PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Birthday: _____ Sex: ☐ Male ☐ Female
Cell Phone: _____ Email: _____
Social Security #: _____
Check One: ☐ Married ☐ Single ☐Widowed ☐ Divorced ☐ Separated
Preferred Language: ☐ English ☐ Spanish ☐ Other _____
Ethnicity (Check all that apply): ☐ Caucasian ☐ African/African American ☐ Asian/Asian American
☐ Hispanic/Latino ☐ Hawaiian/Pacific Islander ☐ Other: _____

Business Employer: _____ Type of Work: _____
Business Phone: _____
Name of Spouse: _____ Spouse's Social Security #: _____
Names and Ages of Children: _____
Referred to Office By: _____
Emergency Contact: _____ Emergency Contact #: _____
Relationship to Emergency Contact: _____

Who is Responsible for Your Bill? You ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medical
(If insured, please provide the front desk with your insurance card and driver's license for verification.)

PAST HEALTH HISTORY

Major Surgeries/Operations (Describe and Date):

_____

_____

Major Accidents or Falls (Describe and Date):

_____

_____

Hospitalization (Other Than Above):

_____

_____

Allergies:

_____

_____

Ongoing Medical Conditions:

_____

_____

Family Medical History:

_____

_____

What Were You Doing For Preventive Care:

_____

_____

Please List Past Medications, Vitamins, and Dose:

_____

_____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other Doctors Seen for This Condition? □ Yes □ No If yes, who? _____

Is Condition Related to: □ Job □ Auto Accident □ Home Injury □ Fall □ Other _____

When Did This Condition Begin? _____ Has This Occurred Before? □ Yes □ No

Date of Accident: _____ Time of Accident: _____

Have You Made a Report to Your Employer? □ Yes □ No

Do You Wear a Shoe Lift? □ Yes □ No

Do You Currently : □ Smoke □ Consume Alcohol □ Consume Coffee □ Consume White Sugar

Please List Current Medications, Vitamins, and Dose:

_____

_____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

_____

_____

Most patients that come to our office have one of two objectives in concerning their health care. Some patients come from symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Jiho Jason Yoon, L.Ac. will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care □ Corrective Care □ Doctor's Selection Based on Condition

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Vitality Chiropractic Wellness Inc will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Vitality Chiropractic Wellness Inc will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Print Name: _____

Consent to Treat a Minor: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

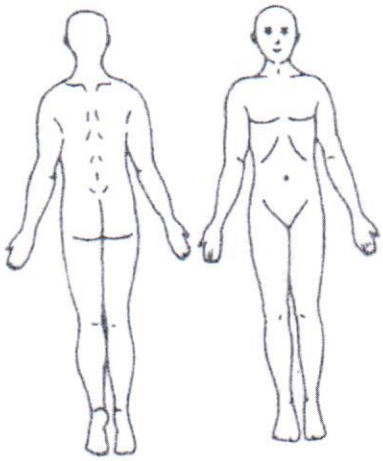
☐ Yes ☐ No ☐ Not Sure

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke



Please outline on the diagram the area of your discomfort

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

OUR FINANCIAL POLICY

Jiho Jason Yoon, L.Ac. and his staff are here to help in all aspects of your care, including financial arrangements. Our policy is that payment is made at the time services are rendered. Unless special arrangements are made in advance, and an additional service fee is paid. We are open to discuss any special circumstances that affect your ability to pay for services rendered, but special arrangements must be made prior to treatment with an agreement signed by both parties.

INSURANCE COVERAGE

Jiho Jason Yoon, L.Ac. is licensed as an acupuncturist by the state of California. Since some insurance companies or government agencies, including Medicare, do not provide full or even partial coverage for the services he provides, he will provide you with a superbill to send in to your insurance company if you wish to try to receive reimbursement. You are responsible for contacting your insurance company directly to determine the full extent of your insurance coverage and sending the superbill into them directly. Payment is due to Jiho Jason Yoon, L.Ac. at the time services are rendered.

MISSED APPOINTMENTS POLICY

When you make an appointment, professional time is especially reserved to provide for your care. If you fail to appear for a scheduled appointment, or fail to give at least 24 hours notice prior to canceling your appointment, you will be charged in full for that appointment.

RELEASE OF MEDICAL RECORDS AND AGREEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Jiho Jason Yoon, L.Ac., to provide copies of my medical records, billing statements, and other relevant information regarding my diagnosis and treatment to referring physicians, my insurance carrier(s), and/or my attorney. I agree that regardless of insurance or other coverage I may have, I am personally and directly responsible for all financial obligations incurred (unless my care has been authorized by a Worker's Compensation Insurance Carrier). I agree to abide by the above policies and to pay for services in full at the time they are rendered unless other arrangements have been made previously and in writing. If Jiho Jason Yoon, L.Ac., is forced to take legal action against me to collect an outstanding balance, I agree to pay for any and all reasonable collection costs, legal fees and court costs incurred to do so.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures including various modes of physio-therapy on me) by Jiho Jason Yoon, L.Ac. at this clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western Herbal Medicine, and Nutritional Counseling.

I have had the opportunity to discuss with Jiho Jason Yoon, L.Ac. personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception or pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are front plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

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

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Patient Name(Print):_____ Signature:_____

Date: _____

NOTICE OF PRIVACY PRACTICES

To my patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

OUR COMMITMENT TO YOU PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentially of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court of administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. TO correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individual involved in your care or the payment for your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jiho Jason Yoon, L.Ac. at this clinic.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Jiho Jason Yoon, L.Ac. at this clinic. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact out front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jiho Jason Yoon, L.Ac. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jiho Jason Yoon, L.Ac. at this clinic.

I hereby acknowledge that I have been presented with a copy of Jiho Jason Yoon, L.Ac., Notice of Privacy Practices.

To be completed by the patient.

Patient Name(Print):_____

Signature:_____

Date: _____

To be completed by the patient's representative, if necessary.

Patient Name(Print): _____

Patient Representative:_____

Relationship to Patient:_____