Lynn Cheng Holistic Healing

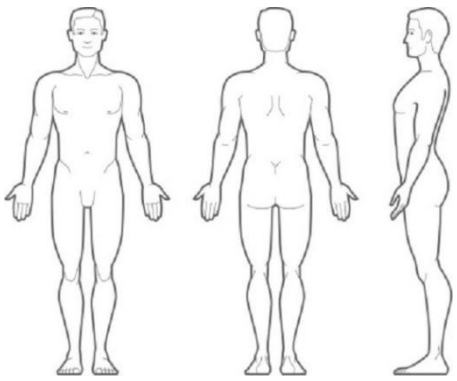
Confidential Patient Information Form

Name:_____Date:_____
Address:_____Zip:____
Phone:_____Cell:_____
Email:_____ Height: _____ Weight: _____
May I contact you via mail or email with newsletters/special offers? _ Yes _ No
How did you hear about me?

- ___Referred by friend or family member: Name: _____
- ___I'm a MindBodyZone member
- ___I attend your yoga classes
- ___Yelp
- ___Online search
- ___Facebook ____Instagram
- ___Other: _____

Sex: __ M __ F __Other Birthdate: _____/_____/_____
_Single __Married/Partnership __Divorced __Widowed __Separated
Occupation:_____Employer:_____
Emergency Contact:_____Phone:_____
Is this your first time receiving acupuncture? __Yes __No
Are you pregnant/is there a chance that you are pregnant? __Yes __No
Have you ever been diagnosed with HIV/Aids, Hepatitis B or C, Tuberculosis, or Herpes? __Yes __No
Are you taking Coumadin, Warfarin or blood thinners? __ Yes __No
Do you bruise easily or bleed for a long time? __ Yes __No
Do you tend to faint? __ Yes __No
Allergies (food, drugs, seasonal, etc):_____

Please indicate areas of pain (if any):
Is the pain/discomfort:
___ sharp __ dull __burning ___achy
__ stiff ___other: _____



Rank the pain on a scale of 1-10 _____
(1-mild, 5-moderate, 10-severe)

LIFESTYLE/HABITS

Exercise: (check one)
__Mostly sedentary (little to no activity in career/home)
__Mild exercise (housework, climb stairs, gardening, etc.)
__Occasional vigorous exercise (moderate manual labor, exercise <4x/week for 30 min)
__Regular vigorous exercise (hard manual labor, exercise >4x/week for 30 min)
__Extreme exercise (professional athlete, serious athlete, exercise 6-7x/week for >45 min)
Type of exercise/activity: _____

Typical Diet:

Morning _____

Lunch_____

Dinner_____

Snacks_____

Please list any dietary restrictions_____

How much of the following do you drink per day? Water (oz.)_____Soft Drinks (cans)_____

Place an **X** where you fall on these continuums:

Temperature (wearing more/less layers): COLD|----------|----------|HOT

Moisture (skin/mouth/hair/bowels etc): DRY|----------|----------|OILY

Digestion: DIARRHEA|----------|----------|CONSTIPATION

Energy: LOW|----------|----------|HIGH

HEALTH HISTORY

Medications, supplements, **herbs** you take regularly (prescribed or otherwise):

Name	Purpose	Date/year started taking
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

Health Conditions:

Circle  if YOU have/had the condition and note the year it started.

Circle  if there is a family history of the condition

	You	Year	Family		You	Year	Family
Cancer: type? _____		_____		Pacemaker		_____	
Diabetes		_____		Osteoporosis		_____	
Hepatitis: type? __		_____		Kidney disease		_____	
High Blood Pressure		_____		Autoimmune disease		_____	
Heart disease		_____		Anemia		_____	
Stroke		_____		HIV/AIDS		_____	
Seizure disorder		_____		Alcoholism		_____	
Thyroid disorder		_____		Drug Addiction		_____	
Asthma		_____		Arthritis		_____	
High cholesterol		_____		Suicide		_____	
Vegetarian/Vegan		_____		Mental Illness		_____	

SYMPTOM SURVEY

Please leave **blank** if never experience, **check (√)** if sometimes experienced in the past 6 months, **plus sign (+)** if frequently experienced in the past 6 months.

WOOD
__irritable/angry/grumpy
__easily triggered or agitated
__stressed/frustrated
__sigh frequently
__difficulty in making plans
__lack of motivation
__depression
__emotional eater
__cold hands and/or feet
__breast lumps/PMS
__feeling of lump in throat
__clenching of teeth at night
__neck/shoulder tension
__bitter taste in mouth
__indecisive
__timid/shy/frightens easily
__difficulty digesting oily or greasy foods
__gall stones

__blush easily or face flushes, turns red or feels hot when upset
__tendonitis
__headaches
__migraines
__vertigo

EARTH
__decreased appetite
__increased appetite
__crave sweets
__lack of taste
__loose stools or diarrhea
__constipation
__hemorrhoids
__vomiting/nausea
__abdominal pain
__digestive problems
__indigestion, belching, burping
__heartburn/reflux
__bad breath
__feeling of food “sitting” in the stomach
__ obsessive or compulsive
__overthinking
__worry
__heavy sensation in body
__edema/swollen
__brain fog/foggy head
__tendency to gain weight
__mucus/phlegm (from chest, nose, throat, abnormal vaginal discharge)

XU
__fatigue/lethargy
__sleepy after eating
__hard to get up in the am
__muscles feel tired often
__weak feeling/lack of strength in arms and legs
__easily bruised
__difficult to stop bleeding
_____
__dry hair
__dry/red/itchy eyes
__blurry vision
__eye floaters/spots
__poor night vision
__soft or brittle nails
__dizziness
__spasms or twitching of muscles/tremors/cramping
__numbness/pins & needles
__pale/brittle/ridges on nails

BLOOD STAG
__fixed, sharp or stabbing pain
__varicose/spider veins
__dark skin spots/liver spots
__purple lips/spots on lips
__clots in menstrual blood

METAL
__cough
__shortness of breath
__itchy/red/painful throat
__dry mouth/throat/nose
__bronchitis/pneumonia
__decreased sense of smell
__nasal problems/congestion
__sinus infection/congestion
__asthma
__allergies/hay fever
__skin rashes/dermatitis
__eczema/psoriasis/dry skin
__tendency to catch colds easily
__intolerance to weather changes
__easy or excessive sweat
__feeling grief or sadness

FIRE
__heart palpitations
__chest/angina pains
__tight chest feeling
__high blood pressure
__low blood pressure
__mouth ulcers
__insomnia, difficulty sleeping
__nightmares or vivid dreams
__manic episodes
__mentally restless
__difficulty concentrating
__frequent crying
__lack of joy in life
__laughing for no apparent reason
__anxiety

WATER
__low back pain/sore/weak/cold
__knee pain/sore/weak
__hearing impairment
__ear ringing/tinnitus
__poor memory
__hair loss
__kidney stones
__urinary problems/incontinence
__frequent urination
__bladder infections
__cavities
__decreased bone density
__feeling cold or hands/feet cold
__decreased sex drive
__impotence
__premature ejaculation
__hot flashes
__increased sex drive
__night sweats
__vaginal dryness
__fear, scared

Lynn Cheng Holistic Healing

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture and other procedures by the licensed acupuncturist Lynn Cheng and/or other licensed acupuncturists who now or in the future treat me while working with Ms. Cheng or serves as a back-up for her in the event of a necessary cancellation, including those working in the same office, whether signatories to this form or not. I have discussed the nature and purpose of my treatment with Lynn Cheng.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, electrical stimulation, and bodywork therapies such as Trigger Point Massage, Medical Massage, Tui Na (Chinese Massage) and yoga. It may also involve the modalities of herbal medicine, nutritional advice, and lifestyle counseling consistent with the principles of holistic Chinese medicine. I understand that Lynn Cheng performs acupuncture treatments with the insertion of acupuncture needles through the skin, or by the application of heat to the skin, or by both in an attempt to support the body's physiological functions.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, bleeding, pain and discomfort, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting and temporary aggravation of symptoms in existence prior to treatment. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. Pain and soreness are a possible result of body work. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, single use, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I also understand that Chinese medicine is not primary care medicine and that if my symptoms worsen, new symptoms arise, or I have any concerning change in my health status I should consult a licensed medical doctor. I do not expect Lynn Cheng to be able to anticipate and explain all possible risks and complications of treatment. I understand that I should inform her prior to being treated if I believe I might be pregnant. I understand that no results are guaranteed concerning acupuncture's and associated techniques, and that I am free to stop acupuncture treatment at any time. None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate. I understand that Lynn Cheng may discuss my case to provide thorough and accurate treatment of my condition. Otherwise, all my records will be kept confidential and will not be released to any party without my written consent.

I agree to abide with the Covid-19 office policies and understand that while extraordinary steps are being taken to ensure the safety and good health of both patients and practitioners, 100% protection from infection cannot be guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

Date Consent Completed _____

_____ Print Name of Patient

_____ Print Name of Patient Representative (if applicable)

_____ Signature of Patient or Representative

_____ Name & Signature of Acupuncturist: Lynn Cheng

Lynn Cheng Holistic Healing

Office Policies

POLICY IN THE WAITING AND TREATMENT ROOMS: All types of electrical equipment (i.e. cell phones) must be turned off during the treatment and while in the waiting room. Please keep voices to a minimum as others may be receiving treatments at this time.

PAYMENT: Payment is due at the time of service. Cash, checks, Zelle, and Health Savings/FSA cards are all acceptable forms of payment. Please be advised that any returned checks will be charged a $30 handling fee.

REASONS FOR BEING DISMISSED/DENIED TREATMENT: Patients who show inappropriate conduct, non-or late payment of fees, have signs/symptoms of Covid-19, or safety concerns may be denied treatment.

LATE POLICY: If you are more than 10 minutes late, you may not be seen or may have an abbreviated treatment and the treatment will still end at the regularly scheduled time. For example, if your appointment is from 5-6pm and you arrive at 5:15, the treatment will still end at 6pm and you will be expected to pay the full cost of the treatment.

COVID-19: You will NOT be seen in person if you are sick and have ANY of these symptoms: fever, body aches, sore throat, cough, shortness of breath, fatigue, loss of taste/smell, stuffy nose, sinus issues, new or sudden digestive upset. Instead, we can do an online telemedicine appointment. Also, if you have tested positive for Covid, you must wait 10 days and/or receive a negative Covid-19 test result to schedule an in-person appointment. If you make an in-person appointment and develop any of the above symptoms, you will need to cancel the appointment. I am waiving cancellation fees for this reason only.

INSURANCE: This office does not file insurance forms. I will gladly give you a receipt for all your treatments so you can submit them to your insurance company for request of reimbursement. Please verify with your insurance company that you will be reimbursed.

PLEASE INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THESE POLICIES BY SIGNING BELOW.

Signature of patient/guardian:_____ Date:_____

Printed name of patient:_____

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Cancellation and Missed Appointment Policy

Your appointment time is reserved specifically for you. Please give a minimum of 24 hours' notice when canceling your appointment. Patients who do not show up for their appointment or cancel less than 24 hours prior to their treatment will be charged $95 on the credit card listed below. Insurance will not pay for a missed appointment.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Last 4 digits of card number: _____

Expiration Date (mm/yr): _____ CVV: _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, understand that Lynn Cheng Holistic Healing has a 24-hour cancellation policy. If I do not cancel my appointment within the 24 hours or fail to show up for my appointment, I understand that I will be charged $95. I hereby authorize Lynn Cheng Holistic Healing to charge my credit card above for any late cancellation, no show, missed appointments or any other agreed purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Lynn Cheng Holistic Healing

Privacy Policies

Dear Valued Patient,

This notice describes my office's 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. To maintain the level of service that you expect from my office, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at my office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

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

- About your financial transactions with me (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, claim payment information).

Marketing: This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

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. There is a copy fee of $20 and 10 working days to process it.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing. If you have questions, complaints or want more information, please contact this office. I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

Patient Signature_____

Date_____

If I would like to review the Privacy Policies, I may request a copy from Lynn Cheng Holistic Healing LLC.