DR. PARK
ACUPUNCTURE

# PATIENT AND INSURANCE INFORMATION

**Dr. Park Acupuncture**
**5550 Sterrett Pl Ste 303, Columbia, MD 21044**
**(410) 997-0390 / FAX: (410) 885-4744**

The following information is important for the maintenance of your account and for your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

**PATIENT INFORMATION:**

Name_____

Age_____ Date of Birth_____ ☐ Male ☐ Female

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Address_____ City_____ State_____ Zip_____

Home phone_____ Work phone_____ Cell Phone_____

Email_____

Occupation_____ Employer_____

**RESPONSIBLE PARTY:**

Name of responsible party_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Work phone_____ Cell Phone_____

Email_____

**INSURANCE INFORMATION: Insurance Company:**_____

Subscriber name_____

Subscriber date of birth_____ Relationship to subscriber_____

Secondary Insurance_____

Subscriber date of birth_____ Relationship to subscriber_____

**EMERGENCY CONTACT / NEXT OF KIN:**

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Whom may we thank for referring you?_____

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# HEALTH HISTORY QUESTIONNAIRE

*Important:* 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.*

Name of your primary physician:

Is there anything limiting you from care? ☐ Yes ☐ No If yes,

Other physicians/therapists seen for the condition:

How did you hear about our office?

Medications you are current taking:

1) 2) 3) 4)

5) 6) 7) 8)

Prescribed by:

For Treatment of:

Results:

Supplements (if any, vitamins, herbs, minerals, etc.)

Major Complaint(s), in order of significance to you:

1. 4.

2. 5.

3. Additional:

How do these conditions impair your daily activities?

## II. **Patient Medical History**

How was your childhood health?

Hospital Visits/Stays:

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# INFORMED CONSENT

ACUPUNCTURE WELLNESS LLC d.b.a. DR. PARK ACUPUNCTURE
5550 Sterrett Pl Suite 303, Columbia, MD 21044
(410) 997-0390 / FAX : (410) 885-4744

I voluntarily consent to be treated by Dr. Park Acupuncture. The Clinic offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

Dr. Seok Park is licensed in the state of Maryland to practice Acupuncture. Dr. Seok Park has a Ph.D. in Oriental Medicine from American Liberty University, a Master's degree in Traditional Oriental Medicine from Emperors College of Traditional Oriental Medicine, and a Bachelor's degree in Genetic Engineering from Korea University.

The treatments consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and channels
2. Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and channels
3. Acupressure
4. Infra-red
5. Dietary advice based on traditional Chinese medical theory

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following:

1. Some pain following treatment in the insertion area
2. Minor bruising
3. Infection
4. Needle sickness
5. Broken needle
6. Patients with severe bleeding disorders or pacemakers should inform the practitioner prior to any treatment. If you are pregnant or have a history of seizures, you should also inform the practitioner.

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment of series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I hereby authorize the Dr. Park 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. With notification, I also authorize the Dr. Park Acupuncture to obtain my medical records from other physicians or medical centers.

Payment in full is expected at the time of each appointment. The clinic will help you in preparing the necessary papers for your insurance. I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates after 3 missed appointments when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

Thank you for your cooperation and consideration.

Signature_____ Date_____

Name_____

Patient's Representative or Parent_____

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# PATIENT POLICIES

## ACUPUNCTURIST – PATIENT AGREEMENTS

Welcome to the office of Dr. Park Acupuncture

The purpose of these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following policies get the best results.

## 1. PATIENT POLICY: CLOTHING

The acupuncture points used for your condition will determine the areas of your body that need to be exposed. Please wear clothing that is loose fitting (e.g.: pants that can be moved above the knee) or bring shorts. You will be notified if a gown is necessary. If you need to change clothing, you may use one of the restrooms.

## 2. PATIENT POLICY: NO-WAIT CLINIC PROCEDURES

1. Please arrive 5 minutes before your designated time (for example, if you have an appointment at 9:00, arrive at 8:55). This will help to ensure that patients are treated in a timely manner.

2. Take yourself to the treatment room with your portfolio and then place your portfolio in the chart holder outside your room. This will notify the Acupuncturist that you are ready for your treatment.

3. Take off your shoes and socks. Move clothing as appropriate (e.g.: pull your pant legs above the knee and roll up your sleeves if appropriate). If you need to change clothing, please ask the Front Desk Clinic Assistant for a gown.

4. Lay down on the table, face up. The reason we ask you to lay down is so that you can relax a moment, which will allow you to get a better treatment.

5. To hold your preferred treatment time, we request that all appointments be made in advance. This will save you and the office time and will help to eliminate waiting.

## 3. PATIENT POLICY: PAYMENT OF BILLS

We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. It is not our policy to bill patients. Our policy is that patients not maintain a personal balance due.

## 4. PATIENT POLICY: MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

1. If you need to change the time of your appointment, plan to come at another time on the same day.

2. If the same day is not possible, be sure to make up the missed appointment within 7 days.

3. If you miss/cancel/re-schedule your appointments without at least a 24 hour notice, and this happens more than three times, you will be charged the full rate for each appointment every time it happens thereafter.

## 5. PATIENT POLICY: RE-EXAMINATIONS

During your treatment series, Re-Examinations may take place approximately once a month. The purpose of these visits will be to review your progress and make any adjustments necessary. It will also give us time to determine if any new condition needs to be treated and how you are progressing so far. It is important to arrive 10 minutes early for the Re-Exam since forms have to be filled out by the patient, and the Re-Exam will take approximately 15 – 20 minutes.

## 6. PATIENT POLICY: DIETARY SUGGESTIONS, LINIMENTS, FOOD SUPPLEMENTS, AND HERBS

If applicable, dietary suggestions should be followed, herbs and food supplements taken, and liniments used. Any problems you may have with these recommendations should be communicated to your Acupuncturist.

## 7. PATIENT POLICY: NOTIFY THE OFFICE IF YOU BECOME SICK

Infections and illnesses, such as colds, flu's, ear infections, and allergies (known as wind invasions in Oriental Medicine), are, often times, easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization, and second, it could be complicated by your current herbal formula. It is essential to let your acupuncturist know of such illnesses.

## 8. PHARMACEUTICAL DRUGS: ALWAYS CONSULT YOUR DOCTOR

An Acupuncturist in the State of Maryland is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated, we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency condition. **If the patient decides they want to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so.**

**I agree (Initial)_____**

## 9. PATIENT POLICY: UPSETS

We are here to serve you. Please speak with your acupuncturist about any upsetting matter. We see your comments as allowing us to help you and others.

---

I have read the above and I understand and accept these policies.

_____ _____

Patient's Signature Date

_____

Patient's Name (Print)

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## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Dr. Park Acupuncture
5550 Sterrett Pl Suite 303
Columbia, MD 21044
(410) 997-0390  Fax: (410) 885-4744

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

You can find details of the Notice of Privacy Practices at our office or online at the following address: www.drparkacu.com

Your signature below is acknowledgment that you have been provided with information on how to obtain a copy of our Notice of Privacy Practices to read.

| | |
|---|---|
| Patient or legally authorized individual signature | Date |
| Printed name and signed on behalf of the patient | Relationship<br>Parent, legal guardian, representative. |

Witness/Staff Member

(Notation, if any, by staff)

This form will be retained in your medical record.

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# Late Arrival Rescheduling/No Show/Cancellation Policy

To ensure that we can provide timely services to all patients, we may have no choice but to reschedule and/or cancel your visit if you are more than **10 minutes late** for your appointment.

Please be considerate and arrive early so that others may receive treatment without delay.

1. If you miss/cancel/re-schedule your appointments without at least a 24 hour notice, and this happens more than once, you will be charged a **late cancellation fee of $30** for each appointment thereafter.

2. The late cancellation fee is waived for inclement weather and emergencies.

I have read and understand the above and I will do my best to be considerate of others.

_____ ____/____/20____

Patient's Signature Date

_____

Patient's Name (Print)

PATIENT NAME: _____

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

| | | |
|---|---|---|
| PATIENT SIGNATURE | X _____ | (Date) _____ |
| (Or Patient Representative) | | (Indicate relationship if signing for patient) |
| OFFICE SIGNATURE | X | (Date) |

**Patient Name** _____ **Date** _____

## PLEASE CIRCLE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

**Gastrointestinal**
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Loss of appetite
- ☐ Stomach pain
- ☐ Blood in stool

**Eyes and vision**
- ☐ Wear glasses or contact lenses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury

**Ears, nose, throat**
- ☐ Ringing in the ears
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck
- ☐ Mouth sores

**Genitourinary**
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force or strain with urination
- ☐ Incontinence or dribbling
- ☐ Frequent urination
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge

**Endocrine**
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Glandular or hormone problem
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in nails or Hair

**Skin and breasts**
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

**Heart and Cardiovascular**
- ☐ Chest Pains
- ☐ Rapid Heart Beat
- ☐ Slowed Heart Rate
- ☐ Swelling of feet, ankles, hands
- ☐ History of Heart Disease
- ☐ Shortness of Breath

**Respiratory**
- ☐ Spit up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing
- ☐ Frequent coughing

**Hematologic/Lymphatic**
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Slow to heal
- ☐ Phlebitis
- ☐ Transfusion History

**Neurology**
- ☐ Stroke
- ☐ Head Injury
- ☐ Tremors

**Psychiatric**
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss

Patient Signature/Guardian _____ Date _____

NOTES: _____

_____

_____

_____

Doctor Signature: _____ Date _____

# GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____