Ursula Marquez, EAMP
Ohana Wellness Center
2340 130th Avenue NE | Bldg D - Suite 200 | Bellevue, WA 98005

(Please print clearly)

PATIENT INFORMATION

Name: _____ Birth Date: ____ /____ /_____ Sex: M F

Marital Status (circle one): Single Married Divorced Widowed Separated Domestic Partner

Address: _____ City/State: _____ Zip: _____

• Home Ph: _____-_____-_____ • Work Ph:_____-_____-_____ • Cell Ph: _____-_____-_____

• Email address (print clearly) _____

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In case of emergency, notify: _____

• Home Ph: _____-_____-_____ • Cell Ph:_____-_____-_____ • Work Ph: _____-_____-_____

• Relationship to Patient (spouse, father, mother, etc) _____

.....

Employer: _____ Referred by: _____

Primary Care Provider (Dr.'s name): _____

.....

Insurance Information:

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE

Your relationship to the Insured (subscriber) on the card: Self / Spouse / Child / other_____

Name of Insured (subscriber): _____ Birth Date of Insured: ____ /____ /_____

Employer of Insured: _____

.....

Motor Vehicle Accident Information:

PIP: _____ DOI ____/____/_____ Claim #_____ Claim Rep. Ph # _____ - _____ - _____

.....

Patient/Guardian Signature: _____ *Today's Date:* ____ /____ /_____

Place copy of Insurance Card & Driver's License – next page

CONSENT FORM

For Acupuncture and Associated Therapies

I, the undersigned, hereby authorize Ursula Marquez, a National and Washington state Licensed Acupuncturist to perform the following procedures:

1. **Acupuncture** – Insertion of special, sterilized needles through the skin into the underlying tissue at specific points on the surface of the body.
2. **Cupping** – A technique to relieve symptoms with cups made of glass, bamboo or other materials to put on the skin with a vacuum created by heat or other device.
3. **Gua Sha** – A rubbing technique on an area of the body with a round instrument.
4. **Moxa** – An indirect warming technique on an acupuncture point using an herbal stick, string or ball to relieve symptoms.
5. **Tuina** – an ancient massage used to treat a wide variety of common disharmonies.
6. **Herbal Consultation** – Dietary advice based on traditional Chinese medical theory.

I recognize the potential risk and benefit of these procedures as described below:

Potential risks: discomfort, pain, bruising, infection and blistering at site of procedure. Temporary discoloration of the skin even an aggravation of the presenting problem.

Potential benefits: drugless relief to presenting symptoms and an improved balance of bodily energies, which may lead to prevention or elimination of the presenting health problems.

With this knowledge, I voluntarily consent to the above procedures. I acknowledge that no guarantees have been given to me by Ursula Marquez regarding cure or improvement of my condition.

I hereby release Ursula Marquez from any and all liability that may occur in connection with the mentioned procedures, except for the failure to perform the procedures with appropriate medical care.

I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.

_____ _____

Signature of patient Date

_____

Signature of person authorized to consent

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PAYMENT POLICY / CANCELLATION POLICY

IF NOT COVERED BY YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICES.
It is then your responsibility to submit claims to your insurance plan for reimbursement of the office fees. This office and your insurance card/company will provide you with the information necessary.

Acupuncturists are not always covered by all plans of insurance companies.
Call the Customer Service Phone # on the back of your insurance card to check your benefits before your first visit.

IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS OF YOUR COVERAGE FOR EACH VISIT INCLUDING:

1. Whether Acupuncture services are covered.
2. If there is a deductible to meet first.
3. Is a referral required from your primary care provider? If yes, it is your responsibility to obtain the referral and provide our office with a referral number before your appointment.
4. If you have a co-payment, it is due at the time of services.
5. If lab tests are covered – both the test itself and the facility used are separate practices and bill separately. It is your responsibility to give your insurance info to the labs.

• **We try to give courtesy reminder calls for appointments 1 – 2 days in advance. However it is your responsibility to be aware of your appointment date & time.**
• **We request at least 24-hour notice from you for an appointment cancellation or rescheduling. Failure to do so may incur a cancellation fee or missed appointment fee up to the cost of the scheduled visit**
• **Arrival by a patient 15 minutes or more after scheduled appointment time may result in cancellation of the appointment and patient may incur a missed appointment fee up to the cost of the scheduled visit.**
• **Patient understands that a cancellation fee or missed appointment fee is not covered by insurance and payment is the sole responsibility of the patient or guardian in the case of a minor.**

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED UNDER OUR CARE.

All Pharmacy items are to be paid for when they are received.
We accept payment by cash, check, Visa, and MasterCard
We charge $35.00 for returned checks.
We charge $10.00 fee/month for patient balance portion not paid within 30 days. Delinquent accounts may be sent to a Collections Service for collection.

• I understand that I am responsible for my account balance with Ohana Wellness Center doctors.
• I understand that certain procedures (e.g; Myers infusion, etc) may not be covered by your insurance and I understand in such cases, if payment is denied by insurance, I am responsible for payment of such received procedures.
• I authorize release of information to all my insurance companies if requested.
• I authorize my doctor to help me obtain payment from my Insurance if she is contracted.
• I authorize payment direct to my doctor from my Insurance.
• I understand that I am responsible for my account balance with facility used for any lab work.
• I permit a copy of this authorization to be used in place of the original.

I understand and agree to the above policy. I will abide by its terms.

Name (printed): _____ **Date:** _____

Signature: _____

Acknowledgment of Receipt of Privacy Practices (HIPPA)

Ursula Marquez, EAMP

I, (**print name**) _____, patient of the above-mentioned provider, do hereby acknowledge receipt/offer of a **copy** of this provider's Notice of Privacy Practices.

Signature: _____ **Date:** _____

Authorization to Leave Personal Health Information
By Alternate Means.

Please check all that apply:

☐	May send an email message:	Email address
☐	May leave a detailed message on voicemail at home:	Home phone number
☐	May leave a detailed message on voicemail at work:	Work phone number
☐	May leave a detailed message on cell phone:	Cellular phone number
☐	May leave a detailed message at different location:	Phone number & location
☐	May leave a detailed message with spouse/partner:	Name of spouse/partner phone #
☐	May leave a detailed message with other family member:	Name & relationship phone #

By signing below, I understand and acknowledge that this information will be kept in my medical record and the above information will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Signature: _____ **Date:** _____

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Ohana Wellness Center

Patient Medical History: ***Date:*** / /

Please check the following that pertain to the last three month

Skin And Hair:		***Gastrointestinal:***		***Musculoskeletal:***	
Rashes		*Nausea*		*Neck Pain*	
Itching		*Constipation*		*Back Pain*	
Dandruff		*Black Stool*		*Hand Pain*	
Change in Hair/Skin		*Bad Breath*		*Wrist Pain*	
Ulceration		*Use of Laxatives*		*Knee Pain*	
Eczema		*Vomiting*		*Foot Pain*	
Hair Loss		*Gas*		*Ankle Pain*	
Hives		*Blood in stool*		*Weakness*	
Pimples		*Rectal Pain*		*Shoulder Pain*	
Recent Moles		*Diarrhea*		*Muscle Pain*	
Cardiovascular:		*Abdominal pain and or Cramps*		***Head, Eyes, Ears, Nose and Throat:***	
High Blood Pressure		*Belching*		*Dizziness*	
Irregular Heart Beat		*Indigestion*		*Poor Vision*	
Cold Hands/Feet		*Hemorrhoids*		*Glasses*	
Blood Clots		***Genito-Urinary:***		*Cataracts*	
Low Blood Pressure		*Pain w/ Urination*		*Ringing in Ears*	
Dizziness		*Urgency to Urinate*		*Sinus Problems*	
Swelling of Hands/Feet		*Decrease in Flow*			
Chest Pain		*Wake up to Urinate*			
Fainting		*Unusual Urine Color*			
Difficulty Breathing		*Frequent Urination*		***Pregnancy/Gynecology***	
Respiratory:		*Unable to Hold Urine* *Impotency*	__	*Number of Pregnancies:*	
Cough/Bronchitis		*Blood in Urine*		*Number of Miscarriages*	
Phlegm		*Kidney Stones*		*Period Between Menses*	
Coughing Blood		***Neuropsychological:***		*Heavy or Light Periods*	
Pneumonia		*Seizures*		*Painful Periods*	
Asthma		*Numbness (Where)*		***Additional Information:***	
Pain w/ Deep Breath		*Poor Coordination*			
		Depression			
		Poor Memory			
		Anxiety *Susceptible to Stress*	__		

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Please list all current medications

Date	*Medication*	*Dosage*	*Length of Time on medication*

Please list Family Health History

_____

_____

_____

_____

Please provide brief summary of the reason for your visit today:

_____

_____

_____

_____

***Pain Scale**: Given a scale of 1 to 10…with 1 being the least and 10 begin the most painful…Circle how you rate your pain.*

1 2 3 4 5 6 7 8 9 10

Check any of the following terms that describe your pain

☐ Aching	☐ Deep	☐ Itchy	☐ Tight
☐ Sharp	☐ Intense	☐ Pinching	☐ Tingling
☐ Prickling	☐ Throbbing	☐ Beating	☐ Tiring
☐ Splitting	☐ Tender	☐ Cold	☐ Swollen
☐ Burning	☐ Unbearable	☐ Crampy	☐ Hot
☐ Stabbing	☐ Pounding	☐ Dull	☐ Shooting
☐ Bruised	☐ Mild	☐ Sore	☐ Radiating

Patient Signature: _____ Date: _____