240 Mathistown Road, Unit 109
Little Egg Harbor, NJ 08087
(609) 994-0906
www.BeachAcuNJ.com

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

Prefix / Title (circle one): Mr. Mrs. Ms. Miss Mr. **Today's Date**_____

Name _____ Preferred name/nickname_____

Home Phone_____

***Cell phone**_____

***A mobile phone is required if you would like to receive SMS appointment reminders*

Email address _____

Street Address_____

City _____ **State** _____ **Postal / Zip** _____

Date of Birth _____

Occupation (if retired, what was your occupation?)_____Emergency Contact *Required*

_____

Emergency Contact Phone *Required*

_____

Emergency Contact Relationship *Required*

_____

Family Physician _____ Phone: _____

How did you hear about us?

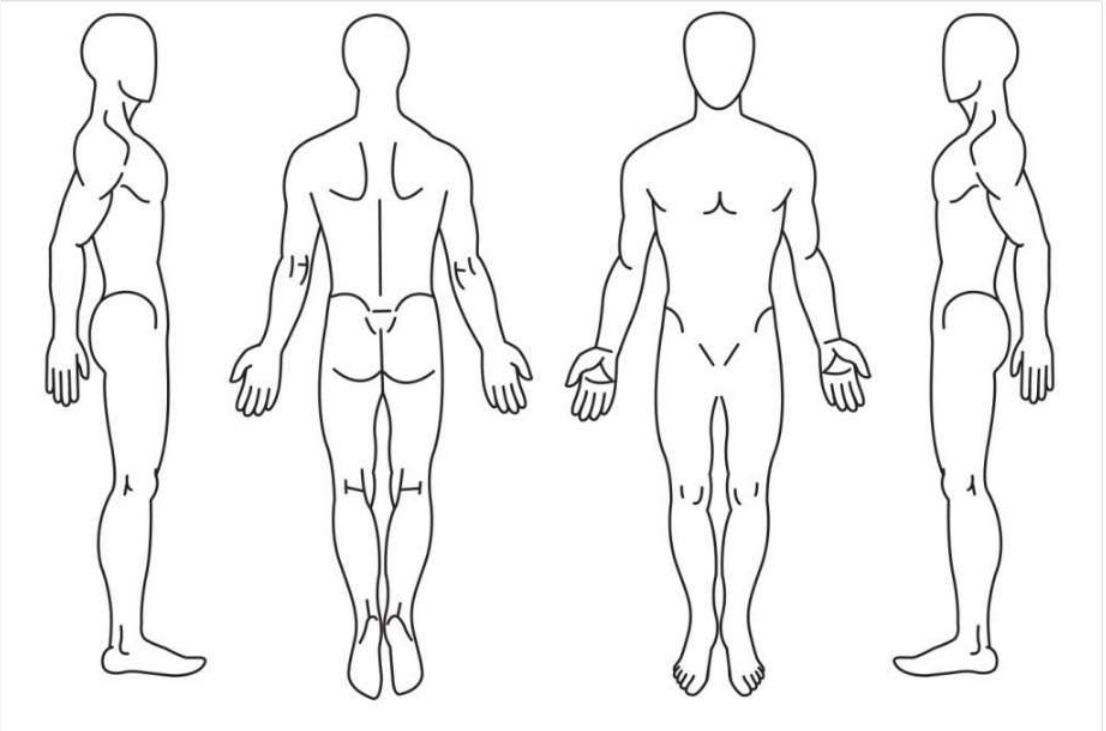
_____

Reason for coming for Acupuncture:_____

_____

What helps your symptoms?_____

What makes symptoms worse?_____



Circle the areas where you have pain. Draw arrows where the pain radiates if applicable.

Rate your pain (1 through 10, 10 being the worst pain): _____

HEALTH HISTORY

Please list any major surgeries:

_____

_____

Medications currently taking: _____

_____

Medication allergies:_____

Allergies to latex / environmental / foods:_____

Please CIRCLE all that apply to you:

Pacemaker

Heart attack

Depression

Anxiety

Arthritis

Autoimmune

Fibromyalgia

Headaches

Migraines

Sinus Allergies

Organ transplant

Constipation

Diarrhea

Gastric reflux / heartburn

Complications from surgery

Lymphedema / swelling

Neuropathy (hands / arms / legs / feet)

Plantar fasciitis

Muscle tension

Muscle cramps

Insomnia

Post-COVID symptoms

Mood disturbance

Feel cold all the time

Feel hot all the time

Thirsty often

No desire to drink fluids

Sweat often

Tooth Extractions

Silver/amalgam fillings

Other_____

Female patients only (circle all that apply):

Infertility	Hot flashes	Migraines aggravated by cycle
Irregular periods	Polycystic ovarian syndrome	Heavy periods
Premenstrual syndrome symptoms	Endometriosis	Other_____
Cramps with cycle	Fatigue related to cycle	

I confirm that all I have indicated above is true.

Print name:_____ Signature:_____

CANCELLATION POLICY - THERE IS A $50.00 NO SHOW FEE if you do not cancel within 24 hours of your appointment time. YOUR CREDIT CARD WILL BE CHARGED AUTOMATICALLY.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, **we require 24 hours notice for any cancellations or changes to your appointment.** You may cancel an appointment online, via text or email, or via phone call / leave message.

Patients who provide less than 24 hours notice, or miss their appointment, will be charged a $50 cancellation fee to the card on file.

**********I AM AWARE OF THIS CANCELLATION POLICY.**

Signature_____ Date:_____

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission, in compliance with HIPAA Act policies.

Initial _____

Texting Policy

Beach Acupuncture utilizes a text and email system when making, changing, canceling appointments. An SMS text message will be generated whenever an appointment is made, changed, canceled; also text/email reminders will be sent.
** I am able to opt out of text messaging later, if I am no longer interested.
I give my permission to text/email me with confirmations and updates regarding my appointments.

Initial _____

Financial Responsibility

I understand that I am responsible for all charges incurred in connection with the receipt of services and care from Beach Acupuncture. I promise to pay the amount of charges promptly to Beach Acupuncture.

I authorize Beach Acupuncture to release all information necessary regarding services rendered to my insurance company and referring physician.

If I am using my health insurance for payment for services rendered:
I hereby assign and transfer to Beach Acupuncture, all of my rights, titles and benefits payable by my insurance carrier for services performed by Beach Acupuncture.
I authorize Beach Acupuncture to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits, and all other insurance benefits through the carriers themselves, plan administrator, payor or third party.

If applicable to me,
I authorize Beach Acupuncture to obtain an attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize Beach Acupuncture to represent me directly in appealing a claim to the appropriate insurance company for all insurance plans.

I direct my insurance carrier, or intermediaries, to issue a payment check directly to Beach Acupuncture.

If my insurance company will not directly pay Beach Acupuncture, I authorize and direct that the insurance company sends all checks and copies of Explanation of Benefit forms in connection with services rendered here, to Beach Acupuncture at 240 Mathistown Rd., Unit 109, Little Egg Harbor, NJ 08087, as my agent for delivery of said items and use.

** In the event checks are mailed to me instead, **I am responsible to bring or mail these checks and Explanation of Benefits to Beach Acupuncture, 240 Mathistown Rd., Unit 109, Little Egg Harbor, NJ 08087**
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Print name_____

Signature_____ Date_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME:

ACUPUNCTURIST NAME: Kathy Martin, MS. Ac. / Beach Acupuncture

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)