

Victoria Argo, LAc.  
Balanced Heart Acupuncture  
310 SW 4<sup>th</sup> Ave., Suite 415  
Portland, OR 97204  
503-515-1971 Fax: 503-222-1819

### **OFFICE PROCEDURES**

Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions, please ask.

#### **FINANCIAL POLICY:**

Thank you choosing me to work with you towards better health. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The initial visit is \$95 for 1.5 hours and \$75 for all 1hour follow up treatments for non-insured cash clients. Because I do not feel that money should impede wellness, if needed please feel free to discuss my Sliding Fee Scale with me.

#### **PAYMENT OF SERVICES:**

Payment is due at the time of service unless arrangements are made in advance. Payment for the initial office visit and treatment are due at the time of service. Payment can be made with *cash, check or credit card*.

This policy is most effective for both patients and practitioners. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you foresee any financial challenges, be sure to address them with me prior to your treatment.

#### **APPOINTMENT SCHEDULING:**

My commitment is to remove the cause of illness rather than to treat the symptoms. In order to identify the cause(s) of your condition I will conduct a consultation, examination and any other indicated assessment (e.g. lab, nutritional, stress, etc.). If at the end of your evaluation I feel you will respond favorably to treatment, I will prescribe a course of care that can include a combination of education materials, specific therapies, consultations and subsequent re-evaluation and re-examination.

These assessments and re-examinations are crucial to my ongoing evaluation of your response to the prescribed program. They are necessary to help distinguish whether changes in your treatment plan are needed. Remember that symptoms may resolve long before the underlying causes of disease have been eliminated completely. My aim is to support you in eliminating the cause of any condition.

#### **APPOINTMENT CHANGES:**

I require a minimum of 24 hours advance notice in order to reschedule an appointment. I reserve the right to charge for patients who neglect to reschedule 24 hours in advance.

I have read, understand, and agree to the above statements regarding responsibility for my health care and payment policy.

Signature of patient or legal guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT REGISTRATION INFORMATION

### PERSONAL & WORK INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Accident or Injury date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birthdate: / / M /F ? Social Security #: \_\_\_\_\_  
Single /Married /Divorced ? Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_  
Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
How did you learn about me? Friend (if so, whom? \_\_\_\_\_ )/Ad /Yellow Pages /Health Professional /other \_\_\_\_\_

### FINANCIAL & INSURANCE INFORMATION

I will pay my balance in full at time of service: \_\_\_\_\_ or I prefer to make payment arrangements prior to service rendering: \_\_\_\_\_  
Do you have medical insurance that covers acupuncture? Yes /No If Yes, please check type of insurance: Private Insurance  
Co. \_\_\_\_\_ / Medicare \_\_\_\_\_ / Medicaid \_\_\_\_\_ / Workman's Compensation \_\_\_\_\_ / Personal Injury \_\_\_\_\_ /Other \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Group or Plan or Program: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Insured's Address: \_\_\_\_\_  
Insured's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insured's Phone: \_\_\_\_\_ Is Insured M or F ?  
Insured's SS# \_\_\_\_\_ Insured's Birthday / / \_\_\_\_\_  
Insured's relationship to patient: Spouse /Child /Partner /Other \_\_\_\_\_  
Insured's Employer & Employer's Address: \_\_\_\_\_

### RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my acupuncturist to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (patient) \_\_\_\_\_ hereby authorize (insurance co.) \_\_\_\_\_ to pay and hereby assign directly to (practitioner) Victoria Argo, LAc all owed benefits. I understand I am financially responsible for all charges incurred.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT FORM AND AGREEMENT

Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin in certain points or areas on or near the surface of the body in an attempt to treat pain, blockages, or other dysfunction.

Adverse side effects may result. These could include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.

Acupuncturists may recommend treatment with substances from the Oriental Materia Medica (herbs). Adverse side effects may result from taking these substances. These include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. If I experience any problems which I associate with these substances, I understand that I should stop taking them and call my practitioner.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result. The above treatment, alternatives and risks have been explained to me by my practitioner and I have had an opportunity to ask questions. I hereby consent to acupuncture treatment.

Signature of patient or legal guardian \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT HEALTH HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital status: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark.  
Thank You!**

1. Are you currently receiving health care: Y N If yes, where and from whom? \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you here today:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

4. What are your most important health problems? Please list in order of importance:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

5. Do you have any reason to believe that you are pregnant?      Y      N

6. Do you have any chronic infectious diseases?      Y      N      If yes, please explain: \_\_\_\_\_

7. Are you currently suffering from any chronic illness?      Y      N      If yes, please explain: \_\_\_\_\_

8. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

\_\_\_\_\_

9. Please circle any of the following medications that you are currently taking:

- Laxatives      Pain Relievers      Antacids      Thyroid Medication      Appetite Suppressants
- Antibiotics      Tranquilizers      Sleeping Pills      Cortisone      Blood Pressure Medication

10. Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

11. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum Weight: \_\_\_\_\_ When? \_\_\_\_\_

12. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

13. **Childhood Illness** (please circle any that you have had):

- Scarlet Fever      Diphtheria      Rheumatic Fever      Mumps      Measles      German Measles      Chicken Pox

14. **Immunizations** (please circle any that you have had):

- Polio      Tetanus      Measles/Mumps/Rubella      Pertussis
- Diphtheria      Others: \_\_\_\_\_

15. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
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16. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
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17. <b>Family History:</b>	<u>Mother</u>	<u>Father</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age if living:	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor):	_____	_____	_____	_____	_____	_____
Age at death (if deceased):	_____	_____	_____	_____	_____	_____
Cause of death:	_____	_____	_____	_____	_____	_____
Check any conditions that members of your family have had below:						
Cancer:	_____	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____	_____

18. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                      Nervousness                      Mental Tension

19. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue      Slow Wound Healing      Chronic Infections      Chronic Fatigue Syndrome

20. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision                      Eye Pain/Strain                      Glaucoma                      Glasses/Contacts                      Tearing/Dryness

Impaired Hearing                      Ear Ringing                      Earaches                      Headaches                      Sinus Problems

Nose Bleeds                      Frequent Sore Throats                      Teeth Grinding                      TMJ/Jaw Problems                      Hay Fever

21. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                      Frequent Common Colds                      Difficulty Breathing                      Emphysema

Persistent Cough                      Pleurisy                      Asthma                      Tuberculosis

Shortness of Breath                      Other Respiratory Problems: \_\_\_\_\_

22. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                      Chest Pain                      Swelling of Ankles                      High Blood Pressure

Palpitations/Fluttering                      Stroke                      Heart Murmurs                      Rheumatic Fever                      Varicose Veins

23. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain
<b>Stool:</b>	Diarrhea	Constipation	Undigested Food	Mucous	Blood In Stool

24. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent Urinary Tract Infections	Frequent Urination	Venereal Disease
Kidney Stones	Impaired Urination	Frequent Urination at Night	Blood in Urine	

25. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Bleeding Between Cycles	Vaginal Discharge	Clotting	Premenstrual Problems
Menopausal Symptoms	Difficulty Conceiving		

26. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

27. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostrate Problems	Testicular Pain/Swelling	Penile Discharge
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28. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

29. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy
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30. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold
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32. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet
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Do you have any chronic infectious diseases? \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_

33. Lifestyle:

a. Please indicate typical food intake:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

b. Daily Exercise: \_\_\_\_\_

c. Sleep Habits: \_\_\_\_\_

d. Education: \_\_\_\_\_

e. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y      N      Why/Why not? \_\_\_\_\_

f. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

g. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_

\_\_\_\_\_

h. Consumption of Liquids: \_\_\_\_\_

i. Television Habits: \_\_\_\_\_

j. Reading Habits: \_\_\_\_\_

k. Interests and Hobbies: \_\_\_\_\_