



Welcome to Meridian Acupuncture.

As a practitioner of Traditional Oriental Medicine, I offer an integrated approach to health, including acupuncture, herbs, and nutrition. My goal is to provide the highest quality medical care by combining traditional wisdom with modern technology. I am committed to helping you achieve health and vitality through a program of healing, prevention, and education. I believe the quality of your health determines the quality of your life.

Enclosed are the intake forms for you to fill out. Please complete and bring them to your appointment. The initial intake and treatment will take approximately 1-½ hours. I **recommend a protein-rich meal two to three hours before each treatment and no refined sugar or caffeine** due to acupuncture's strong effect on the body. For your convenience, I accept cash, checks, and credit cards. I am also happy to check if your insurance covers acupuncture, as many do today. Feel free to call me if you have any questions. Thank you for choosing Meridian Acupuncture. I look forward to meeting you.

Sincerely,

Chantelle DeShazer, L.Ac.

2831 Camino Del Rio South, Suite 218 ♦ San Diego, CA 92108  
Phone 619-325-0771 ♦ [www.meridianacupuncture.net](http://www.meridianacupuncture.net)

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone # (Home): \_\_\_\_\_ Work #: \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security #: \_\_\_\_\_ Primary Health Plan: \_\_\_\_\_ Patient/Member ID #: \_\_\_\_\_

2<sup>nd</sup> Health Plan: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ PCP phone #: \_\_\_\_\_

Please describe your current health problem(s): \_\_\_\_\_

How and When it began: \_\_\_\_\_

If you are undergoing acupuncture treatments, describe your progress: \_\_\_\_\_

Worsened  No change  25% improved  50% improved  75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: \_\_\_\_\_  
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present?  Constantly  Frequently  Intermittently  Occasionally

Describe your current health condition:  Good  Fair  Poor  Chronically ill

Can you perform your daily activities?  Yes, all activities  Some activities  Not at all

Are you currently under the care of a physician?  No  Yes, please explain \_\_\_\_\_

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) \_\_\_\_\_

**Past Present**

- Alcohol/tobacco/drug dependence
- Abnormal menstruation
- Allergies
- Angina
- Arthritis/ rheumatoid arthritis
- Artificial joints
- Asthma
- Blood disorder
- Breast lumps
- Cancer/tumor
- Convulsions/seizures
- Diabetes
- Diarrhea/constipation
- Excessive thirst
- Fainting or dizziness
- Fatigue

**Past Present**

- Frequent urination
- Headache
- Heart attack
- Heartburn or indigestion
- High blood pressure
- Hospitalizations/surgical procedures \_\_\_\_\_
- Kidney disease
- Liver problems
- Pacemaker
- Painful menstruation
- Palpitation/arrhythmia
- Peptic ulcer
- PMS
- Pregnancy, months \_\_\_\_\_
- Prostate problems
- Rapid weight gain/loss

**Past Present**

- Sinusitis
- Stroke
- Thyroid Disease
- Medications \_\_\_\_\_
- Other: \_\_\_\_\_

If a family member has had any of the following, please mark the appropriate box and explain:

- Arthritis  Lupus
- Cancer  Mental disorders
- Heart disease  Hypertension
- Other: \_\_\_\_\_

**Comments:** \_\_\_\_\_

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my ASH Plans Acupuncture Provider or an ASH Plans Clinical Services Manager may need to contact my PCP if my condition needs to be co-managed. Therefore, I give my authorization to ASH Plans to contact my medical doctor if necessary.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMED CONSENT:**

\_\_\_\_\_  
Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgement during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow *direct* moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

**Authorization for Release of Medical Information:** I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

**Treatment of Pediatric Patients <3 Years.** I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child's medical doctor if/when necessary.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Patient ID Number

\_\_\_\_\_  
Primary Care Physician (or specialist) Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Primary Care Physician (or specialist) Telephone

\_\_\_\_\_  
Date

# PAIN ASSESSMENT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Chief Complaint 1. \_\_\_\_\_ 2. \_\_\_\_\_

Is your present problem due to an injury

On the job?  Auto Accident?  Personal Injury?  Other \_\_\_\_\_

Did your pain begin  Gradually?  Suddenly?

Do you have pain  All the time?  Sometimes?

Is your pain worse when you

Sit  Bend  Walk  Lift  Push  Pull  Other \_\_\_\_\_

Which of the following areas do you have the most pain, discomfort or restriction of motion?

Neck  Shoulders  Arms  Hands  Upper Back  Mid Back  Low Back

Pelvis  Hips  Legs  Knees  Feet  Other \_\_\_\_\_

**IN AN 8 HOUR DAY RATE THE PERCENTAGE OF YOUR PAIN WHEN YOU:**

Sit \_\_\_\_\_ % of the time

Stand \_\_\_\_\_ % of the time

Walk \_\_\_\_\_ % of the time

OCCASIONALLY = 33%  
 FREQUENTLY = 34-66%  
 CONTINUOUSLY = 67-100%

**WHAT PERCENT OF YOUR TIME ARE YOU:**

Housebound? \_\_\_\_\_ %

Chairbound? \_\_\_\_\_ %

Bedfast? \_\_\_\_\_ %

**RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE**

1 = LEAST PAIN  
10 = EXTREME PAIN

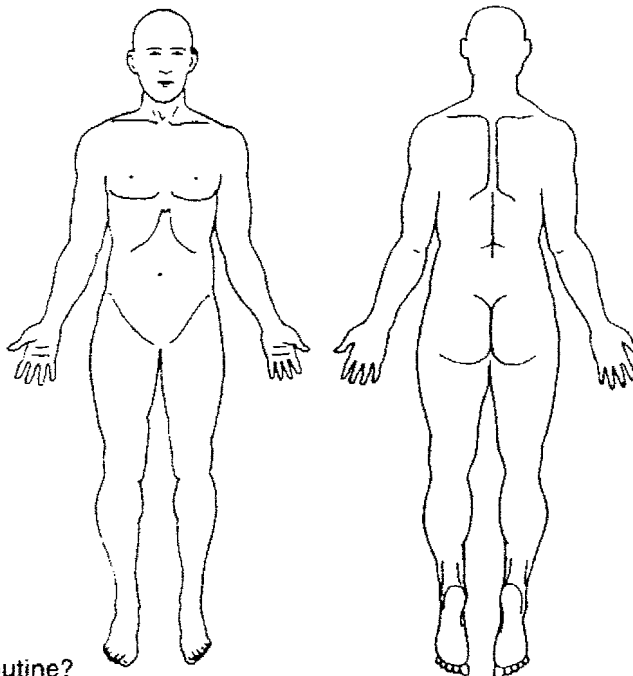
**EXTREME**

10
9
8
7
6
5
4
3
2
1
0

**NO PAIN**

**MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES**

+++ BURNING  
 000 STABBING  
 --- SHARP  
 . . . CONSTANT



Does your pain interfere with your  Work?  Sleep?  Daily Routine?

Do you feel your present condition is  Temporary?  Permanent?  Don't know

List any additional comments you wish to make regarding your condition \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_

**American Specialty Health Plans (ASHP)**  
P.O. Box 88802, San Diego, CA 92188-8802  
Fax: 619/297-8711

**ELIGIBILITY GUARANTEE  
ASSIGNMENT OF BENEFITS FORM**  
For Questions, Please Call ASHP at 888/226-1

CHANTELLE DESHAZER

(name of ASHP Acupuncturist)

*Meridian Acupuncture*  
2831 Camino Del Rio S. # 218  
San Diego, CA 92108  
(619)325-0771

**Eligibility Guarantee:**

I, \_\_\_\_\_ hereby certify that I am eligible for  
(name of patient/Member/guardian)  
acupuncture benefits offered by \_\_\_\_\_ through my employer,  
(name of health plan)  
\_\_\_\_\_ as of \_\_\_\_\_  
(name of employer group) (today's date)

I understand that if the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above Acupuncturist or health plan.

**Assignment of Benefits:**

I authorize the release of any health information necessary to process this claim. A photo copy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the Acupuncturist listed above who accepts assignment through his/her contract with ASHP and/or ASHP's Health Plans.

I understand that the ASHP Acupuncturist will not bill me for any charges over and above the insurance payment, other than the applicable copayments, coinsurance or deductibles, since the ASHP Acupuncturist has agreed in his/her contract with ASHP and/or ASHP's Health Plans to waive all un-paid fees.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Member (Or Subscriber)

**Note to Acupuncturist's Office Personnel:**

Please keep the original copy of the completed Eligibility Guarantee/Assignment of Benefits Form in the patient's file. If you need to submit this form to ASHP, please send it to ASHP at the address above. If you have any questions, call ASHP Provider Services at 888/226-8879.

# NOTICE OF HEALTH INFORMATION PRACTICES

This office creates detailed records of the care and services you receive. We at Meridian Acupuncture are committed to maintaining the privacy of your protected health information.

The Federal Government and the State of California have passed legislation requiring health plans, healthcare clearinghouses, and healthcare providers furnish the individuals with a notice as to how their health information may be used and disclosed to third parties. This notice also details your rights regarding your protected health information. Please read the notice carefully. Copies are available at the front desk.

Chantelle DeShazer is the privacy officer for this office. She will be happy to answer any questions you have regarding how your health information is handled in this office.

*Please sign below and return to the front desk:*

I have ( ) read and ( ) received a copy of the Meridian Acupuncture Privacy Notice.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print name: \_\_\_\_\_