Kyoungsook Sakumoto, L.Ac.
1903 Atlantic Avenue, Manasquan NJ 08736

ACUPUNCTURE CASE HISTORY FORM

Name_____ Date: _____

Address_____ City: _____ State:____ Zip:_____

Age:_____ Date of Birth: _____ S.S. #____-____-____ Marital Status: M __ S __ D __ W__

Email: _____ Home Phone: (____)_____ Cell: (___)_____Work: (____)_____

Occupation & Duties _____ Employer:_____

Emergency Contact (Name & Phone#) _____

How did you hear about our office? Referred by PCP Insurance Booklet Friend _____

Search Engine Yellow Pages Newspaper/TV Ad Website / Internet Other _____

Previous Acupuncturist: Name & Town: _____ Last Seen:_____

What are your main complaints that brought you to this office? Please provide a brief history.

#1_____ #3_____

#2_____ #4_____

Do you have any other health conditions that are causing you worry or discomfort?_____

_____

List all major accidents, surgeries, or hospitalizations (including date or age) _____

_____

List medications and/or supplements you are currently and why. _____

_____

List Allergies?_____

When and where were you last seen by your PCP (family physician) and/or medical doctor of any specialty?

Physician's Name & Address:_____ Date: _____

Reason for visit: _____ Diagnosis:_____

In your family, have you or anyone else had following diseases? If yes, please indicate the relationship to you.

Cancer Tuberculosis Diabetes Hypertension HIV Positive Hepatitis Depression

Do you have any of the following conditions or problems?

Digestion	Constipation	Dizziness/ Fainting	High Cholesterol
Fatigue	Diarrhea	Infectious Diseases	Excessive Weight Loss
Menstrual Pain	Bleed Easily	Sexually Transmitted Disease	Excessive Weight Gain
Hypertension	Heavy Menstruation	Easily Anxious or Nervous	Weight Loss Difficulty
Heart	Urinary Tract	High Blood Pressure	Other_____

What type of care do you desire?

Temporary relief of symptoms/pain control. Eradication of tendencies causing your condition.

Maintenance care/ balance to stay in good health. Elimination of root cause of problem, if possible.

How would you classify your condition? mild moderate severe

Is your condition worsening? Yes No

Rate pain on a scale from 1-10 (Circle One) **10 = Most Painful** **1 2 3 4 5 6 7 8 9 10**

What other treatments / therapies have you tried for this condition? _____
Lab results: (please include copies, if available_____

Please indicate frequency of use: 0=NEVER 1=RARELY 2=OCCASSIONALLY 3=FREQUENTLY

tobacco _____ coffee/black tea _____ alcohol _____ non-medical drugs _____ exercise _____

PATIENT PROFILE (for all patients) Indicate frequency of symptom Circle the number for symptoms that apply.

1 = SOMETIMES 2 = OFTEN 3 = FREQUENT / MAJOR CONCERN

1 2 3 Nausea
1 2 3 Hearing loss
1 2 3 Headaches
1 2 3 Dry scalp
1 2 3 Bronchitis
1 2 3 Dizziness
1 2 3 Migraines
1 2 3 Skin rash
1 2 3 Asthma
1 2 3 Low back pain
1 2 3 Ringing in ears
1 2 3 Cysts/tumor
1 2 3 Weak breath
1 2 3 Neck pain
1 2 3 Poor eyesight
1 2 3 Ear infection
1 2 3 Cough
1 2 3 Sinus congestion
1 2 3 Eye infection
1 2 3 Sore throat
1 2 3 Sinus problem
1 2 3 Edema
1 2 3 Dry eyes
1 2 3 Lymph swelling
1 2 3 Allergies
1 2 3 Dark under eyes
1 2 3 Eczema
1 2 3 Hot palms/soles

1 2 3 Nose infection
1 2 3 Emotional instability
1 2 3 Shingles
1 2 3 Heart palpitations
1 2 3 Grief/Weeping
1 2 3 Aversion to cold
1 2 3 Herpes simplex
1 2 3 Aversion to heat
1 2 3 Skin problems
1 2 3 Hair thinning/loss
1 2 3 Warts
1 2 3 Bitter taste in mouth
1 2 3 Premature aging
1 2 3 Nervousness
1 2 3 Gum problems
1 2 3 Frequent urination
1 2 3 Convulsions
1 2 3 Nose bleed
1 2 3 Underweight
1 2 3 Kidney stones
1 2 3 Spasms
1 2 3 Facial redness
1 2 3 Indigestion
1 2 3 Perspire easily
1 2 3 Irritability
1 2 3 Itch/burn skin
1 2 3 Flatulence
1 2 3 Weak legs/knees

1 2 3 Constipation
1 2 3 Thirst
1 2 3 Food allergy
1 2 3 Asthmatic cough
1 2 3 Hemorrhoids
1 2 3 Vivid dreaming
1 2 3 Stomach ache
1 2 3 Rapid weight change
1 2 3 Hepatitis
1 2 3 Dark urine
1 2 3 Ulcer
1 2 3 Loose teeth/loss
1 2 3 Ulcer
1 2 3 Night sweats
1 2 3 Diarrhea
1 2 3 Vomiting
1 2 3 Excess Joy
1 2 3 Anemia
1 2 3 Thyroid problems
1 2 3 Gallstones
1 2 3 Halitosis
1 2 3 Diabetes
1 2 3 Indecisive
1 2 3 Mouth sores
1 2 3 Excess fear
1 2 3 Fullness below ribs
1 2 3 Heartburn
1 2 3 Hearing problems

1 2 3 Shoulder tension
1 2 3 Fatigue
1 2 3 Big appetite
1 2 3 Neck tension
1 2 3 Arthritis
1 2 3 Weak appetite
1 2 3 Insomnia
1 2 3 Sciatica
1 2 3 Abd. bloating
1 2 3 Nerve pain
1 2 3 Excess worry
1 2 3 Cold hands/feet
1 2 3 Obsessive
1 2 3 Bursitis/tendonitis
1 2 3 Acid reflux
1 2 3 Trigeminal Neuralgia
1 2 3 Bell's Palsy
1 2 3 Obesity
1 2 3 Libido
1 2 3 PTSD
1 2 3 ADHD
1 2 3 Fibromyalgia
1 2 3 Pediatric Issues
1 2 3 Fever
1 2 3 _____
1 2 3 _____

FOR WOMEN ONLY

Are you pregnant? Yes No If Yes, Morning sickness Breech presentation 1st Pregnancy

If no, has it been at least 10 days since the first day of your last menstrual cycle? Yes No # of children birthed_____

Pregnancy complications? _____

Any menstrual difficulties or concerns?_____

_____

Any other issues you are concerned about:_____

FOR MEN ONLY (check all that apply)

Painful urination Yes No. Groin pain Yes No. Reduced sexual energies Yes No. Prostate problems Yes No.

Any other issues you are concerned about:_____

_____

HEALTH INSURANCE INFORMATION:

Primary Insurance Name:_____ Policy #:_____

Name of insured & date of birth?_____ Relationship to insured?_____

Secondary Insurance Name:_____ Policy #:_____

Name of insured & date of birth?_____ Relationship to insured?_____

INSURANCE COVERAGE: PATIENT RESPONSIBILTY & REFERRALS:

You the patient are responsible for checking with your insurance company to verify acupuncture coverage before treatment begins. Our staff will also call your carrier to verifying coverage. However verification of coverage is not a guarantee of payment. **If you, or our staff, receive inaccurate coverage details from your insurance carrier you the patient are still financially responsible for ALL services rendered.** In addition, patients are responsible for obtaining all referrals (if needed). Referrals must be presented to the front desk before you are seen by the provider. DO NOT expect your primary care physician to "back-date" your referral. If treatment is not covered by your insurance because a referral was not obtained or an unsatisfied deductible, you the patient will be responsible for payment.

Co-Payments are due at the time services are rendered. Insurance companies forbid the waiving of deductibles, Co-Insurance and/or co-payments by healthcare providers. Balances must be paid in full.

ALL appointment cancellations must be confirmed within 24 hours of your scheduled time.
Office charges for time reserved will apply for ANY appointments cancelled without proper notice.

ASSIGNMENT OF BENEFITS: I understand that health and auto accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me, my insurance carrier and/or my attorney (if applicable, charges may apply). In making collection or settlement from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I irrevocably authorize, direct and instruct insurance carrier and/or my attorney (if applicable) to make payment to Kyoungsook Sakumoto, L.Ac. from my settlement, fees due, to his office as mandated within the PIP fee schedule. I authorize assignment of benefits to Kyoungsook Sakumoto, L.Ac and allow Stiso Chiropractic & Acupuncture staff the right to appeal any claim denials from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment.

Furthermore, I understand that if I am accepted as a patient I am authorizing Kyoungsook Sakumoto L.Ac., Dr. Frank R. Stiso and/or staff to proceed with any standard treatment that may be necessary. Furthermore, any risk involved regarding acupuncture, chiropractic and/or massage therapy will be explained to me upon my request. I am aware it is my responsibility to make it known, or to learn through health care procedures, the existence of underlying conditions that would otherwise not come to the attention of the attending provider and/or staff. Conditions include, but are not limited to: latent pathological defects, skin damage, illnesses or deformities.

AUTHOURIZATION TO PAY PROVIDER DIRECTLY: Kyoungsook Sakumoto, L.Ac. is an out-of network provider. This means your insurance carrier may be send payments to you instead of the office. When a provider is out-of-network, insurance companies expect you to pay for your treatment at the time of service and submit your receipt to them for reimbursement. However, as per NJ State law P.L.2001, c.367, you may authorize your carrier to send payment directly to this office by signing an assignment of benefits form.

I authorize my insurance carrier to pay directly to Provider, the amount due to me under the terms of the above-referenced policy for out-of-network services rendered by Kyoungsook C. Sakumoto, L.Ac.

I HEREBY ATTEST ALL INFORMATION GIVEN IS TRUE AND AGREE TO ALL OFFICE POLICIES LISTED ABOVE.

Patient's Signature_____ Date: _____

Guardian's or Spouse's Signature:_____ Soc. Sec. #:_____

Kyoungsook Sakumoto, L.Ac. 1903 Atlantic Avenue, Manasquan NJ 08736

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

I hereby request and consent to the performance of the following on me (or on the patient named below, for whom I am legally responsible) by licensed providers of acupuncture and oriental medicine who now or in the future provide me with healthcare while employed by, working or associated with, or serving as back-up for Kyoungsook Sakumoto, L.Ac. including those working at this clinic or any other associated clinic: acupuncture, and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on variety of areas of my body, range of motion evaluation, muscle, orthopedic and neurological testing; various physical medicine modalities and therapeutic procedures such as massage, manipulation of joints and viscera, heat and cold therapy and electrical or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements and other natural health care products and devices; dietary recommendations, advise regarding exercise regimens, and lifestyle counseling.

I understand and am informed that, as in the practice of any system of medicine, there are risks associated with oriental medical treatment. I understand that while unlikely, possible risks that have occurred as a result of treatment at this clinic include an occasional small bruise, hematoma or spot of blood, general aches and, with some conditions, a temporary aggravation of the symptoms. In addition, even though the following have not occurred as a result of treatment, other possible risks include but are not limited to: large bruises, bleeding, inflammations, infections, burns, sprains, strains, dislocation, fractures, disc injuries, strokes, puncture of organs, nerve pain and appearance of new symptoms. I do not expect the practitioner to be able to anticipate and explain all risks and complications during the course of treatment. I wish to rely on the doctor's judgment based on the facts known at the time. With regard to acupuncture treatment, I understand that generally I should experience no pain or discomfort. However, some vigorous needle manipulation techniques may cause a variety of sensations, which may be somewhat painful at times for some people. These sensations may occur at the location where a needle is inserted or may radiate from that location.

I understand that there is no way to determine in advance exactly how many treatments may be necessary for my condition. I understand that in general the recommended treatment frequency is once or twice a week and as my condition improves treatment frequency decreases. I also understand that for some individuals and for some conditions less, or more, frequent treatment will provide satisfactory results. Since the number of treatments needed for a given condition will vary greatly depending on such factors as the patient's vitality, the patient's health history, the type of condition, the length of time the condition has existed, the patient's lifestyle and many other factors, I understand that it is not possible to initially determine how many I may need. However, after the initial examination and treatment the doctor will discuss with me what my options are with regard to treatment frequency and how many treatments I may need. I understand that although acupuncture and other oriental medical therapies have helped millions of people no guarantee of cure or improvement in my condition is given or implied. I have had an opportunity to discuss any questions I might have regarding the nature and purpose of acupuncture and other oriental medical procedures and the potential risks of treatment.

I have read, or have had read to me, the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures.

Patient's Name (Print)_____ Date: _____

Patient's or Guardian's Signature *(if under 18)*:_____ Soc. Sec. #:_____

Kyoungsook Sakumoto, L.Ac.,
Frank R. Stiso, DC, LLC & BrainCore of Manasquan LLC
1903 Atlantic Avenue, Bldg B. Suite 2, Manasquan NJ 08736

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The *Notice of Privacy Practices* has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for Kyoungsook Sakumoto, L.Ac., Frank R. Stiso DC LLC and/or BrainCore of Manasquan LLC to provide treatment to me, and also for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

2. Kyoungsook Sakumoto, L.Ac., Frank R. Stiso, DC, LLC and BrainCore of Manasquan reserves the right to change its privacy practices as described in its *Notice of Privacy Practices*, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders and/or birthday cards that will be used by the Practice: a) a postcard mailed to me at the address provided by me, and b) telephoning, texting or emailing me at any of the contact numbers supplied to this office by me as well as leaving a voice message recording or with any individual answering the phone that may or may not include personal and/or medical information.

4. I authorize this office to receive, use and/or disclose my PHI and all insurance information in order for Kyoungsook Sakumoto, L.Ac., Frank R. Stiso, DC, LLC and/or BrainCore of Manasquan LLC to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. My PHI may be viewed by all of the staff members at this office and Frank A. Stiso, DC, PA *(Colonia Office).*

5. I understand that I have a right to request that Kyoungsook Sakumoto, L.Ac., Frank R. Stiso, DC, LLC and/or BrainCore of Manasquan LLC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the *NOTICE OF PRIVACY PRACTICES*, then Dr. Stiso will not treat me.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature: _____ Date Signed: _____

Print Name: _____ Witness: _____

Signature of Legal Guardian: _____ Relationship: _____

Kyoungsook C. Sakumoto, L.Ac. **1903 Atlantic Avenue, Wall NJ 08736**

OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

TIME OF SERVICE (TOS) DISCOUNT

Whether your insurance covers chiropractic services or not, Kyoungsook C. Sakumoto, L.Ac offers a Time of Service (TOS) Discount to everyone. There is approximately a 15% savings if you choose to pay for your services with this method of payment. In order to qualify for this discounted payment option, you would have to agree to the following:

1. All services are paid THE SAME DAY they are provided (at the discounted rate).
2. You submit the paid receipt to your insurance for direct reimbursement without our assistance.
3. Your insurance company will reimburse you at a later date for the services performed at our office.

When could this payment option benefit me? Kyoungsook C. Sakumoto, L.Ac does not participate with any insurance companies. As such, by choosing the Time of Service discount your insurance company will send you a reimbursement check directly.

Please initial option 1 or 2 below.

1. Self-Pay

_____ 1. I choose to take the TOS discount. I understand that I will pay for the services at the time of service and I will be responsible for sending the claim in to the insurance company in order to be reimbursed.

2. Insurance

_____ 2. I choose not to take the TOS discount. I understand that Frank R. Stiso, DC, LLC will bill my insurance(s) for acupuncture services. If payment is sent to me or the primary policy holder on my plan, I agree to remit this payment to this office within 10 business days. If the insurance reimbursement payments are not delivered or mailed within this allotted time I give Frank R. Stiso, DC, LLC permission to charge the reimbursement amount I received to the credit card given below.

□VISA □MASTERCARD □AMEX □DISCOVER CARD #_____

_____	_____	_____	_____
Name as it appears on card	Security Code	Expiration Date	Billing Zip Code

I have read the office policies and agree to the payment option I have selected above.

Print Full Name:_____

Patient or Legal Guardian's Signature:_____ Date:_____