TIAN SHI ACUPUNCTURE
Caring for the Whole You

FERTILITY QUESTIONNAIRE

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

PATIENT INFORMATION

Date
Name
Address
City State Zip
Birth Date Age Sex
Marital Status Occupation
Your Physician
Physician's Phone
Your OB/GYN
OB/GYN Phone
How did you hear about our office?

CONTACT INFORMATION

Home Phone
Work Phone
Cell Phone
E-mail
Emergency Contact:
Name
Relationship
Home Phone
Work Phone
Cell Phone
Have you ever had acupuncture?

MEDICAL HISTORY

Reason for visit today
How long have you had this condition? Is it getting worse?
What seemed to be the initial cause?
List medications/supplements taken in the last two months

FAMILY HISTORY ***(please check any of the following that have occurred in your blood relatives)***

- ❑ Alcoholism
- ❑ Allergies
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____

PAST MEDICAL HISTORY ***(please check any conditions you have or have had in the past)***

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth Trauma
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Surgery (list below)
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Major Trauma (car, fall, etc. [list below])
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other (list below)

Details:

HEALTH HISTORY *(please check any symptoms you currently have or have had in the past year)*

GENERAL SYMPTOMS

- ❑ Like cold drinks
- ❑ Like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Peculiar taste (describe below)
- ❑ Chills
- ❑ Fever
- ❑ Aversion to cold
- ❑ Aversion to heat
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Vertigo/dizziness
- ❑ Muscle cramps
- ❑ Other _____

Details: _____

HEAD, EYES, EARS, NOSE, THROAT

- ❑ Headaches
- ❑ Migraines
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Gum problems
- ❑ Dry mouth
- ❑ Sores on lips or tongue
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm (Color _____)
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Recurrent sore throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Nasal discharge
- ❑ Nasal obstruction
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Ear discharge
- ❑ Concussion
- ❑ Other _____

Details: _____

SKIN/HAIR

- ❑ Dryness
- ❑ Hematomas
- ❑ Bruise easily
- ❑ Rashes
- ❑ Itchiness
- ❑ Psoriasis
- ❑ Eczema
- ❑ Acne
- ❑ Oily skin
- ❑ Jaundice
- ❑ Brittle hair/nails
- ❑ Dandruff
- ❑ Premature gray hair
- ❑ Hair loss
- ❑ Dry scalp
- ❑ Dark circles under eyes
- ❑ Bags under eyes
- ❑ Other _____

Details: _____

RESPIRATORY

- ❑ Asthma
- ❑ Cough (❑ Wet ❑ Dry)
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Phlegm/sputum
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Sneezing
- ❑ Snoring
- ❑ Tightness in chest
- ❑ Bronchitis
- ❑ Frequent colds
- ❑ Sensitivity to humidity
- ❑ Sensitivity to dryness
- ❑ Sensitivity to wind
- ❑ Sensitivity to heat
- ❑ Sensitivity to cold
- ❑ Other _____

Details: _____

CARDIOVASCULAR

- ❑ Low blood pressure
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Tachycardia
- ❑ Blood clots
- ❑ Heart palpitations
- ❑ Irregular heartbeat
- ❑ Swelling of ankles
- ❑ Edema
- ❑ Varicose veins
- ❑ Other _____

Details: _____

GASTROINTESTINAL

❑ Nausea	❑ Hiccup	❑ Intestinal pain	❑ Bloody stools
❑ Vomiting	❑ Acid regurgitation	❑ Diarrhea/loose stools	❑ Mucous in stools
❑ Bloating	❑ Indigestion	❑ Constipation	❑ Hemorrhoid
❑ Gas	❑ Stomachache	❑ Black stools	❑ Other _____

Details: _____

MUSCULOSKELETAL

Pain, numbness, and/or weakness in:

❑ Arms	❑ Shoulders	❑ Ankles	❑ Middle back
❑ Elbows	❑ Legs	❑ Feet	❑ Lower back
❑ Wrists	❑ Hips	❑ Neck	❑ Joints
❑ Hands	❑ Knees	❑ Upper back	❑ Other _____

Details: _____

NEUROPSYCHOLOGICAL

❑ Paralysis	❑ Depression	❑ Easily stressed	❑ Fear
❑ Tremor	❑ Anxiety	❑ Feel angry	❑ Nervousness
❑ Seizures	❑ Irritability	❑ Feel sad	❑ Suicidal thoughts
❑ Poor memory	❑ Mood swings	❑ Forgetful	❑ Other _____
❑ Difficulty focusing/concentrating		❑ Mind not clear	

Details: _____

GENITO-URINARY

❑ Bed wetting	❑ Blood/pus in urine	❑ Decreased libido	❑ Frequent urination
❑ Inability to control urine	❑ Kidney infection/stones	❑ UTI	❑ Wake to urinate
❑ Other _____			

Details: _____

DIET & LIFESTYLE *(List average daily menu)*

Morning	Morning Snack	Lunch
_____	_____	_____
_____	_____	_____
_____	_____	_____

Afternoon Snack	Evening	Evening Snack
_____	_____	_____
_____	_____	_____
_____	_____	_____

❑ Alcohol	❑ Tobacco	❑ Good appetite	❑ Occupational hazards
❑ Caffeine	❑ Artificial sweetener	❑ Poor appetite	❑ Exercise excessively
❑ Drugs	❑ Sugar	❑ Stress	❑ Exercise regularly
❑ Other _____			

Details: _____

PREMENSTRUAL SYMPTOMS

Check if you have any of the following symptoms:

❑ Acne ❑ Fatigue ❑ Irritable, depressed
❑ Bloated abdomen ❑ Sore, tender breasts ❑ Mood swings

Please check all that apply:

❑ Abdominal pain	❑ Before period	❑ During period	❑ After period
❑ Low back pain	❑ Before period	❑ During period	❑ After period
❑ Loose stools	❑ Before period	❑ During period	❑ After period
❑ Headaches	❑ Before period	❑ During period	❑ After period

Other _____

MENSTRUAL CYCLE

Age at which menses began _____
Have your cycles changed since they began? ❑ Yes ❑ No How? _____
Date of last menstrual period _____ How many days between cycles? _____
Do you bleed or spot between periods? ❑ Yes ❑No
Are your menstrual cycles spaced irregularly? ❑ Yes ❑ No Please explain _____

How long does your period last? _____
Are your periods painful? ❑ Yes ❑ No How many days does the pain last? _____
How heavy is the bleeding? ❑ Light ❑ Medium ❑ Heavy
What color is the blood? ❑ Light red ❑ Red ❑ Dark red ❑ Purple ❑ Brown ❑ Black
Is there clotting? ❑ Yes ❑ No Clot size: _____ Is there any mucus? ❑ Yes ❑ No
On what day of your cycle do you ovulate? _____
What method do you use to determine ovulation? _____
Do your breasts get tender at/during ovulations? ❑ Yes ❑ No
Do you have pain or cramping during ovulation? ❑ Yes ❑ No Where? _____
Do you notice an increase in discharge within the first two weeks after your period? ❑ Yes ❑ No
If you answered "yes" above, please fill in the next two questions:
First week discharge is: ❑ Light ❑ Medium ❑ Heavy Texture: ❑ Clear/stretchy ❑ Thick/cloudy
Second week discharge is: ❑ Light ❑ Medium ❑ Heavy Texture: ❑ Clear/stretchy ❑ Thick/cloudy

GYNECOLOGY HISTORY

Have you ever been diagnosed with any of the following:

❑ Endometriosis ❑ Menopause ❑ Tumors in the adrenal glands
❑ Endometritis ❑ POF (premature ovarian failure) ❑ Tumors in the pituitary glands
❑ Amenorrhea ❑ Pelvic inflammatory disease ❑ Tumors in the ovaries
❑ Anovulation ❑ PCOS (polycystic ovary syndrome) ❑ Fallopian tube blockage
❑ Candidiasis ❑ Hypothalamic anovulation ❑ Uterine and cervical abnormality
❑ Chlamydia ❑ Hyperprolactinaemia ❑ Vaginal infection
❑ Genital herpes ❑ Uterine fibroids or polyps ❑ Vaginal prolapse
❑ HPV (human papiloma virus) ❑ Resistant ovary syndrome ❑ Venereal disease
❑ Inherited parental genetic abnormalities ❑ Other _____

If you checked any above, when were you treated? _____
How were you treated? _____

Have you ever had any of the following?

❑ Regularly occurring yeast infections ❑ Chronic vaginal discharge ❑ Painful intercourse

Please fill in the following if applicable:

	Number	Year(s)		Number	Year(s)
Pregnancy(ies)	_____	_____	Miscarriages	_____	_____
Children	_____	_____	D&Cs	_____	_____
Abortions	_____	_____	Tubal Pregnancy(ies)	_____	_____

Have you ever taken oral contraceptives? ❑ Yes ❑ No When? _____ How long?_____
Have you ever had an IUD? ❑ Yes ❑ No When?_____ How long?_____
Have you ever had a cervical biopsy, operation, cauterization, or conization? ❑ Yes ❑ No
Have you ever had an abnormal Pap smear? ❑ Yes ❑ No Date of last Pap smear: _____
Other gynecological procedures: _____

Gynecological surgeries: _____

FERTILITY TREATMENT HISTORY

How long have you been trying to conceive?_____
Do you have a diagnosis related to infertility?_____
Has there been a sperm analysis? ❑ Yes ❑ No What were the results?_____
Is there or was there any indication of male factor infertility? ❑ Yes ❑ No What is it?_____
Have you ever conceived naturally in the past? ❑ Yes ❑ No How many times?_____
Have you had fertility treatments? ❑ Yes ❑ No
If yes, when and where?_____

What type(s)?_____
What were the results?_____
Have you taken medication to help you ovulate? ❑ Yes ❑ No When?_____How long?_____
What were the results?_____
Have you had a fallopian tube evaluation? ❑ Yes ❑ No What were the results? _____

Have you had other functional tests? ❑ Yes ❑ No What were the results?_____

What hormonal laboratory tests were performed?_____
What were the results?_____
Have you had a mid-cycle vaginal ultrasound? ❑ Yes ❑ No What were the results?_____

Have you had a post-coital test? ❑ Yes ❑ No What were the results?_____

Diagnosed with hostile cervical mucus? ❑ Yes ❑ No

Please list all medications you are currently taking for infertility:

Medication	Reason	Duration	Medication	Reason	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

LIFESTYLE

Do you use vaginal lubricants? ❑ Yes ❑ No
Are you more than 20% over your ideal body weight? ❑ Yes ❑ No
Are you more than 20% below your ideal body weight? ❑ Yes ❑ No
Do you have excessive facial hair? ❑ Yes ❑ No
Have you experienced an excessive loss of hair? ❑ Yes ❑ No
Do you douche regularly? ❑ Yes ❑ No
Have you noticed discharge from your nipples? ❑ Yes ❑ No
Do you have a stressful occupation? ❑ Yes ❑ No
Do you have excessively oily skin? ❑ Yes ❑ No
Have you or your partner ever had X-rays? ❑ Yes ❑ No
Are you presently taking steroids? ❑ Yes ❑ No
How is your sexual energy? ❑ Low ❑ Medium ❑ High
Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ❑ Yes ❑ No
Have you been exposed to any known environmental toxins or hormones? ❑ Yes ❑ No
Do you exercise regularly? ❑ Yes ❑ No
If so, what kind? _____

IN THE SECTIONS BELOW, PLEASE CHECK ANY SYMPTOMS YOU HAVE OR HAVE HAD SINCE YOUR FIRST PERIOD

- ❑ Shadow around or under eyes
- ❑ Low energy
- ❑ Difficulty with urination
- ❑ Frequent urination
- ❑ Incontinence
- ❑ Developmental disorders in reproductive organs
- ❑ No fertile mucus
- ❑ Irregular ovulation
- ❑ Late puberty

OFFICE USE ONLY (DX: KIDNEY JING DEFICIENCY)
BBT: No pattern or not recorded
Follicular phase:

Luteal phase:

Pulse: weak and thready
Tongue: pale
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

- ❑ Prematurely gray hair
- ❑ Hair loss
- ❑ Dry hair
- ❑ Dry skin
- ❑ Dry throat
- ❑ Thirsty
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Low back pain or soreness
- ❑ Night sweats
- ❑ Hot flashes
- ❑ Heat sensation in chest, palms, and soles
- ❑ Anxiety
- ❑ Insomnia
- ❑ Heavy, bright red periods
- ❑ Menstrual bleeding is light or scanty
- ❑ Vaginal dryness
- ❑ Cervical mucus scanty or missing

OFFICE USE ONLY (DX: KIDNEY YIN DEFICIENCY)
BBT :
Follicular phase: unsteady, longer than 13 or 14 days or average temperature around 98° F, short follicular phase if Yin-deficient heat

Luteal phase: poor temperature rise

Pulse: weak/deep lvl., floating/superficial lvl., rapid/Yin-def. heat
Tongue: dry, small, red, little coat
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

- ❑ Low back pain or soreness
- ❑ Leg pain /worsens in cold
- ❑ Knee pain/worsens in cold
- ❑ Edema
- ❑ Low libido
- ❑ Fatigue
- ❑ Often fearful
- ❑ Wake up to urinate
- ❑ Frequent urination
- ❑ Get cold easily
- ❑ Cold feet (especially at night)
- ❑ Early morning loose, urgent stools
- ❑ Profuse vaginal discharge
- ❑ Period cramps alleviated with heat
- ❑ Premenstrual low back pain
- ❑ Menstrual blood that is dull in color
- ❑ Clots during period
- ❑ Diarrhea just before or at the beginning of period

OFFICE USE ONLY (DX: KIDNEY YANG DEFICIENCY)
BBT:
Follicular phase: 96.8° F. or less

Luteal phase: not high or doesn't stay raised

Pulse: slow, deep
Tongue: pale and swollen
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

- ❑ Foul-smelling vaginal discharge
- ❑ Yellow or greenish vaginal discharge
- ❑ Vaginal itching
- ❑ Rectal itching

OFFICE USE ONLY (DX: DAMP HEAT)
BBT :
Follicular phase:

Luteal phase:

Pulse:
Tongue:
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

❑ Hysteria
❑ Anxiety
❑ Agitation
❑ Fidgety
❑ Insomnia
❑ Nightmares
❑ Heart palpitation
❑ Irregular ovulation
❑ No ovulation

OFFICE USE ONLY (DX: HEART QI STAGNATION)
BBT:
Follicular phase: unsteady graph

Luteal phase: high if there is Heart fire

Pulse: choppy or thready
Tongue: red tip
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

❑ Easily depressed
❑ Uncontrollable anger
❑ Headaches
❑ Difficulty falling asleep
❑ Heartburn
❑ Bitter taste
❑ Nipple discharge
❑ Feel bloated around ovulation
❑ Irritable around ovulation
❑ Breasts sensitive at ovulation
❑ Premenstrual bloating
❑ Premenstrual breast/nipple soreness
❑ Premenstrual irritability
❑ Painful period
❑ Menstrual cramps
❑ Clots during period
❑ Menstrual blood is thick or dark
❑ Menstrual blood is purple

OFFICE USE ONLY (DX: LIVER QI STAGNATION)
BBT:
Follicular phase: instability

Luteal phase:

Pulse: wiry
Tongue: red (fire) or purple (blood stagnation)
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

❑ Rapid pulse rate
❑ Dry mouth and throat
❑ Thirsty for cold drinks
❑ Wake up sweating/have hot flashes
❑ Feel warmer than those around you
❑ Vaginal irritation or rashes
❑ Break out with red acne before period
❑ Short menstrual cycle

OFFICE USE ONLY (DX: EXCESS HEAT)
BBT:
Follicular phase:

Luteal phase:

Pulse:
Tongue:
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

❑ Dizzy
❑ Oppressed feeling in the chest
❑ Heart palpitation
❑ Feel tired and sluggish after a meal
❑ Tendency to gain weight
❑ Overweight
❑ Like rich, sweet food
❑ Foul-smelling stools
❑ Pituitary tumors
❑ Blocked fallopian tubes
❑ Ovarian cysts
❑ Polycystic Ovary Syndrome
❑ Endometrial congestion
❑ Prone to yeast infections
❑ Prone to vaginal itching
❑ Excessive vaginal discharge
❑ Thick period
❑ Period contains mucus

OFFICE USE ONLY (DX: PHLEGM – DAMP ACCUMULATION)
BBT:
Follicular phase: temperature is high in the beginning, little of the usual biphasic pattern

Luteal phase:

Pulse: slippery, choppy, tight
Tongue: white, thick, or greasy coat
Rt. Cun:_____ Guan:_____ Chi:_____ Body:_____
Lt. Cun: _____ Guan:_____ Chi:_____ Coat: _____

- ❑ Painful, unmovable breast lumps
- ❑ Lower abdominal tenderness/pain
- ❑ Lumps in lower abdomen
- ❑ Vascular abnormality
- ❑ Varicose or spider veins
- ❑ Numbness in hands and feet
- ❑ Blood clotting disorder
- ❑ Pituitary tumors
- ❑ Endometriosis
- ❑ Uterine fibroids or polyps
- ❑ Fallopian tube blockages
- ❑ Ovarian cysts and tumors
- ❑ Brown or black menstrual flow
- ❑ Clots during period
- ❑ Mid-cycle pain around ovaries
- ❑ Piercing /stabbing menstrual cramps

OFFICE USE ONLY (DX: BLOOD STASIS)
BBT:
Follicular phase: high initially

Luteal phase:

Pulse: choppy or tight
Rt. Cun:_____ Guan:_____ Chi:_____
Lt. Cun: _____ Guan:_____ Chi:_____

Tongue: purple or some purple areas
Body:_____
Coat: _____

- ❑ Chapped lips
- ❑ Dry, flaky skin
- ❑ Brittle fingernails or toenails
- ❑ Brittle or dry hair
- ❑ Hair loss
- ❑ Diminished nighttime vision
- ❑ Ringing in ears
- ❑ Period is light and/or late
- ❑ Dizziness or light-headedness around time of period

OFFICE USE ONLY (DX: BLOOD DEFICIENCY [not necessarily equated with anemia])
BBT:
Follicular phase:

Luteal phase:

Pulse:
Rt. Cun:_____ Guan:_____ Chi:_____
Lt. Cun: _____ Guan:_____ Chi:_____

Tongue:
Body:_____
Coat: _____

- ❑ Crave sweets
- ❑ Poor appetite
- ❑ Energy becomes lower after a meal
- ❑ Feel bloated after eating
- ❑ Hypothyroidism
- ❑ Anemia
- ❑ Prone to feeling heavy or sluggish
- ❑ Lack of strength in arms and legs
- ❑ Lack of strength in breathing
- ❑ Loose stools
- ❑ Abdominal pain
- ❑ Hemorrhoids or polyps
- ❑ Allergies
- ❑ Bruise easily
- ❑ Poor circulation
- ❑ Varicose veins
- ❑ Excessive worry
- ❑ Sweat easily
- ❑ Low blood pressure
- ❑ Feel dizzy or light-headed
- ❑ Uterine prolapse
- ❑ Tired around ovulation
- ❑ Spotting before period
- ❑ Tired around menstruation
- ❑ Menstrual cramps
- ❑ Thin or watery periods
- ❑ Profuse or pinkish periods

OFFICE USE ONLY (DX: SPLEEN QI DEFICIENCY)
BBT:
Follicular phase:

Luteal phase:

Pulse: weak or slippery
Rt. Cun:_____ Guan:_____ Chi:_____
Lt. Cun: _____ Guan:_____ Chi:_____

Tongue: swollen with teeth marks
Body:_____
Coat: _____

TIAN SHI ACUPUNCTURE
Caring for the Whole You

OFFICE POLICIES

Consent to Medical Treatment

I voluntarily consent to receive Acupuncture and/or Chinese Herbal Medicine treatment administered by Batbayar Damdin, Dipl. Ac., L.Ac. I understand his training is in Acupuncture and Oriental Medicine and that he is not, nor claims to be, a medical doctor. I understand that the practice of Traditional Chinese medicine is not an exact science and diagnosis and treatment may involve risk of injury. I acknowledge that no guarantee has been made to me as to the results of any examination or treatment by Batbayar Damdin, Dipl.Ac., L.Ac.

Initials _____

Financial Policy

The following is a statement of Tian Shi Acupuncture's Financial Policy. All patients must complete the Patient Intake and Office Policy forms before receiving treatment from Batbayar Damdin, Dipl. Ac., L.Ac. Full payment is due at the time of service for all office visits and procedures. No discounts for services or products will be allowed unless written and agreed upon by Batbayar Damdin. The terms of any applicable prepayment discounts, treatment packages, or third-party financing plans are available for review at our office. We accept cash, checks, and credit or debit cards. This office is not a participating provider with any insurance carrier. However, if your insurance carrier does cover your services, you may elect to forward your receipts of payment for reimbursement.

This office requests 24-hour notification of any change to or cancellation of an appointment. If no notice of appointment cancellation is provided, it is our policy to charge the missed visit at the normal office visit rate. If the appointment was purchased in a package, the missed appointment charge will be deducted from the remaining appointments in the package. This office recognizes that emergencies and extenuating circumstances arise and those will be considered on an individual basis.

Accounts are considered delinquent after 60 days. Interest will be charged accordingly to all past- due accounts. Any collection charges that are incurred on balances that are turned over to a collection agency or legal representative are the responsibility of the patient.

Initials _____

I have read and understand each of the sections contained above. I understand that by signing this document, I am agreeing to and providing the authorization/consent contained in each of the above sections where my initials or those of my representative are located. I have had the opportunity to ask questions regarding each of these sections and all such questions have been answered to my satisfaction.

_____ _____ _____

Signature of Patient or Representative | Print Name | Date

_____

Relationship to Patient if Representative

TIAN SHI ACUPUNCTURE
Caring for the Whole You

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO OBTAIN, USE, AND DISCLOSE HEALTH INFORMATION

Notice of Privacy Practices
I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. **Prior to signing this acknowledgement and consent, I have had the opportunity to review the Notice of Privacy Practices in this organization's office or at www.tianshiacupuncture.com.**

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Request for restrictions
This organization will release information relating to my office appointments, directions for treatment or herbal supplements via telephone calls, answering machine messages, facsimile, or electronic mail. This organization may also communicate general information to you about the practice of acupuncture via newsletter using the name, address, and e-mail information you provided.

Please specify below any request to restrict the use, dissemination, or method of communication of your medical information as provided in the Notice of Privacy Practices, including notification to your primary care provider that you are receiving treatment at Tian Shi Acupuncture.

_____

_____

I hereby acknowledge that I have received and understand the Notice of Privacy Practices, consent to the use and disclosure of information as described therein, and release Batbayar Damdin, Dipl. Ac., L. Ac. and his employees from any legal responsibility or liability in connection with the disclosure of the information.

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Signature of Patient or Representative	Print Name	Date