

**Westside Family Acupuncture**  
**PERSONAL INFORMATION**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Gender/Sex: (M) (F)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: (S) (M) (D) (W) In emergency notify (Name): \_\_\_\_\_

Emergency contact Phone#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

How did you hear about us?    Yellow Pages    Lecture    Healthfair    Saw Location    Brochure  
   Business Card    Website    Referred by \_\_\_\_\_

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What is your health concern for which you are seeking treatment? \_\_\_\_\_

When did this condition start? \_\_\_\_\_

Have you been treated or are now being treated for this condition by another healthcare provider? (Y) (N)

Have you had acupuncture before? (Y) (N)

Do you bruise or bleed easily? (Y) (N)

Do you have a Pacemaker (Heart)? (Y) (N)

How do you feel about receiving an acupuncture treatment?    (Fine)    (Nervous)    (Fearful)    (Unsure)

**Do you have any infectious diseases?** (ex. AIDS/Hepatitis/Staph ) **(Y) (N) List** \_\_\_\_\_

Females only: Are you pregnant or is it possible that you could be pregnant? (Y) (N)

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**MEDICAL HISTORY: MAJOR ISSUES**

List any western diagnosis

(ex. Diabetes/Hepatitis/High Blood Pressure)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any past traumas or injuries

(ex. Car accidents/Falls )

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgery or hospitalizations

Please list with approximate dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Westside Family Acupuncture**  
**DRUG LIST & FURTHER MEDICAL HISTORY**

Please list prescription and over-the-counter medications you are taking (Or Provide a list)

Drug Name	Reason for Taking	For How Long	Dose	Frequency

**MEDICAL HISTORY: RECENT** - Indicate items for the past 4 weeks only!

<p><b>Head - Ears -Eyes Nose - Throat</b></p> <input type="checkbox"/> Headaches <input type="checkbox"/> Impaired vision <input type="checkbox"/> Dry or Tearing Eyes <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore Throat <input type="checkbox"/> Dry Throat	<p><b>Respiratory</b></p> <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Difficult Breathing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Emphysema <input type="checkbox"/> Heavy Chest <input type="checkbox"/> Tight Chest <input type="checkbox"/> Congested Chest	<p><b>Cardiovascular</b></p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema <input type="checkbox"/> Stroke	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Heart Burn <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Strong Appetite <input type="checkbox"/> Passing Gas <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Recent Bowel Changes
<p><b>Genito-Urinary Track</b></p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Incontinence	<p><b>Neurological</b></p> <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures/Epilepsy	<p><b>Musculo-Skeletal</b></p> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Osteoporosis	<p><b>Emotional/Mental</b></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Frustration/Anger <input type="checkbox"/> Sadness <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia

**MEDICAL HISTORY: FAMILY**

**In my Family History there has been:**

- Alcoholism
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Mental Illness
- Stroke

## WORK & SOCIAL SUPPORT

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

**Employed**  **Retired**  **Full-time Student**  **Part-time Student**  **Other**

Do you enjoy your work? Always Usually Sometimes Rarely No Do you smoke? (Y) (N)

My family/social support network is: Non-existent Not Adequate Adequate Good Great

My stress level is: Overwhelming Very High High Mild Low Do you drink alcohol? (Y) (N)

I feel my life is: Significant /Meaningful Stagnant Fine In need of direction/support

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## FINANCIAL ARRANGEMENTS

### Out of pocket, Discounts & Insurance

First, check below to see if you are eligible for a discount on your bill. Discounts apply to services only.

#### Paying at Time of Service (TOS) Discount

Because of the risk of nonpayment and also due to the amount of costly time, effort, paperwork, follow-up etc. that are a part of billing an individual or insurance carrier, we offer the following flat fee discount to those who pay their full bill at the time of service.

TOS Discount for new patients is \$57 + tax (\$60.92)

TOS Discount for repeat patients is \$50 + tax (\$53.44)

#### Armed Services\*-Financial Hardship (ASFH) Discount

Because armed services members potentially risk their lives to protect us, because they generally fall into a low income scale, and because the military often does not cover acupuncture, we offer the following flat fee discount to armed services members (current and retired) and their spouses.

AS-FH Discount for new patients is \$52 + tax (\$55.58)

AS-FH Discount for repeat patients is \$45 + tax (\$48.09)

#### Insurance Specific

Second, insurance companies often treat acupuncture treatments differently than western treatments. Although you are responsible to understand your own coverage, we advise you to keep the following in mind:

- Many health insurance plans do not cover acupuncture or only cover it in a limited fashion.
- If you've recently changed insurance coverage, your new provider may not cover treatments for conditions that they consider pre-existing.
- If you go to a massage therapist or a chiropractor, your provider may bundle those treatment with acupuncture when they assess any limits or caps that you may have on your coverage.
- Your coverage may require you to first meet an individual and/or family deductible amount before they will pay for any portion of your treatment.
- Health insurance rarely covers products such as herbs. Products are an out of pocket expense.

**We will endeavor to check your insurance coverage for the above-mentioned issues when we verify your benefits and check co-pay amounts; however, you are responsible for your bill.**

\*For purposes of this discount, our definition of 'armed services member' includes both current and retired members of the Army, Air Force, Navy, Marines, National Guard, Coast Guard, Albuquerque Police Department personnel and Albuquerque Fire Department personnel.

**INSURANCE BENEFITS VERIFICATION**

**Patient Name** \_\_\_\_\_ **Patient Date of Birth (DOB)** \_\_\_\_\_

**Insurance Company** \_\_\_\_\_ **Member ID #** \_\_\_\_\_

**Group or FECA #** \_\_\_\_\_ **Plan/Program Name** \_\_\_\_\_

**Patient's Relationship to Primary Insured Policy Holder: (SELF) (SPOUSE) (CHILD) (OTHER)**

Policy Holder's Name (if patient is not the primary insured) \_\_\_\_\_

Policy Holder's Address (if patient is not the primary insured) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone # \_\_\_\_\_

**Policy Holder's Employer** \_\_\_\_\_ **Policy Holder's DOB** (if not patient) \_\_\_\_\_

Is there another Health Benefit Plan for Patient? (Y) (N) If yes, please list information on back of this page.

**Please skip to "financial agreement" - office staff will verify insurance information below**

Is acupuncture a covered benefit for this patient? (Y) (N) Is prior approval required? (Y) (N)

Is there a co-pay/per visit amount? (Y) (N) Amount/Comments \_\_\_\_\_

Is there an individual deductible that must be met first? (Y) (N) Amount \_\_\_\_\_ Portion met \_\_\_\_\_

Is there a family deductible that must be met first? (Y) (N) Amount \_\_\_\_\_ Portion met \_\_\_\_\_

Limitations? (Y) (N) \$ Amount/# of visits \_\_\_\_\_ Portion used \_\_\_\_\_ Combined w/chiro? (Y) (N)

Date verified \_\_\_\_\_ Spoke with \_\_\_\_\_ Renewal January 1<sup>st</sup> or on \_\_\_\_\_

**FINANCIAL AGREEMENT**

\_\_\_\_ **I authorize payment of medical benefits to the physician/supplier of services listed below.**

Dr. Paul Dumont, Westside Family Acupuncture, 5115 Coors Blvd NW Suite C, Albuquerque, NM 87121

\_\_\_\_ **I authorize the release of any medical or other information necessary to process claims.**

\_\_\_\_ **I authorize the use of this form or a photocopy, which shall be considered as valid as the original, on all of my insurance submissions (billings) and the physician/supplier of services may use my name as "signature on file".**

**I understand that the information I provided will be used to guide the doctor's diagnosis and treatment and is true to the best of my knowledge. I understand that (if I am insured) it is my responsibility to know my insurance coverage and any limits to my coverage. I understand and accept that I am responsible for full payment of my account whether I use insurance or not.**

Signature of Patient: \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient (Printed): \_\_\_\_\_ Chart # \_\_\_\_\_

Signature of Insured or Parent/Guardian (if either is applicable): \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Name of Witness (Printed): \_\_\_\_\_

\_\_\_\_ **(payment choice 1) I provided a copy of my insurance ID card and will pay my co-pay (if any).**

\_\_\_\_ **(payment option 2) I will pay my full bill at the time of service and am eligible for a TOS discount.**

\_\_\_\_ **(payment choice 3) I will pay my full bill at the time of service and am eligible for an ASFH discount.**