Patient Information Form

Name:	*Age:*
Address:	*Single / Married / Other*
City: *State:* *Zip:*	*Date of Birth:*
Cell Phone: *Work / home phone (optional):*	*Email:*
I consent for text messages regarding appointment times, reminders, and general information at the phone number I have provided above. ☐ *Yes* ☐ *No*	*I consent for emails regarding appointment times, reminders, and general information at the email address I have provided above.* ☐ *Yes* ☐ *No*
Preferred Pronouns:	*Occupation:*

Please present a copy of your medical insurance card and Driver's License for billing verification

Insurance company:	*Insurance ID number:*
Policy holder Date of Birth:	*Insurance Group number:*

Consent for Shared Information with Family and Significant others

I understand that when I give my consent, information regarding my or my child's (under the age of 18) detailed appointment reminders/instructions may be left on my voicemail or answering machine. I understand that "sensitive" information as noted below will be excluded.

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

The name(s) listed below are family members or significant others to whom I grant permission for my healthcare providers and their representatives at our clinic to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment. Circle one: **YES or NO**. Please list names if yes:

____

Emergency Contact Name and Phone Number:____

How did you hear about our office? (Circle one) Google / Instagram / Facebook / Other:__________________

No Show and Late Cancel Policy: Our office requires at least a 24-hour notice for the cancellation of appointments. Repeated no shows or late cancellations will be charged at the full cash rate of the visit and cannot be billed to insurance.

Patient Signature: ____ Date: ____________________

Source Wellness Center, PLLC
2320 130th Ave NE, #110, Bellevue, WA 98005
T: (425) 533-7320 F: (425) 484-0518

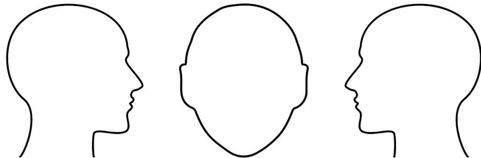
Medical History Questionnaire

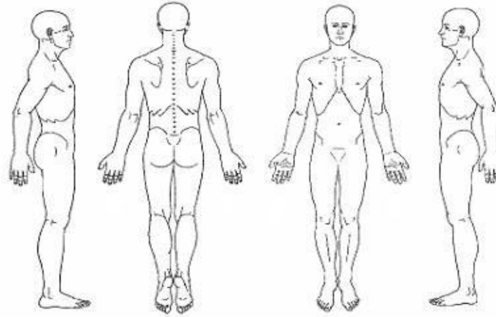
Date:_______________ Name: ____

Main problem you would like help with: __________________ Date first noticed: _____________

Other concurrent therapies: ____

Please indicate where your symptoms are occurring:





Past Medical History - please note dates

Cancer:__________________ HIV/AIDS:_________________ Thyroid Disease:____________

Diabetes:_________________ High Blood Pressure:________ Venereal Disease:__________

Hepatitis:_________________ Heart Disease:_____________ Other:____________________

Surgeries (types & dates):____

____

Allergies (drugs, chemicals, foods, etc):____

Family Medical History

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Other:___________

Medications

What medications and/or supplements are you currently taking?__________________________

Have you had any courses of antibiotics recently?(Circle one) Many / A few / 1 or 2 / None

Habits

Please indicate usage per day or per week:

Cigarettes:_______________ Coffee/tea:_______________ Recreational drugs:______________

Please describe any restrictions or limitations in your daily diet:___________________________

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Do you suffer from any of the following? Please check and note if it is current or past.

General

- ☐ Recurrent Infections
- ☐ Hot or Cold Temperature
- ☐ Fatigue/Energy issues
- ☐ Sleep issues
- ☐ Allergies
- ☐ Spontaneous sweats
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Bleed or bruise easily
- ☐ Strong thirst/no thirst
- ☐ Prefer hot or cold drinks

Cardiovascular

- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Cold hands or feet
- ☐ Swelling of hands or feet
- ☐ Blood clots
- ☐ Spider veins
- ☐ Fainting
- ☐ Heart palpitations

Respiratory

- ☐ Difficulty breathing
- ☐ Pain with breathing
- ☐ Shallow breathing
- ☐ Shortness of breath
- ☐ Production of phlegm color:____________
- ☐ Recurrent cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma/Wheezing
- ☐ Status asthmaticus

Skin

- ☐ Rashes
- ☐ Eczema
- ☐ Itching or Hives
- ☐ Psoriasis
- ☐ Other skin:_____________

Genito-urinary

- ☐ Pain on urination
- ☐ Urgency with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incontinence at night
- ☐ Waking at night to urinate
- ☐ Dribbling urination
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotency
- ☐ Changes in sexual drive
- ☐ Other:________________

Behavioral

- ☐ Anxiety
- ☐ Moody
- ☐ Easily susceptible to stress
- ☐ Aggressive/Bad temper
- ☐ Lose control of emotions
- ☐ Fear
- ☐ Panic attacks
- ☐ Depression
- ☐ Substance abuse
- ☐ Other:______________

Have you ever considered or attempted suicide?

- ☐ Yes
- ☐ No

Head/Eyes/Nose/Throat

- ☐ Headaches / Migraines
- ☐ Sinus Issues / Infections / Discharge
- ☐ Decrease in urinary flow
- ☐ Sores on Mouth or Lips
- ☐ Dental Issues
- ☐ Ringing in Ears High/Low
- ☐ Vertigo or Dizziness
- ☐ Blurry vision or spots
- ☐ Recurrent sore throat
- ☐ Teeth grinding

Musculoskeletal

- ☐ Neck ache/pain
- ☐ Back ache/pain
- ☐ Knee ache/pain
- ☐ Shoulder pain
- ☐ Elbow/Forearm pain
- ☐ Hand/Wrist pain
- ☐ Foot/Ankle pain
- ☐ Joint/Bone problems
- ☐ Torn tissues
- ☐ Surgery:_______________

Neurological

- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Lack of coordination/balance
- ☐ Seizures
- ☐ Nerve damage
- ☐ Stroke
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Vertigo

Do you suffer from any of the following? Please check and note if it is current or past.

(CONTINUED)

Gynecological

- ☐ PMS
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Light periods
- ☐ Heavy periods
- ☐ Endometriosis
- ☐ Breast lumps
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Infertility
- ☐ Fibroids
- ☐ Clots
- ☐ Other: ________________

# of pregnancies: _______________

# of births: ______________________

Age of 1st menses: ______________

Duration of menses: _____________

days between menses:__________

Last PAP:_______________________

Age Perimenopause:_____________

Age Menopause:________________

Do you practice birth control?

- ☐ Yes
- ☐ No

Are you pregnant now?

- ☐ Yes
- ☐ No

Informed Consent for Acupuncture & Chinese Herbal Medicine Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited too,

> **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
>
> **Moxibustion:** Application of heat by burning of herbs on/near acupuncture points.
>
> **Infrared Heat Therapy:** Application of heat generated by an infrared lamp over a specific area of the body.
>
> **Cupping:** Glass, bamboo, or silicone cups are placed on the skin with a vacuum created by heat.
>
> **Electro-acupuncture:** Use of very small amounts of electricity to stimulate specific acupuncture points.
>
> **Liniments, Oils, Plasters,** Topical herbal formulas (liquids, creams, pastes, plasters, washes and other forms) applied to the skin.
>
> **Acupressure/Tui Na:** Traditional medical massage.
>
> **Herbs/Natural Medicines:** Prescription of various therapeutic substances including plants, minerals, and animal materials. These substances may be given in the form of teas, pills, powders, tinctures, and other forms (may contain alcohol).

I recognize the potential risks and benefits of these procedures as described below:

> **Potential Risks:** Discomfort, pain, bleeding, blistering, bruising, burns, infection, temporary discoloration at site of procedure; injury from topical procedures, heat, electromagnetic or frictional therapies, and possible aggravation of symptoms existing prior to the treatment.
>
> **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of the body's energies, which may lead to prevention, improvement, or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by any clinicians at Source Wellness Center, PLLC regarding the cure or improvement of my condition. I hereby release Source Wellness Center, PLLC from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

______________________________________ ____________________

Signature of Patient or Person authorized to consent Date

____

Print of name of Patient or Patient's representative

If you have been diagnosed with a bleeding disorder, are on anticoagulant therapy, have a pacemaker, or are pregnant, please inform the practitioner prior to receiving treatment.

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2024 Financial Agreement

Thank you for choosing us as your healthcare provider. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your appointment. If you have any questions, please ask.

- Failure to give 24 hour notice for cancellation of any appointment will result in a late cancellation fee equal to the full cash price of the visit.
- We have put into place a credit card on file program. To keep your information safe and secure, we have partnered with an off-site, third-party company that will securely store your credit/debit/health insurance card information. It will **not** be kept at our office, and none of your information will be visible to our staff. We will submit your claim to your insurance company, and they will process the claim and send us and you an Explanation of Benefits. This will show what they covered and what your responsibility is. Our practice will then charge your credit/ debit/ health insurance card for the remaining balance your insurance company has determined that you owe. We will mail or email you a receipt. This program in no way hinders your ability to dispute a charge or question your insurance company about their determination of payment.
- Payment is due at time of service, unless otherwise arranged prior to treatment. This applies to applicable treatment fees, co-pays, and past due balances. New patient visits can range from $185.00 to $350.00, depending upon services provided. Return acupuncture visits range from $115.00 to $250.00. If you pay for services by check and that check is returned for non-sufficient funds, we will charge an additional $35.00 to your account for bank fees.
- For balances over 120 days past due with failure to make contact with us within 30 days following, a late fee will be determined. This fee also applies if there is failure to commit to an agreed upon payment plan. Repeated failure to make payments may result in our inability to continue providing your medical services or action that may affect your credit.
- Our practice is committed to providing the best treatment for our patients and our charges are based on the value scale developed by the American Medical Association which is supported by most local insurance companies. You are welcome to view our current fee schedule for any of our services.

Payment Agreement (please check one):

WITHOUT INSURANCE COVERAGE

☐ I agree to keep my account balance current by paying (cash/check/credit) at each visit.

WITH INSURANCE COVERAGE

☐ I fully understand that insurance policies are arrangements between my insurance company and myself, and that billing done by this office is a courtesy. I am ultimately responsible for any expenses not paid by my insurance company, and I assume responsibility for keeping my account current. I hereby authorize the release of any information requested by my insurance company needed in the process of treatment verification, claim eligibility, and payment authorization. Unpaid insurance claims over 120 days become the responsibility of the patient, and must be paid in full by the patient.

I authorize my insurance benefits to be paid directly to my practitioner. I am financially responsible for any unpaid balance due or amount designated by my insurance company.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY.

____ ______________________

Signature of Responsible Party Date

____

Please Print name