Kelly Shaw M.S.O.M. L.Ac Acupuncture and Chinese Medicine
6018 SE Stark St. Portland, OR 97215 (503) 808-9145

Initial Intake Form

Thank you for taking the time to complete the following information which will help me to assess your health needs. All information is confidential. I will be happy to answer any questions.

Today's date___/___/___

General Information

Name______________________________Birthdate___/___/___Age_____Gender___________________

Adress______________________________City______________________State__________Zip________

Phone Numbers (please mark * next to best number)

Home______________________Cell________________________Work__________________________

E-Mail address____

Marital Status________________________# of children__________Ages_________________________

Highest grade completed_______________Occupation_________________hours per week___________

Employer and location_________________________________Health Insurance Co.________________

How did you hear about us?____

Emergency Contact

Name:__________________________Phone:_____________________Relationship_________________

Under 18--- Responsible Party or Guardian information

Name______________________________Relationship to patient_________________________________

Healthcare providers---please list those who you work with.

Physicians: GP/Primary Care:_________________________ Seeking one? Y N

OB-GYN________________________________ Seeking one? Y N

Specialist_______________________________ Seeking one? Y N

Naturopath________________________________ Seeking one? Y N

Chiropractor_______________________________ Seeking one? Y N

Massage Therapist__________________________ Seeking one? Y N

Physical Therapist__________________________ Seeking one? Y N

Midwife___________________________________ Seeking one? Y N

Other_____________________________________ Seeking one? Y N

May I contact these providers to ensure coordination of your care? Y N

Health History

Please list your major health concerns in order of importance to you:____

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Circle those that apply to your past medical history:

- Adverse reaction to medical treatment
- Alcoholism
- Allergies
- Arthritis or rheumatism
- Asthma
- Attempted suicide
- Birth Trauma
- Bleeding disorder
- Blood disorder
- Cancer or tumor
- Diabetes
- Emphysema
- Eating disorder
- Fibromyalgia
- Heart disease
- Hepatitis/Liver disease
- Herpes
- High blood pressure
- HIV/AIDS
- Immune disorder
- Joint replacement
- Kidney disorder
- Low blood pressure
- Lyme's disease
- Lymph nodes removed
- Mental illness
- Multiple sclerosis
- Pacemaker
- Polio
- Rheumatic arthritis
- Rheumatic fever
- Sciatica
- Scarlet fever
- Seizures/Epilepsy
- Sinus infections
- Skin disease
- Special diet
- Stroke
- Substance abuse
- Thyroid disease
- Tuberculosis
- Ulcer
- Venereal Disease/STD
- Other

List any serious disease, injuries, surgeries, or hospitalizations you have had and the year they occurred:

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____

Family History (List any family physical or mental illnesses and age and cause of death)

Mother____

Father____

Grandparents____

Siblings____

Children____

Medications, Herbs, Supplements (list those you are currently taking):

Name_____________________Reason____________________How Long and dose__________

Name_____________________Reason____________________How Long and dose__________

Name_____________________Reason____________________How Long and dose__________

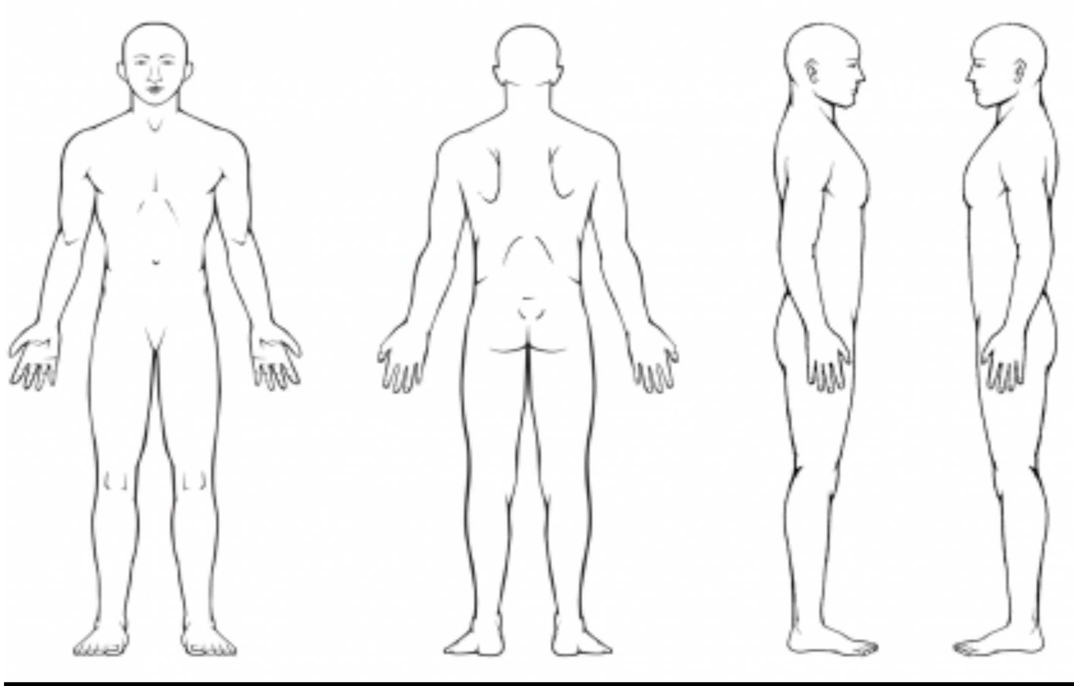
Name_____________________Reason____________________How Long and dose__________

Name_____________________Reason____________________How Long and dose__________

Do you have any communicable diseases or infections? Y / N
If yes, please list:____
____

Are you seeking treatment related to a personal injury case involving lawyers, and/or as a work related injury (i.e.Worker's Compensation benefits)? Y / N
If yes, please briefly specify and summarize:____
____

Please circle any areas of pain, numbness, and /or discomfort.



(1 = low, 10 = very high)

Please rate by circling, your level of energy, from 1 to 10. 1__2__3__4__5__6__7__8__9__10

Please rate by circling, your level of stress, from 1 to 10. 1__2__3__4__5__6__7__8__9__10

Please rate by circling, your level of pain, from 1 to 10. 1__2__3__4__5__6__7__8__9__10

Women's Health
For pre-menopausal women, please describe if you have any discomfort before, during or after your Menstrual cycle (such as breast tenderness, cramping, mood swings, etc...) ____

How many days in between each cycle?____

What is the duration of your flow ("how many days") and how heavy is it?_______________________________________

Color of the blood: (black, brown, bright red, dark red)____

Clots: Y/N, if so, what size? (dime, quarter etc...)____

Are you pregnant? Y / N, if so, how far along? _____________ Number of pregnancies ____ Number of children ______

Please mark the appropriate squares in the following list of symptoms.

If you have had a symptom in the PAST and do not have it now check the box.
If you are having a symptom CURRENTLY, fill the box in entirely

Liver/Gallbladder

☐ Depression/Stress
☐ Headaches/Migraines
☐ Red/Dry/Itchy eyes
☐ Visual problems/Blurred vision
☐ Dizziness
☐ Feeling of lump in throat
☐ Clenching teeth in throat
☐ Muscle cramping/Twitching
☐ Neck/Shoulder pain/Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle nails
☐ Bitter taste in mouth
☐ PMS/Menstrual problems
☐ Tendonitis
☐ Pain below ribcage
☐ Do you crave sour
☐ Tend to be irritable/Angry

Heart/Small Intestine

☐ Heart palpitations
☐ Rapid or Irregular heartbeat
☐ Chest pain
☐ High blood pressure
☐ Low blood pressure
☐ Insomnia/Sleep problems
☐ Vivid dreams/Nightmares
☐ Easily startled
☐ Dark urine
☐ Red complexion
☐ Do you crave bitter?
☐ Anxiety/Nervous or restless

Spleen/Stomach

☐ Body heaviness
☐ Hard to get up in the morning
☐ Muscles often feel tired
☐ Edema in hands or feet
☐ Bruise easily
☐ Bad breath
☐ Sweet taste in mouth
☐ Lack of taste
☐ Excess or low appetite (circle one)
☐ Excess of lack of thirst (circle one)
☐ Nausea/Vomiting
☐ Gas/Bloating
☐ Hemorrhoids
☐ Organ prolapse
☐ Chronic loose stools
☐ Abdominal pain
☐ Indigestion/heartburn
☐ Brain fog
☐ Mouth ulcers
☐ Tendency to gain weight
☐ Do you crave sweet
☐ Over-thinking/worry

Lung/Large Intestine

☐ Bloody cough
☐ Dry cough
☐ Chronic cough
☐ Cough with sputum
☐ Nasal discharge
☐ Post nasal drip
☐ Sinus infection/congestion
☐ Itchy, red, or painful throat
☐ Dry mouth/Nose/Throat
☐ Skin rashes/hives
☐ Snoring
☐ Shortness of breath
☐ Allergies/Asthma
☐ Low immunity
☐ Catch colds easily
☐ Bronchitis
☐ Black or bloody stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis/spastic colon
☐ Do you crave pungent/spicy
☐ Greif/sadness

Kidney/Urinary Bladder

☐ Urinary Problems
☐ Bladder infection
☐ Incontinence
☐ Weakness/Pain in lower back
☐ Osteoporosis
☐ Feel cold or hot easily (circle one)
☐ Cold hands/feet
☐ Low or excess sex drive (circle one)
☐ Dark circles under eyes
☐ Thyroid problems
☐ Poor memory
☐ Hair loss/grey hair
☐ Hearing problems/Tinnitus
☐ Cavities
☐ Hot flashes/night sweats
☐ Impotence or Premature ejaculation
☐ Do you crave salt
☐ Fear

Treatment Goals and Health Vision

The purpose of treatment is not just to avoid disease or overcome existing disease, but to move towards health and vitality and to empower your life. It is also to help people get the resources they need to live the life they want, and to allow that life to be full of meaning. My purpose is to help facilitate the creation of the physical, emotional and mental well being that you want to create for your life. Towards this, I encourage all patients to take some time to review what their goals for treatment are. Doing so allows the patient to acknowledge what it is they really want from our time together, and allows both of us the opportunity to see if we are moving towards that goal together for more efficacious treatments. Goals may include a few elements.

- First, they are what you really want, and not what you think you should want.
- Second, they are honest and represent the full truth of what you want.
- Third, they are not limited by what you think is possible.
- Fourth, whenever possible, they are stated positively as moving towards what you want rather than avoiding something you do not want.[1]

You may use the rest of this page to fill out your goals.

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[1] These steps are adapted from The Path of Least Resistance by Robert Fritz. I highly encourage all patients to read this book.

Treatment Terms and Conditions

The following are specific policies that will govern our work together.

Cancellation Policy

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hour's notice. We will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged the full fee for your session if you do not show up for your appointment or cancel your appointment with less than 24 hour's notice (1 full day).

Late Policy

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session

Phone Calls and Emails

You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. We are generally unavailable on weekends. Except for emergencies, phone and email contacts are limited to 10 minutes or our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed a flat rate of $35.

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other health care professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days of a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays, and seasonal greetings, announcements and to inform you about our practice and its staff.

Fees

It is our policy that you pay the entire session fee or co-pay at the time of each session. If you would like to arrange another payment option, please discuss it with us. We will provide a minimum of one month's notice of any changes to our fees.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Agreement

I have read and understood the clinic's policies. I agree to all of the above treatment terms and conditions.

Signature: ____ Date: ______________

Kelly Shaw L.Ac and Bitter Root Clinic of Chinese Medicine
6018 SE Stark St. Portland, OR 97215 (503) 808-9145

Consent for Treatment

I, ____, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture within the state of Oregon on me (or on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed at the Bitter Root Clinic of Chinese Medicine.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), shiatsu, gua sha, Chinese herbal medicine, and nutritional counseling. I understand that the herbs need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I have been informed that acupuncture is a generally safe method of treatment, but it may include side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring or bruising are potential risks of moxibustion, cupping and gua sha. I understand that while this document describes the major risks of treatment. other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff think at the time, based upon the facts then known are in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 conditions for which I seek treatment.

______ ____

Date Patient's Name (Print) Patient's Signature Date of Birth

Consent to treatment of a Minor Child:

I, ____, being the parent/legal guardian/personal representative of ____ have read and fully understand the above informed consent and hereby grant permission for my child to receive treatment at Bitter Root Clinic of Chinese Medicine.

HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my Protected Health Information by the Kelly Shaw, L.Ac for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

• Kelly Shaw, L.Ac has posted his Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

• I have the right to request restrictions to the usage and disclosure of my Protected Health Information.

• I have the right to request an alternative to the standard method of communication of my Protected Health Information.

• I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Kelly Shaw L.Ac at the following address:

6018 SE Stark St.
Portland, OR 97215

• I understand that while Kelly Shaw L.Ac may honor these requests, they are not required by law to do so.

• I am aware that Kelly Shaw L.Ac reserves the right to change the terms of the Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that he maintain. In the event of amendments, Kelly Shaw L.Ac will make available a revised Notice of Privacy Practice for my review.

____ _______________________

Patient (18 years or older) Date

____ _______________________

Parent, Guardian, Responsible Party Date

Kelly Shaw L.Ac, Fee Schedule

Welcome to our office! The information below is provided to make you aware that our fees are different if you are a cash paying patient versus if you have insurance, a personal injury (auto accident) or worker's compensation case.

Insurance patients: You will be responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance provider (the amount of these costs varies). Please note that we usually charge insurance companies between $150-350 per visits, dependent on the therapies performed in conjunction with the acupuncture, such as: manual therapy (massage), infrared, e-stim, moxibustion, therapeutic exercises, etc. Charges are often higher for new patient visits or re-evaluation of your case. We rarely receive what we bill since all charges are reviewed ad reduced by insurance companies. When you receive your explanation of billing (EOB) from your insurance company, it may tell you what you owe Bitter Root Clinic of Chinese Medicine the difference between what we charged for your visit and what your insurance actually paid. This is not necessarily the case. We will inform you if we will need to collect this balance or a portion of it.

There may be times when our billing service is misquoted information and payment is not made as initially described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change.

Cash Patients: Currently our cash rate for a new patient visit (thorough exam, treatment, and report of findings) is $110 and follow-up visits are $80.

These fees are called "point of service fees" as they are paid at the time services are delivered. Understand that this is also a discounted fee because it does not involve the administration and processing of insurance, and because we know most people are unable to pay our regular fees that we bill insurance companies. Since this is a discounted rate off of our usual fees, it, at any time, you have any other coverage either through insurance, an auto accident, or worker's compensation claim, please notify our office immediately so that we can make efforts to receive our regular rates.

Low-income/financial hardship: Kelly Shaw L.Ac strongly believes that everyone should have the opportunity to access medical care. As such we provide sliding scale payments in our practice for those who are under financial hardship or low income. Documentation of income is required to receive discounted services under financial hardship or low income. This documentation will be placed in the patient's records.

Worker's compensation (injury on the job) and Personal Injury (car accident) Cases: Patients are not usually responsible for any costs associated with a worker's comp or personal injury claim with the exception of herbs/supplements. Please speak directly without billing service about your case and provide adjuster's information. The fees charges are our standard rates for third-party payers, which are dependent on the therapies you receive with your treatment. If for any reason we are denied payment, you will be responsible for payment on the account (a plan that works with your budget can be devised).

All fees charged by Kelly Shaw L.Ac are reasonable and in keeping with industry standards.

Other services:

- Herbal and dietary consultation; 30 minutes $50
- Shiatsu massage; $80 per hour
- House calls an additional $50 for first 30 minutes of travel and $100 for up to 60 minutes of travel
- Bazi Suangming Consultation; $125 per session

Herbal and nutritional supplements are not covered by insurance or third party payers and must be paid for at the time these items are received.

I have read and understood the fees charged by Kelly Shaw L.Ac.

____ ______________

Patient Signature Date

Statement of Financial Responsibility
I understand and agree to the following general responsibilities:

- Financial options are extended to me based on the information I have provided.

- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service (unless payment arrangements have been made), including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.

- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.

- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the Kelly Shaw L.Ac to release information necessary to secure payment.

I have fully read and understand the above agreements and authorizations.

____ ___________________
Sign Patient (18 years or older) **Date**

____ ___________________
Print Name Patient (18 years or older)

____ ___________________
Sign Parent, Guardian, Responsible Party **Date**

____ ___________________
Print Name Parent, Guardian, Responsible Party