recent Health Care Providers

| Name | Dates | Care Provided |
|------|-------|---------------|
| | | |
| | | |

Hospitalizations/Surgery

| Date | Hospital | Diagnosis/Operation | Doctor |
|------|----------|---------------------|--------|
| | | | |
| | | | |

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 _____

Date _____ Chemotherapy/Radiation/Other Treatment _____ Duration _____

Allergies

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc. _____

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

| Medication Name | What it's for | For how long? | Potency | Dose | Frequency |
|-----------------|---------------|---------------|---------|------|-----------|
| | | | | | |
| | | | | | |

SUPPLEMENTS/HERBS Were these recommended by: a practitioner self both_

| Supplement/Herb Name | Brand Name | Potency(mg or IU, etc) | Dose | Frequency |
|----------------------|------------|------------------------|------|-----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Height _____ Weight _____ Blood Pressure _____

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

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

EARTH ELEMENT & DIGESTION

___ hypoglycemia ___ overweight ___ eating disorder ___ other:
___ diabetes ___ underweight ___ loss of appetite

After eating do you experience any of the following: ___ fatigue ___ gas, ___ bloating, ___ heartburn/acid indigestion

METAL ELEMENT

___ asthma ___ colitis ___ diarrhea ___ undigested food in stool
___ bronchitis ___ Chron's ___ constipation ___ hard, dry stool
___ pneumonia ___ diverticulitis ___ alternating diarrhea and constipation
___ shortness of breath ___ blood in stool ___ pass gas regularly

Elimination regular daily? Yes No Bowels: Float Sink Bad odor No odor

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

enemas laxatives purgatives What type/brand? _____

WATER ELEMENT

___ scanty urination ___ prostate problems ___ ringing in ears ___ no/low sex drive
___ painful urination ___ urinary tract infections ___ kidney stones ___ impotence/frigidity
___ dribbling urine ___ blood in urine ___ mental fog or fatigue ___ hair loss/thinning
___ frequent urination ___ anxiety ___ adrenal deficiency/fatigue ___ memory difficulty

WOOD ELEMENT

___ migraines ___ frequent depression ___ hemorrhoids ___ drug addiction
___ frequent headaches ___ frequent frustration ___ jaundice ___ alcoholism
___ stroke ___ frequent anger ___ hepatitis: Type ___ When: _____
___ gall bladder issues ___ oily or rich foods cause distress ___ varicose veins:

FIRE ELEMENT

___ palpitations ___ tightness in chest ___ severe mood swings ___ heart issues: _____

MIXED PATTERNS

___ frequent colds/flu ___ chronic fatigue ___ arthritis ___ dizziness
___ sinus problems ___ mononucleosis ___ afternoon persp/fever ___ night sweats
___ allergies ___ Epstein-Barr ___ gum/teeth problems ___ lots of fillings

EYES ___ eye problems ___ photophobia ___ other: _____

OTHER ___ HIV positive/AIDS ___ epilepsy ___ other: _____

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

Sleep _____

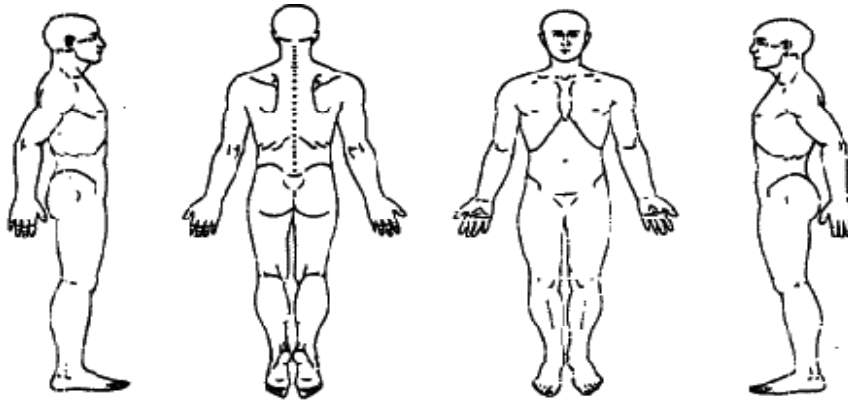
___ light sleep ___ trouble falling asleep ___ fall asleep well, wake up later ___ sleep well

Usual bedtime _____ Usual hours of sleep per night _____

Energy Level _____

Best time of day _____ Lowest energy time _____

Please circle or mark any areas of pain or injury



Pain: dull sharp stabbing throbbing cramping burning

Area/Description of symptoms

Pain Level: 0 to 10 (10 highest)

Frequency

| | | |
|--|--|--|
| | | |
| | | |
| | | |

Diet, Exercise, Lifestyle

Dietary preferences/restrictions _____ Favorite food? _____

Favorite flavor? _____ Cravings? _____ Do you eat meals regularly? Yes No

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Water and fluids _____

Physical exercise: Avid Regular Sporadic Rare Not now

Type: _____

Tobacco: Past Present: How much? ____ Alcohol: how much/often? ____ Caffeine ____

Marijuana: ____ Other mood/mind altering substances (past/present) _____

Exposure to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? _____

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

| | GREAT | GOOD | FAIR | POOR | Comments |
|----------------|-------|------|------|------|----------|
| Self | | | | | |
| Work | | | | | |
| Spouse/Partner | | | | | |
| Sex | | | | | |
| Family | | | | | |
| Diet | | | | | |
| Spiritual Life | | | | | |
| Stress Level | | | | | |

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
 pain during ovulation 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 ___ ovarian cysts ___ endometriosis ___ mastectomy
___ ablation ___ yeast infections ___ breast implants
___ breast lumps (please describe _____) ___ fibrocystic breasts
___ vaginal discharge (color _____ frequency/when _____ amount _____)

Date of last PAP smear _____ Results _____

___ Have you ever had an irregular PAP? Yes No If yes, when? _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? Yes No Do you think you may be? Yes No
Difficulty in conceiving? Yes No Number of pregnancies: _____ Number of children _____
Terminations? _____ Miscarriages? _____ Tubular pregnancies? _____

Birth control method(s): _____

MENOPAUSE

No menses since: _____

Current experiences/symptoms? _____

Past experiences/symptoms 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

If signing for a minor: 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

Signing for: (Name of Minor)

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.

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.

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

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

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

**Ashland Acupuncture Office Manager
545 A Street, Suite 1 Ashland, OR 97520
541.488.9696**

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for Healthcare Services in this office.

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.

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 to make arrangements.

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

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.

Printed Name

Signature

Date