LAWRENCE MILLER, L.AC
Acupuncture • Herbal Medicine • Holistic Healthcare

12655 Washington Blvd, Suite 106
Los Angeles, CA 90066

(310) 399-6029

www.VeniceAcupuncture.com

WELCOME TO OFFICE OF LAWRENCE MILLER, L.Ac.

We find that communicating our office policies will assist us in providing you with optimal service. Should you have any questions regarding these guidelines, please feel free to ask us.

Payment is required at the time services are rendered. If you have an insurance carrier, present your insurance membership card so that we can determine whether your insurer covers acupuncture treatment, and to what degree of reimbursement. If your insurance company covers acupuncture, you will be required to pay the balance beyond the amount your insurer will cover for treatment.

In certain cases, Lawrence Miller, L.Ac. may recommend lifestyle modification, follow-up visits, or additional outside medical care/consultation. If the patient refuses to comply with these recommendations, Lawrence Miller, L.Ac. can not be held liable for any health conditions which may arise due to patient non-compliance. Optimal health requires diligence and some effort on the patient's part—it is not something that is *done* to you! Understanding this is important to achieve optimal health.

Should you need to reschedule an appointment, 24 HOURS NOTICE is required. If you fail to notify us 24 hours in advance, you may be charged in full for your missed appointment. A missed appointment is a loss to everyone. For a Monday cancellation, please call on Saturday.

I understand these policies.

_____

Signature Date

PATIENT CONFIDENTIAL INFORMATION

Date_____ Name _____

Address _____City _____Zip_____

Sex: ☐ M ☐ F Age:_____ Date of Birth (mm/dd/yyyy) _____

Credit Card No. (req'd for new patients): _____ Exp. ___/___ Code _____

Occupation _____ Employer _____

Referred to this office by: _____

PHONE/EMAIL CONTACT INFO

Home: _____ Work _____ Email: _____

In case of emergency, contact:

Name_____ Relationship _____ Phone _____

Please turn over

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PATIENT MEDICAL INFORMATION AND HISTORY

Thank you for providing this personal information; it will enable me to more completely understand your individual pattern and come up with the most accurate diagnosis for your condition. Everything you disclose will be held in the utmost confidentiality, *and will not be shared in any circumstance without the patient's expressed, written consent.*

Primary reason(s) for visit: _____

_____

Have you had acupuncture before? ☐Yes ☐No Chinese herbal medicine? ☐Yes ☐No

Are you under the care of a physician now? ☐Yes ☐No If yes, for what? _____

Who is your physician? _____ Physician's phone _____

Other concurrent therapies_____

YOUR PAST MEDICAL HISTORY

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ Acne
☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Autoimmune disorder
☐ Birth Trauma (your own birth)
☐ Cancer
☐ Candida
☐ Chicken Pox
☐ Chronic Fatigue Syndrome
☐ Depression
☐ Diabetes
☐ Ear Infections
☐ Eating disorder
☐ Emphysema
☐ Epilepsy
☐ Gallstones
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Insomnia
☐ Intestinal Disorder/IBS
☐ Kidney stones
☐ Lupus
☐ Migraines
☐ Mononucleosis
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Parasites
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Shingles
☐ Sinus/Ear infections
☐ STD _____
☐ Strep throat
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Urinary Tract infections
☐ Vaccinations
☐ Whooping Cough
☐ Yeast infections
☐ Other (Specify)
_____
_____
_____

Please list all past surgeries (include dates):

_____

_____

Please list any major traumas (accidents, falls, etc.), hospitalizations or severe illnesses (include dates):

_____

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Mar Vista, CA 90066

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Pharmaceutical drugs taken in the last 2 months: _____

_____

Vitamins/Herbs/Supplements taken in the last 2 months:

_____

_____

FAMILY MEDICAL HISTORY

Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	mother	father	sibling	spouse	children
cancer or tumors					
diabetes					
blood or bleeding disorders/anemia					
seizures					
high blood pressure/heart disease					
allergies					
stroke					
drug abuse					
depression or mental illness					
age of death					
hepatitis					
kidney disorders					
thyroid disorders					
musculo-skeletal disorder					
blood transfusion (if before 1985)					

DIET & LIFESTYLE

My Level of Thirst is ☐Low ☐High

How many glasses of water/liquid do you drink per day? _____

My Appetite is ☐Low ☐Moderate ☐High

I prefer ☐ Hot ☐ Cold food and drinks

I tend to crave ☐ sweets ☐sour ☐bitter ☐ salty foods ☐spicy foods

I regularly consume ☐Coffee ☐Soft Drinks ☐Artificial Sweetener ☐Sugar ☐Fast food

I am ☐Omnivorous ☐Vegetarian ☐Lacto-ovo Vegetarian ☐Vegan ☐Strict Carnivore

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AVERAGE DAILY MENU

Breakfast	Lunch	Dinner	Snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke tobacco? Yes No Occasionally

Alcoholic drinks per week, on average: _____

Do you smoke marijuana? Yes No Occasionally

Do you use other recreational drugs? Yes No Occasionally

(all information provided is held in the utmost confidentiality, and will not be shared without the patient's expressed, written consent.)

Regular Exercise:

Type _____ Frequency _____

Type _____ Frequency _____

PLEASE ANSWER THE FOLLOWING:

Do you have a tendency to faint? ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No

Are you HIV positive? ☐Yes ☐No

Are you currently on blood-thinning medication? ☐Yes ☐No

Do you have hepatitis? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Due Date _____

Please turn over

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General
__ Insomnia
__ Dreams/ nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Infections
__ Earache
__ Hearing aids
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat & Mouth
__ Sinus infection
__ hay fever/ allergies
__ Frequent sore throat
__ difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easy bruising
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing when lying down
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Mucus in stool
__ Hemorrhoids
__ Gall Bladder disorder

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain
__ Paralysis
__ Poor coordination
__ Other (describe)

Genito-urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles

Infection Screening
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes: oral/ genital

Other

_____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.

b) Payment - To bill you or a third party for payment for services provided to you.

c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you

b) As required by federal, state, or local law

c) If child abuse or neglect is suspected

d) Public health risks (for public health activities to prevent and control spread of disease)

e) Lawsuits and disputes (in response to a court or administrative order)

f) Law enforcement (to help law enforcement officials respond to criminal activities)

g) Coroners, medical examiners and funeral directors

h) Organ or tissue donation facilities if you are an organ donor

i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.

b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request

b) Right to amend information in your health record you believe is inaccurate or incomplete

c) Right to know to whom we have disclosed your health information

d) Right to ask for limits on the health information data we give out about you

e) Right to receive communication from us about your health information in alternate ways

f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of patient or representative Date

_____

Print patient name Patient Birth Date

Please turn over

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CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha/Graston technique. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

_____

Patient Signature Date

Please turn over