Patient Name: DOB: Date:
Address: City: State: Zip Code:

Lucky Flow Acupuncture

NEW PATIENT INTAKE FORMS

Sex: ❑ Male ❑Female | **Height:** | **Weight:** | **State*:** | **Zip*:**

Address* | **City*:**

E-mail *(only if you would like to be on our mailing list):*

Phone #: (H) (W) (C) | **Can we leave a message, if you are not available?** ❑ Yes ❑ No

Occupation: | **Can we call you at work?** ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

EMERGENCY CONTACT: Name: **Relationship:** **Phone #:**

How did you hear about us? ❑ Newspaper ❑ Drive-by ❑ Facebook ❑ Google Ads ❑ Yelp ❑ BNI

❑ internet search: _____

❑ Referral/Other:_____

HEALTH HISTORY

CHIEF COMPLAINTS	Intensity	
If you could get rid of any health problems, what would you want to get rid of? (please list in the order of importance below), and we will let you know if we can help.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = ***no discomfort***, 10 = ***extreme discomfort***)	
	on **AVERAGE** your complaint is	at **WORST** your complaint is:
1.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Onset		What have you tried doing to resolve these problems that DID NOT work?
For each condition listed above, please mark when it first began, or when you started experiencing them?		The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability to heal itself.
1	Date began:	
2	Date began:	
3	Date began:	

Frequency		Duration
Please check the box that best represents how frequent you feel your chief complaint(s):		when you are feeling your symptoms, how long do your symptoms last?
1	❑ daily ❑ ____ day(s) per week ❑ ____ day(s) per month ❑ ____ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
2	❑ daily ❑ ____ day(s) per week ❑ ____ day(s) per month ❑ ____ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
3	❑ daily ❑ ____ day(s) per week ❑ ____ day(s) per month ❑ ____ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant

What Aggravates or Alleviates your Chief Complaints?		
	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?
1		
2		
3		

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How are your health problems interfering with the following areas of your life?	
Work	
Family	
Hobbies	
Life	

Do your work activities mostly involve: ❑ Sitting (time:) ❑ Standing (time:) ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following: Caffeine _____ Alcohol _____ Nicotine/Tobacco _____

Illicit Drugs: ❑Yes ❑No Comments _____

List ALL disorders you have had or been diagnosed with (include the dates of when you were diagnosed):

_____

_____

List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & Dosage):

_____

_____

List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking:

_____

_____

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INFORMED CONSENT TO CARE

A patient coming to Lucky Flow, LLC gives them permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

I assume all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, and physical medicine services. I understand that the herbs may 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 the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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, stomachache, 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.

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

I hereby authorize Lucky Flow, LLC DBA Lucky Flow Acupuncture to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim.

Prior to receiving care a health history and physical examination will be completed. These procedures will assist the practitioner in determining which modalities are needed, or if any further examinations or studies are required. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the above consent form.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian (if under 18) printed name: _____

Parent or Legal Guardian Signature: _____

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Patient Name:		**DOB:**	**Date:**
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Your Personal Healing Journey Begins Here
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PATIENT POLICIES

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatments given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired result. If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. DO YOUR BEST KEEP ALL YOUR APPOINTMENTS. Arrange the activities in your life so that this can occur. Schedule your life around your health, and not the other way around. If you aren't here, we can't help you.

A. To hold your preferred treatment time, we request that **all appointments MUST be made at least 1-2 weeks in advance**. This will save you and the clinic time and eliminate waiting.

B. If you are unable to make it to your appointment, please call us and let us know so we can reschedule your appointment (24 hours in advance to avoid a late fee).

C. **All missed appointments must be rescheduled and made up within one week**, in order to maintain your healing process. Your results are based on the number of kept appointments per week.

D. If cancellations are not made less than 12 hours prior, the appointment will be charged as full.

E. If cancellations are made between 12-24 hours prior, there will be a $25 cancellation fee.

F. For patients who arrive late, the appointment will end at the same time to allow cleaning for the next patient.

G. If you are able to make up the canceled appointment on the same day it was originally scheduled, we will wave the penalty.

2. CLINIC PROCEDURES

A) Please arrive **five minutes before** your designated time to sign in. Once your sign-in is complete, you may use the restroom or get a drink of water before we begin. Once you're in the treatment room, place your belongings in the **bin** on the floor. Help yourself with hand sanitizer while you wait for the acupuncturist.

B) Feel free to communicate with our Clinic Assistants if you have special requests such as customizing the ambient sounds or if you have to be out by a certain time.

C) We have added aroma-therapy to our rooms. We will have an essential oil diffuser running in each

Patient Name:		**DOB:**	**Date:**
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room, please let us know if you would like yours turned off for any reason.

D) A heat lamp will be in each room for your comfort, please specify to your acupuncturist whether you would like the heat lamp placed on your mid-section or your feet.

3. OFFICE ETIQUETTE. We ask that you turn off or silent your cell phone and keep your voice low during treatment to avoid disturbing other patients. You are welcome to bring your own music as long as it helps you relax.

4. NO PERFUMES, COLOGNES, and SCENTED LOTIONS. Please do not wear perfumes, colognes, and scented lotions to your treatment. Many of the patients have severe allergies and are very sensitive to different types of perfumes, colognes and scented lotions. Please be considerate of others, as these fragrances tend to linger in the air even after you've left our office.

5. AS FAR AS FINANCES ARE CONCERNED, if this was not already discussed, we wish to avoid any upsets by working out a payment program in advance. We have found it to be a waste of your time to have you make a payment each time you come in. To save you time we recommend payment in advance, which can be done with one payment or by the month. This will be discussed and worked out to your satisfaction.

Patient (Print Name): _____Date: _____

Patient Signature: _____

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Financial Policy Agreement

Will acupuncture work for me? We only accept patients that we think that we can help. Our patients enjoy more than a 90% positive outcome rate through regular visits and our highly effective treatment strategies. We are confident that we may be able to help you.

Your Commitment: In this system of medicine each treatment builds on the previous one. Optimal results are achieved when a patient follows the suggested treatment program. Understand that acupuncture is a therapeutic process, not magic. Please commit to the Treatment Program that has been prescribed by your Acupuncture Physician. Patients who drop out of care before having a chance to receive the benefits acupuncture can offer usually are not highly satisfied. Continue with your prescribed Treatment Program to achieve a new level of health. If you choose to discontinue treatment and receive, a re-exam appointment must be made to discharge from our care.

►Appointments:

- **If cancellations are not made more than 12 hours prior, the appointment will be charged as full.**
- **If cancellations are made between 12-24 hours, there will be a $25 cancellation fee. ● For patients who arrive late, the appointment will end at the same time to allow cleaning and the next patient.**
- **(1 emergency forgiveness for every 3 months applies)**

Patient Initial_____

►Payment:

- **Payment is accepted in the form of cash, check, Visa, Mastercard, AMEX and Discover is due at time of service.**
- **Any unused portion of pre-pay plans are Refundable within *ONE YEAR* of purchase. Prepay discounts are contingent on completion of Treatment Programs.**
- **Please be aware that if you are on a payment plan, we are unable to cancel the recurring charge until the payment goes through. After we receive the payment on our end, you will be reimbursed accordingly.**

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- **If the Treatment Program is unfinished. We will refund the amount you did not use discounting each visit at the regular rate.**
- **There will be a $20 fee for any returned checks.**

Patient Initial_____

►Insurance:

- **We issue Super Bills for patients to self-bill their insurance providers. Herbs and Supplements are not refundable.**

I have read and agree with the above policies. I agree to the release of medical and billing information necessary for treatment, payment, and healthcare operations. I assign benefits payable to Lucky Flow Acupuncture.

Patient (Print Name): _____ Date: _____

Patient Signature: _____

Office Signature: _____ Date: _____

GUANTONG LI, LLC DBA Lucky Flow Acupuncture

Lucky Flow Acupuncture

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Patient Name:		**DOB:**	**Date:**
Address:	**City:**	**State:**	**Zip Code:**

CONSENT AND AUTHORIZATION TO RECORD TREATMENT AND THERAPY SERVICES FOR TRAINING, QUALITY AND COMPLIANCE PURPOSES

I, _____ authorize the use of audio recordings of my treatment and therapy services at Lucky Flow Acupuncture to be used for training, quality and compliance purposes by Lucky Flow Acupuncture.

I understand that these recordings may be used for training of staff providing services to patients at Lucky Flow Acupuncture and for any quality or compliance initiatives undertaken by Lucky Flow Acupuncture. The recordings will only be used by employee or agents of Lucky Flow Acupuncture and will not be heard by individuals who are not affiliated with Lucky Flow Acupuncture.

I understand that I will not be given copies of the audio recordings and that I will not be able to use the audio recordings for my own personal use.

I understand that the staff at Lucky Flow Acupuncture may not refuse to treat me if I refuse to sign this consent and authorization.

I understand that I may not make my own audio or video recording of any treatment or therapy services provided by Luck Flow Acupuncture without written consent from Lucky Flow Acupuncture.

I understand that I may revoke this consent and authorization at any time, in writing, and that following such revocation my audio recordings will no longer be used for any training, quality or compliance purposes.

I understand that all audio recordings made during my treatment are not considered a part of my medical record and will be destroyed following Lucky Flow Acupuncture's use of the audio recording. All recordings will be maintained in a secure manner and in accordance with Lucky Flow Acupuncture's applicable policies and guidelines for the protection of patient information.

I agree that this consent and authorization is intended to be as broad and inclusive as permitted by the laws of the state of Michigan and will be interpreted according to Michigan law.

I hereby acknowledge my voluntary and independent decision to allow audio recordings of my treatment and therapy services to be used by Lucky Flow Acupuncture for training and any quality or compliance initiatives undertaken by Lucky Flow Acupuncture.

_____ _____

Signature of Patient/Legal Guardian Date

Name of Patient/Legal Guardian: _____

Patient's Date of Birth: _____

Address: _____

_____

Phone: _____

E-mail:_____