ACUPUNCTURE ZEN™

Tony Willcox, D.O.M, Doctor of Oriental Medicine
"Double Board Certified Acupuncture & Chinese Herbal Medicine"
Official Acupuncturist of the NHL Florida Panthers

PATIENT MEDICAL HISTORY

Name: ____
Address: ____
City: ___________________________ State: _________ Zip: _______________
Phone: (Home)______________________ (Cell)____________________________
Age: ________ Date of Birth: _____/_____/______
E-mail: ____
Occupation: ____
Emergency Contact: ____
Relationship:______________________ Phone: ___________________________
Gender: Female _____ Male _____
Are you (check one): Single ____ Married ____
Are you pregnant? Yes _____ No _____ How many weeks? ______________
How did you hear about us? ____

What is the best way to communicate with you between office visits? (E-mail, Home, Work, Cell, Text).
____
____
Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

IS YOUR CONDITION DUE TO:

___ Accident ___ Illness ___ Injury ___ Accident occurring at work
___ Automobile Accident – Date of Accident _______/_______/_______
Claim #: _______________________________________

Have you ever had Acupuncture before: YES / NO

Are you interested in a treatment plan: YES / NO

Chief Complaint

State your main issue that you would like to address:

____

____

How long ago did the problem begin: ______________________________

Have you been given any MD's diagnosis? If so, what?

____

____

What kind of treatments have you had? Results?

____

____

Secondary Complaint

Significant Illnesses: PLEASE CIRCLE

High Blood Pressure	Diabetes	Cancer	Thyroid Disease
Heart Disease	Hepatitis	Seizures	HIV

Other: ____

Major Operations and approximate dates:

____

____

Allergies:

____

____

Accidents/Significant Trauma:

____

____

Medications taken within the last 6 months (including drugs, vitamins, herbs & supplements):

____

____

Patient Signature: ___________________________________

Date: ________/________/________

System Review

For the following conditions and symptoms, please indicate any that apply to you by marking "C" for current or "P" for past:

___ Skin rash
___ Anemia
___ Easy bleeding or bruising
___ Cramps / Soreness
___ Bone or joint disease
___ Mood swings
___ Anxiety or nervousness
___ Difficulty sleeping
___ Sudden Weight Change
___ Tumors
___ Irregular Heart Beat
___ Coughing/Asthma
___ HIV or AIDS
___ Lyme disease
___ Rheumatic fever
___ Difficulty Breathing
___ Chronic pain
___ Fatigue
___ Weakness
___ Dizziness or fainting
___ Numbness / Paralysis
___ Neurological disease
___ Seizures
___ Memory loss
___ Headaches
___ Head injury
___ Fibromyalgia
___ Cold sores
___ Ear infections
___ Impaired hearing / vision
___ Sinus problems
___ Thyroid hyper/hypo
___Difficulty breathing
___Chest pain
___Heart palpitations
___Nose Bleeds
___Gastrointestinal disorder
___Heartburn
___Gastritis or ulcers
___Excessive thirst / hunger
___Hypoglycemia
___Eating disorder
___Parasites
___Liver disease
___Gallbladder disease
___Kidney disease
___Problems with urination
___Sexual difficulties
___ STD's
___ Abortion
___ PMS
___ Psoriasis
___ Eczema
___ Infertility
___ Fungal Infection
___ Localized Swelling
___ Constipation
___ Diarrhea
___ Hepatitis
___ Kidney Stones
___ Bursitis
___ Loss of balance
___ Tremors
___ Cataracts

Other: ____
____
____
____
____
____

The scope of Acupuncture in the state of Florida and the modalities used at this clinic includes but is not limited to:

- Use of acupuncture needles to stimulate acupuncture points.
- Moxibustion
- Laser Therapy
- Use of Micro-Current to stimulate acupuncture needles.
- Cupping (suction applied to areas of the body where there is stagnated energy to improve blood flow and circulation)
- Dermal Friction Technique (Gua Sha – friction on the skin to stimulate blood flow)
- Herbal Medicine/Homeopathic Medicine/Nutrition
- Bodywork/Tuina/Shiatsu/Trigger Point Therapy/Cranio-Sacral Therapy
- Injection Therapy (homeopathic, Vitamin B-12)

POSSIBLE SIDE EFFECTS:

- Drowsiness may occur in a small number of patients and if affected you are advised to recuperate before driving.
- Minor bleeding or bruising may occur as a result of acupuncture, cupping and related therapies.
- Symptoms may become worse before they improve for 1-2 days following your treatment. Please advise an employee of Acupuncture Zen if worsening of the condition continues longer than 48 hours.
- Fainting or a lightheaded sensation may occur (sitting after treatment for a few minutes will generally alleviate this symptom)
- Please do not come in for treatment in a heavily medicated condition.

PLEASE CHECK ANY ITEMS THAT APPLY TO YOU:

___ Pacemaker or other electrical implant: ________________________________

___ Bleeding Disorder ____

___ Anti-Coagulants (blood thinner) or other medications?

____

___ Have a damaged heart valve(s) or have any other particular risk of infection?

____

I consent to having treatments and procedures from this clinic. I release Dr. Tony Willcox D.O.M A.P. and Acupuncture Zen Inc and it's staff from any all claims incurred to me as a result of treatment. I understand that no statement is intended as a medical diagnosis, nor is it considered as such. Dr. Tony Willcox may take notes for my treatment with an audio voice recorder. I understand that I may refuse treatment at any time. I understand that there is no refund policy at Acupuncture Zen Inc. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment. All information that is given is confidential and will not be released without consent by this patient, unless legally required to do so. I confirm that I have read and understand the above information.

If represented by another:

Name of Representative: ____________________ Signature: __________________ Date: __________

Patient Name: ________________________ Signature: _________________________ Date: _________

ACUPUNCTURE ZEN™

HIPPA Privacy Authorization Form

Authorization for Use and Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize TONY WILLCOX D.O.M. A.P. to use and disclose the protected health information (PHI) about me.

I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

This medical information may be used by the person I authorize to receive this information for medical treatment, consultation, billing, claims payment or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtaining as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. But if I refuse to sign this document Acupuncture Zen Inc that the right to refuse me as a patient.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of Patient or Representative Date

____

Printed Name of Patient or Representative & Relationship Date

CONSENT FORM FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
FOR TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS AT THE OFFICE OF ACUPUNCTURE ZEN INC.

As part of my healthcare, this office originates and maintains health records describing my history symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

This information serves as:

- A basis for planning my care ad treatment;
- A means of communication among the many health professional who contribute to my care;
- A source of information for applying my diagnoses and other medical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of HealthCare Professionals.

I have been provided with a Privacy Notice that provides a more complete description of information uses and disclosures.

I have the right to review the Privacy Notice prior to signing this consent.

Dr. Willcox reserves the right to change the Privacy Notice and his office practices and procedures. Prior to implementation, copies of revisions will be handed out in his office.

I have the right to object to using my health information for directory purposes.

I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Dr. Tony Willcox is not required to agree to the restrictions requested.

I may revoke this consent in writing except to the extent that Dr. Willcox has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

I consent to the use and disclosers of my health information for treatment, payment and healthcare operations as described in the Privacy Notice effective today. I understand that my signature below indicated that I have read, understand and agree to the above statement and agree to abide by its provisions.

Signature of Patient or Representative Date