

Patient Information Form



First Name _____ **Middle** _____ **Last** _____
Address _____
City _____ **Zip** _____
Phone (Home) _____ **Phone (Cell / Work)** _____
Email _____
Birth Date _____ **Sex:** Male _____ Female _____
Marital Status: Married _____ Single _____ Widowed _____
Occupation _____
Referring and/or Current Physician _____
Other Referral _____
Emergency Contact _____ **Phone** _____
How Did You Hear About Us? Patient or Doctor Referral (who)? _____
 Internet (which search engine)? _____ Other _____

Statement of Present Health (Please list all medical complaints)

Have you ever had, or do you now have....

	Yes	No
A tendency to bleed or bruise easily		
Heart attack		
Stroke		
Diabetes		
Heart Pace Maker		
High Blood Pressure		
Hepatitis – B or C		
Smoke		
Consume alcohol		

Have you every taken or are you now taking steroidal medication? _____

Please list all medications you are currently taking:



TrueMind® Center is a goal-oriented practice; to help us understand and meet your expectations, please answer the following question:

What are you seeking from your visits? That is, what are your health goals? Please check all that apply.

I want a specific problem targeted and fixed:

- I want long-term relief to my pain if possible.
- I am seeking deep emotional healing.
- I want to feel less stressed and overwhelmed.
- I want overall healing.
- I want preventative care.
- I want to learn how to maintain my health.
- I want to feel like myself again.
- I want to lose weight.
- I want to focus on anti-aging treatment.
- I want to tune-up my body
- I am seeking facial rejuvenation.
- I want to feel more energetic.
- I want a natural “full body makeover.”
- I just want to try a session and decide from there.



APPOINTMENT COMMITMENT

Here at TrueMind™ Center, we place particular pride in our consistent attention to each individual patient. Part of that includes reserving the utmost respect for our patient’s time by beginning each appointment on time and refraining from double- and overbooking our clinic. While that practice helps to ensure satisfying treatments, this policy is also difficult to deal with when last-minute cancellations are made. When a patient cancels with fewer than 24 hours’ notice, it is almost impossible to fill that appointment, and as a result, certain business costs will never be recovered. We employ a cancellation policy so that the frequency of these incidences is minimized.

NOTE: The following applies to any and all appointments made at the TrueMind™ Center.

If, for any reason you are unable to keep your appointment, please phone the clinic 24 hours in advance to cancel. If you phone the clinic the day of your appointment to cancel, you will be charged 50% of the standard treatment fees. If you do not call or show to your appointment, you may be charged 75% of the standard treatment fees. Also, if you are late for your appointment, your treatment time may be shortened so as to not interfere with another patient’s treatment time.

Thank you for your cooperation and understanding.

Signature: _____

Date: _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is sometimes necessary to use and disclose this health information in order to treat you, obtain payment, and conduct healthcare operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. Please feel free to refer to this Notice or to request a copy of this Notice prior to signing this consent.

The use and disclosure of your health information for **treatment purposes** not only includes care and services provided here, but also disclosures as may be necessary or appropriate for you to receive follow-up or emergency care from another health professional.

The use and disclosure of your health information for **payment purposes** includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination for benefits, and payment; and our submission of your health information to auditors hired by third-party payers and insurers.

The use and disclosure of your health information for **healthcare operations** includes quality assessment and improvement activities as well as evaluating practitioners and conducting training programs. A complete list is provided in our Notice of Privacy Practices.

Our Notice of Privacy Practices will be updated if our policies change. You may get an updated copy here at our office.

You can revoke this consent in writing at any time unless we have already treated you, sought payment for services, or performed healthcare operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

We can decline to serve you if you elect not to sign this consent form. Signing this consent signifies that you have been given the opportunity to read our Notice of Privacy Practices and/or given a copy of it if you desire one.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

Name (printed) _____

Signature _____ Date _____

(If applicable) Personal Representative's Name _____

Relationship to Patient _____



DISCLAIMER

Traditional Chinese Medicine is an ancient method of health care that combines the use of acupuncture, moxibustion, medicinal herbs, dietary therapy, cupping, massage and therapeutic exercise. It looks for the underlying causes of imbalances and patterns of disharmony in the body, and views each patient as a unique individual.

Because each patient is different, a few individuals may experience adverse reactions or side effects as a result of treatment. This may include nausea, discomfort, fainting, allergy, some heat sensitivity and redness or blistering during moxibustion, and/or aggravation of some existing symptoms. Patients prescribed herbs may be concerned about possible herb and drug interactions; these are extremely rare and concerned individuals should consult with their primary care provider or pharmacist. Our herbs are customized for the individual patient. Therefore, we are unable to give refunds on herbs and herbal formulas.

The Doctor and/or Clinic expressly disclaim responsibility for any of the aforementioned conditions resulting from treatment. Your understanding and acknowledgement concerning this matter are appreciated.

Patient's Signature _____

Date _____

Mandatory Disclosure

Name: Hongfei Lin, M.D.*, M.S., Dipl. Ac., Dipl. C.H.

TrueMind™ Center for Traditional Chinese Medicine
5 Cook Street, Denver, CO. 80206
Tel. 303-320-1530 Fax 303-320-1319 and
11166 Huron Street, Suite 28, Northglenn, CO 80234
Tel. 303-451-1650 Fax 303- 280-5886

*Dr. Lin is not a licensed physician in the state of Colorado

Fee Schedule:

Initial Consultation	\$ 145
Acupuncture Treatment	\$ 110
Custom Herbal Formula, per 100g	\$ 70 (plus sales tax)

A full schedule of Traditional Chinese Medicine modalities and additional fees that may apply is available at the clinic. Fees are subject to change without notice.

Education and Experience:

- M.D. Degree, 1979-1984, Sun Yat-sen University of Medical Sciences in Guangzhou, China.
- Passed the United States Medical Licensing Examination (USMLE) Part I & II in 1994.
- Master degree of Biomedicine-Traditional Chinese Medicine, 1984-1987, Sun Yat-sen University of Medical Sciences, Guangzhou, China.
- 28 years of practice with combinations of Traditional Chinese Medicine and Western Medicine. Of which, 18 years in practicing acupuncture, Chinese herbal medicine, Acupressure and Chinese Tui Na, three years in acupuncture researches, two years internship, and one year practicing internal medicine.

License and Certification:

NCCAOM Diplomate in Acupuncturist, # 002544.
NCCAOM Diplomate in Chinese Herbology, # 002544.
Education Commission for Foreign Medical Graduate Certificate, October, 1994.
Colorado state license for practicing acupuncture and Chinese herbology, #209.
Colorado Department of Higher education certified acupuncture instructor.

Note: None of the above have ever been suspended or revoked.

Service Statement

- We use disposable needles and keep proper sanitation of our acupuncture office in accordance with the regulations promulgated by the Department of Health.
- Every patient is entitled to receive information about the methods of therapy, technique used, and duration of the therapy, if known.
- Patient may seek a second opinion from another health care professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Regulation, Department of Regulatory Agencies.
- The practice of acupuncture and Chinese herbology are regulated and licensed by the Department of Regulatory Agencies. Thus, complaints regarding acupuncture services should be directed to: **Director of Division of Regulation, Acupuncturist Registration, 1560 Broadway, Suite 1350, Denver CO 80202. Tel (303) 894-7800.**

Patient's Signature: _____ **Date:** _____