PATIENT INFORMATION

Patient Name _____ ☐ Male ☐ Female

Address _____ City _____ State ____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
OK to leave message on ☐ Home Phone ☐ Cell Phone

Email _____

Date of Birth _____ Social Security Number _____ Driver's License _____
Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widowed

Occupation _____ Employer Name _____
Employer Address _____

Whom may we thank for referring you to us?
☐ Self ☐ Ins. ☐ Internet ☐ Event ☐ Website ☐ Corporate Wellness Program

☐ Other: Name _____

RESPONSIBLE PARTY

☐ Self (skip to Emergency Contact Information) ☐ Insurance (please provide card) ☐ HRA/Flex
Subscriber _____ Relationship _____ DOB _____
Subscriber ID Number _____ Company _____

EMERGENCY CONTACT INFORMATION

Name of Contact _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____

Name of Contact _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____
☐ I authorize Dr. Jing F. Li to release my medical information to: _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for service rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical service and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. **Payment is due at the time services are rendered.** All charges are the direct responsibility of the patient. I understand that service cannot be rendered on the assumption that charges will be paid by the insurance company and that insurance is an agreement between me and my insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to the bill. I hereby acknowledge that I have read, understand and agree to hereby give consent to assess, treat, and test.

Patient's Signature _____ Date _____
Print Name _____

Patient Intake Form

Name:	Home telephone:	Work telephone:
Street address:	Age: Height:	Weight:
City:	Birthdate:	Sex:
State: Zip Code:	Occupation:	
Primary physician:	Referred by:	Emergency telephone:
Main problem:	Onset:	Is this: Work / Auto Related? (please circle)
Other concurrent therapies:		

PAST MEDICAL HISTORY (including date):

Significant illnesses: ___Cancer ___Diabetes ___High Blood Pressure ___Heart Disease
___Hepatitis ___Rheumatic fever __Thyroid disease

Surgeries:

Significant trauma (automobile accident, falls, etc.):

Birth history (prolonged labour, forceps delivery, etc.):

Allergies (drugs, chemicals, foods, etc.):

Medicine (taken within the last two months, include vitamins, over-the-counter drugs, herbs, etc.):

Occupational stress (chemical, physical, psychological, etc.):

Average daily diet:

Morning: Afternoon: Evening:

Habits: ___Cigarettes ___Coffee ___Tea ___Soda ___Alcohol ___Drugs ___Sugar ___Salt Other:

Family medical history: ___Diabetes ___Cancer ___High Blood Pressure ___Heart Disease ___Stroke
___Seizures ___Asthma ___Allergies ___Alcoholism Other:

GENERAL:

- ☐ Fatigue
- ☐ Insomnia
- ☐ Cold hands
- ☐ Fevers
- ☐ Chills
- ☐ Sudden energy drop at: _____(time)
- ☐ Strong thirst (cold/hot drinks):
- ☐ Heavy appetite
- ☐ Poor appetite
- ☐ Cold feet
- ☐ Cravings
- ☐ Localized weakness
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Cold abdomen
- ☐ Sweat easily
- ☐ Poor coordination
- ☐ Peculiar tastes/smells
- ☐ Bleed or bruise easily (where):
- ☐ Tremors
- ☐ Vertigo
- ☐ Cold back
- ☐ Night sweat
- ☐ Change in appetite

SKIN AND HAIR:

- ☐ Rashes
- ☐ Eczema
- ☐ Change in hair/skin texture
- ☐ Tumors, masses or lumps (where):
- ☐ Ulcerations
- ☐ Pimples
- ☐ Purpura
- ☐ Hives
- ☐ Dandruff
- ☐ Boils
- ☐ Other hair or skin problems:
- ☐ Itching
- ☐ Loss of hair

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Dizziness
- ☐ Eye strain
- ☐ Colour blindness
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Teeth problems
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Other head or neck problems:
- ☐ Concussions
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Dry throat
- ☐ Jaw clicks
- ☐ Spots in eyes
- ☐ Headaches/Migraines (where/when):
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Grinding teeth
- ☐ Recurrent sore throats (per month):
- ☐ Glasses/Contacts
- ☐ Night blindess
- ☐ Sinus problems
- ☐ Copius saliva
- ☐ Facial pain

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Blood clots
- ☐ Heart Medication:
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pains
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Swelling in hands/feet
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Cough
- ☐ Production of phlegm: Amount/Frequency:
- ☐ Other lung problems:
- ☐ Bronchitis
- ☐ Coughing up blood
- ☐ C.O.P.D
- ☐ Tight chest (how often):
  Colour:
- ☐ Pneumonia
  Consistency:

GASTROINTESTINAL

- ☐ Nausea
- ☐ Gas
- ☐ Halitosis
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Vomiting
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Laxative use (frequency):
- ☐ Diarrhea
- ☐ Black stool
- ☐ Hemorroids
- ☐ Sensitive abdomen
- ☐ Bowel movement:
  Frequency:
  Colour:
  Odor:
  Texture/Form:

GENITO-URINARY

- ☐ Painful urination
- ☐ Unable to hold urine
- ☐ Wake up to urinate How often (per night):
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Venereal disease
- ☐ Urgency to urinate
- ☐ Impotency
- ☐ Other:

PREGNANCY AND GYNECOLOGY

- ☐ Number of pregnancies:
- ☐ Age at first menses:
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Birth control type and duration:
- ☐ Flow (describe):
- ☐ Number of births:
- ☐ Period (duration):
- ☐ Clots
- ☐ Breast lumps
- ☐ Premature births:
- ☐ Irregular periods
- ☐ Last PAP exam (date):
- ☐ Changes in body/psyche prior to menstruation:
- ☐ Miscarriages:
- ☐ Menopause (year):
- ☐ Last menses (date):

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Other joint or bone problems:
- ☐ Muscle pain (where):
- ☐ Back pain (where):
- ☐ Joint pain (where):

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Depression
- ☐ Treated for emotional problems
- ☐ Other neurological or psychological problems:
- ☐ Areas of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Bad temper
- ☐ Concussion
- ☐ Easily stressed
- ☐ Considered/attempted suicide

PATIENT NAME:

DATE:

Integrative Medical Center
Jing Li, M.D., OMD LAc
Board Certified Family Practice
Diplomate American Academy of Pain Management
9940 Research Drive Suite 100 Irvine, CA 92618
949-552-8133 Phone
949-552-1882 Fax

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Integrative Medical Center
Jing F. Li, M.D., LAc, OMD
Yunpo Chen, LAc, OMD
9940 Research Drive Suite 100 Irvine, Ca 92618
949-552-8133

BILLING POLICY

PAYMENT FOR ALL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE

CO-PAYMENT AND/OR DEDUCTIBLE BALANCES WILL BE COLLECTED AT THE TIME OF SERVICE. Due to the high cost and time of statement billing there will be a minimum charge of $5.00 for billing unpaid deductibles and/or co-payment balances that are not paid in full at the time of service. Accounts that are 90 days old that reflect unpaid co-payments and /or deductibles will be forwarded to our collection agency without further notice.

We verify the status of all deductibles with your insurance company. If you believe the status to be different than the information we received, you will need to provide adequate show of cause to avoid making payment. This is necessary to avoid non-payment of service from your insurance company.

WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY TO YOU; HOWEVER, WE ARE NOT RESPONSIBLE FOR FOLLOWING UP WITH THE INSURANCE COMPANY TO ENSURE THAT THEY PROVIDE REIMBURSEMENT. THIS IS YOUR RESPONSIBILITY. Payment for all services billed to the insurance company is due in full within 60 days from the date of service. TO AVOID FINANCE CHARGES AND RE-BILLING COSTS TO YOU, PLEASE FOLLOW UP WITH YOUR INSURANCE COMPANY AND ENSURE THAT PAYMENT IS MADE WITHIN THE ALLOTTED TIME.

If your insurance claim is denied for ANY reason other than error in submission from this office, you will be responsible for payment of the balance in full if payment is not within 60 days of the correct submission date. A charge of $5.00 will be applied for routine resubmission of insurance claims to cover the cost of postage and supplies.

Payment arrangements can be made in advance of services rendered in cases involving extensive treatment and/or financial hardship.

THERE WILL BE A $75.00 SERVICE CHARGE FOR ANY MISSED APPOINTMENTS WITHOUT A MINIMUM OF 24 HOURS PRIOR NOTICE. Adequate notice enables us to schedule another patient that may need to be seen in your appointment time slot. Exceptions will be made for real emergencies.

The cost for reproduction/transfer of patient records is $35.00 to cover the cost of supplies used. This fee will need to be paid in full prior to the release of records. You are ultimately responsible for fees charged for copies of your record being provided to insurance companies if they do not provide reimbursement.

THIS OFFICE IS NOT RESPONSIBLE FOR RECORD KEEPING OF EXPENSES PAID FOR TREATMENTS, CO-PAYS, OR SUPPLEMENTS. The cost for a statement summary of payments of ranges from; $15 to $75 based on the administrative time involved in the preparation of such statement. For your convenience please ask staff for a record keep sheet to help the organization of your own expense record keeping if needed.

I have read and I understand the above information, and I agree to comply accordingly.

_____ _____

Signature of Patient/Legal Guardian Date

INFORMED CONSENT AND ARBITRATION AGREEMENT

I, _____, THE UNDERSIGNED, HAVE BEEN INFORMED BY Dr. Jing F. Li, M.D., LAc, a licensed physician and acupuncturist, Dr. Po Chen, O.M.D., LAc or any other health care provider of the nature, risks, and possible consequences from the use of alternative/complementary medicine.

I hereby request and consent to the performance of acupuncture/acupressure/Tui-Na/soft tissue work/massage treatments and other procedures within the scope of the practice of acupuncture, oriental medicine and nutrition on me (or on the patient named below, for whom I am legally responsible) by the health provider named above and/or other health provider, massage therapist, nutritionist who now or in the future treat me while employed by, working or associated with or serving as back-up for the health provider named above, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, applied kinesiology, mechanical or manual traction, electrical-stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. 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 be 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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothroax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. There may also be soreness of the muscles after the use of applied kinesiology (muscle response testing). I understand that while this document describes the major risks of treatment, other side effect and risks may occur.

I understand that I am participating in a program whereby herbology, nutritional support and supplement treatment is used as a complementary/alternative approach to assist me in managing symptoms related to my condition; which will not replace my medical care.

I have been advised, and I understand and acknowledge that herbal medicine is not a standardized medical treatment and FDA does not approve the herbal/nutritional compounds I receive because they are not considered drugs. Conventional scientific research information on a particular herb/ supplement may not be readily available at this time. I have been advised and acknowledge that there is no guarantee that the treatments shall be successful at all or any more successful than the traditional treatments for my condition.

The traditional Chinese herbal supplements that have been or are being recommended are traditionally considered safe. However, I understand that some patients may experience gastro-intestinal upset, such as nausea, gas, stomachache, vomiting, diarrhea, rash, hives or other side effects or allergic reactions to the herbs (some may be toxic in large doses). I will inform the doctors immediately if I experience any side effects.

I understand that some herbs/ supplements may be inappropriate during pregnancy and may have damaging effects on the fetus. Recognizing these risks, I accept full responsibility for informing the doctors of a suspected or confirmed pregnancy. For the same reasons, I understand and I must inform the doctors if I am a nursing mother.

I hereby request and consent to the use of herbology/nutritional support as an alternative and/or complementary treatment for managing the symptoms related to my condition, by the doctors named above. I have read, or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the below-named treatment. 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 the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the below consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

_____ _____

Patient Name (please print) Signature

_____

Date

CANCELLATION AND ADD-ON POLICY

Dear Patients,

In order for the Doctors and staff to continue to provide you with the most unique and high quality medical service, our office will implement a canceling and add-on policy.

CANCELLATION

A 24 HOUR PRIOR NOTICE WHEN CANCELING AN APPOINTMENT IS REQUIRED TO AVOID YOUR FINANCIAL OBLIGATIONS. **ALL MISSED APPOINTMENTS WITHOUT PROPER 24 HOUR CANCELLATION NOTIFICATION WILL BE SUBJECT TO A MINIMUM 75$ CHARGE PLUS FULL MASSAGE FEE (IF APPLICABLE).**

ADD-ONS

We would like to remind you that as we strive to provide the finest care, we will try our best to accommodate patients with an acute condition (i.e. acute pain, cold/flu, infection). We urge all patients who may need an add-on appointment to call our office as early as possible so that all the necessary arrangements can be made such as urgent lab work, diagnostic tests, and doctor referrals.

Signature_____