ROCKY COAST
Integrated Medicine

FINANCIAL AGREEMENT

Client _____ Date _____

CANCELLATION POLICY

It is important that you appear for all scheduled appointments or cancel/reschedule at least 24 hours prior to your scheduled time. Your failure to do so deprives other clients of an opportunity to visit our office.

Consultation visits require at least 24 hours cancellation notice or a $50 consult fee will be charged.

Functional Medicine visits require at least 48 hours cancellation notice due to the length of appointments. Failure to provide 48 hours notice will result in a $100 cancellation charge. Thank you for understanding.

1. First failure to appear for a scheduled appointment or provide at least 24 hours notice, you will be given a warning.
2. Second failure to appear for a scheduled appointment or provide at least 24 hours notice, you will be charged a fee of $50.00.
3. Third failure to appear for a scheduled appointment or provide at least 24 hours notice, you will be charged a fee of $95.00 and we reserve the right to discharge you from our practice.

I have read, understand and agree to adhere to the cancellation policy stated here.

_____
Client/Authorized Person's Signature

○ **REFERRED BY THE VA** SSN: _____ - _____ - _____

○ **CASH PAYER**

I plan to pay the out-of-pocket, cash rate for all appointments, consultations and/or follow-ups. I understand that these charges are due on the day of service. We charge a one-time consultation fee for all new patients, ($125 for fertility and $50 for acupuncture). **I understand that if I plan to bill insurance but have not completed the process below, this payer scenario will apply until I have done so.**

○ **INSURANCE**

If you believe that you have insurance coverage for acupuncture, we will help you verify your benefits.

If you would like us to do a courtesy verification of your benefits, please email a photo of the front/back of your insurance card to info@rockycoastacupuncture.com. We need one week to verify the benefits on your policy. Failure to send us the card will result in a $175 out of pocket first patient appointment. If you need assistance submitting your insurance card, please call the office for someone to help you.

After your consultation, we will give our best recommendation for an individualized treatment plan going forward. We will do our best to verify what your insurance may cover ahead of time, but we can make **no guarantees** that the estimate provided is the amount owed after the claim is processed.

AUTHORIZATION & SIGNATURE I understand that I am financially responsible for all services that I receive from provider. If applicable, I authorize payment of medical benefits to the undersigned provider for services that I receive, and I authorize the release of any medical or other information necessary to process claims.

_____ _____
Client/Authorized Person's Signature Date

Please inquire in the office for cards on file.

ROCKY COAST
Integrated Medicine

PRIVACY & CONSENT FORM

Client _____ Date _____

NOTICE OF PRIVACY PRACTICES

Understanding your health records: A record is made each time you visit Rocky Coast Integrated Medicine. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits and serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, where, when, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is in the physical property of Rocky Coast Integrated Medicine, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and request the appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of your record to others, and be given an account of these disclosures. Other than activity that has already occurred, you may revoke any further authorization to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibility: Rocky Coast Integrated Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We are required to follow the terms of this notice and to notify if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Rocky Coast Integrated Medicine reserves the right to change our practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Rocky Coast Integrated Medicine, agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem, you may contact Jason S. Stein L.Ac. M.Ac. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.
I, _____, have received a copy of this Notice of Privacy Practices. I understand my health information will be used and disclosed consistent with this notice.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF INFORMATION / PAYMENT AGREEMENT

I authorize and direct that payments be made directly to: Rocky Coast Integrated Medicine, 491 Stevens Ave. Portland, ME 04103 for any and all insurance benefits or reimbursement for services rendered by Jason S. Stein L.Ac. M.Ac., Beth Herzig L.Ac. M.Ac., and/or Sarah Belisle Ph.d., L.Ac. which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

I authorize the release of any information concerning my health and health care services to my insurance companies or pre-paid health care plan.

Rocky Coast Integrated Medicine will gladly bill your insurance on your behalf and make reasonable efforts to collect from that company. I understand that there is no guarantee that my insurance company or pre-paid health care plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____
Client/Authorized Person's Signature Date

CONSENT FOR TRADITIONAL METHODS

I, the undersigned hereby authorize (Jason S. Stein, Beth Herzig, and/or Sarah Belisle) who are nationally certified by the NCCAOM and are currently licensed in the State of Maine to perform the following acupuncture procedures:

Acupuncture: the insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
Cupping: a technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.
Gua Sha: the rubbing of an area of the body with a blunt-edged instrument
Moxabustion (Moxa): the burning of herbs on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms such as a stick, string, ball, cone, or rice grain.
Dietary Advice: food and herbal advice based on traditional Chinese medical theory.
Electro-Acupuncture: the running of very low electrical current through one or more needles to help heal the body
Sonopuncture: the use of tuning forks to help heal the body with sound waves and vibration. The forks are placed near and on the body, often on acupuncture points and energy meridians.

I recognize the potential risk and benefit of these procedures as described below:
Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pacemakers should inform their practitioners prior to treatment.
Potential benefits: drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the client's main complaint(s).

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Rocky Coast Integrated Medicine and its' providers regarding the cure or improvement of my condition(s). I hereby release Rocky Coast Integrated Medicine and its' providers from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

_____ _____
Client/Authorized Person's Signature Date

ROCKY COAST
Integrated Medicine

CLIENT DEMOGRAPHIC & HEALTH HISTORY

Client _____ Date _____

Given Name _____ Date of Birth _____ Pronouns _____

Preferred Name _____ Cell Phone _____

Street Address _____ Other Phone _____

City, State, Zip _____ Email Address _____

Occupation/Employer _____ Would you like appointment reminder emails? ○ YES ○ NO

Have you had an acupuncture treatment before? ○ YES, about _____ ago ○ NO

How did you hear about Rocky Coast Integrated Medicine? _____ May we thank this contact for your referral? ○ YES ○ NO

Emergency Contact Name _____ Emergency Contact Phone _____ Relationship _____

*Clients under 18, please name person who is financially responsible.

Describe your health goals, questions and/or concerns in seeking acupuncture:

Current prescription, over the counter medications or supplements you take:

Surgeries and/or hospitalizations with approximate dates:

Allergies to medications, foods, environmental:

Major illnesses, accidents or traumas (physical and emotional) that we should be aware of:

Check if you have been diagnosed with any of the following:

- ◯ Substance Use Disorders
- ◯ Asthma/Lung Disease
- ◯ Bleeding Disorders
- ◯ Cancer
- ◯ Diabetes
- ◯ Epilepsy/Seizures
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ Hepatitis/Liver Disease
- ◯ Kidney Disease
- ◯ Mental Illness
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Other _____

Do you exercise regularly? ◯ YES ◯ NO If YES, how frequently? _____

Are you a tobacco smoker? ◯ YES ◯ NO If YES, how frequently? _____

Are you a cannabis smoker? ◯ YES ◯ NO If YES, how frequently? _____

Please describe your typical food & drink intake for the following:

Breakfast:

Lunch:

Dinner:

Snacks:

Check the statements that you believe to be true for you:

- ◯ I am a creative/visionary person
- ◯ I am aware of lots of dreams
- ◯ I am healthier than I used to be
- ◯ I am less healthy than I used to be
- ◯ I feel well rested when I awaken
- ◯ I have difficulty falling asleep
- ◯ I have satisfying relationships
- ◯ I often feel irritable or angry
- ◯ I wake up often during the night
- ◯ I have a good balance between work
- ◯ I think of myself as powerful
- ◯ I feel well supported by others
- ◯ I take good care of others
- ◯ I feel appreciated
- ◯ I frequently feel fearful/cautious
- ◯ I have a good sense of humor
- ◯ I have experienced significant loss

Check any of the following that you have experienced in the past year.
Circle any you are currently experiencing, or would particularly like to discuss.

GENERAL

- ◯ Fatigue
- ◯ Fevers
- ◯ Night sweats
- ◯ Perspiration when not exercising
- ◯ Changes in memory
- ◯ Changes in mood

MUSCULOSKELETAL

- ◯ Neck pain
- ◯ Jaw pain (TMJ)
- ◯ Arm/shoulder/wrist pain
- ◯ Back pain
- ◯ Hip pain
- ◯ Leg/ankle/foot pain
- ◯ Joint stiffness
- ◯ Joint swelling
- ◯ Muscle spasm/stiffness

GASTRO-INTESTINAL

- ◯ Difficulty swallowing
- ◯ Nausea
- ◯ Vomiting
- ◯ Excessive belching/gas
- ◯ Indigestion
- ◯ Ulcers
- ◯ Abdominal pain
- ◯ Constipation
- ◯ Diarrhea
- ◯ Changes in bowel habits
- ◯ Blood in stool
- ◯ Hemorrhoids
- ◯ Change in appetite
- ◯ Gained/lost 10 lbs in 6 months

SKIN

- ◯ Acne/pimples
- ◯ Eczema
- ◯ Other rashes
- ◯ Hives
- ◯ Itching
- ◯ Easy bruising
- ◯ New or changing mole

CARDIOVASCULAR

- ◯ Irregular heartbeat/palpitations
- ◯ Chest pain/tightness
- ◯ Pressure in chest
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Varicose veins
- ◯ Blood clots
- ◯ Swelling of feet/ankle
- ◯ Cold hands/feet

RESPIRATORY

- ◯ Shortness of breath
- ◯ Wheezing
- ◯ Dry cough
- ◯ Wet cough (phlegm)
- ◯ Coughing of blood
- ◯ Frequent colds

GENITO — URINARY

- ◯ Discharge from penis
- ◯ Lumps or swelling on testicle
- ◯ Infertility
- ◯ Generally satisfied with sexual life
- ◯ Use contraception

HEAD/EYES/EARS/NOSE/THROAT

- ◯ Dizzy spells/fainting/vertigo
- ◯ Frequent headaches
- ◯ Severe headaches
- ◯ Difficulty with vision
- ◯ Red/itchy eyes
- ◯ Dry eyes
- ◯ Difficulty hearing
- ◯ Ringing in ears
- ◯ Nosebleeds
- ◯ Sinus infections
- ◯ Nasal congestion/runny nose
- ◯ Mouth/lip sores
- ◯ Bad taste in mouth
- ◯ Sore throat
- ◯ Hoarseness of voice
- ◯ Swollen glands

GENITO — URINARY

- ◯ Frequency of urination
- ◯ Pain or burning with urination
- ◯ Blood in urine
- ◯ Urinate more than 2 times a night
- ◯ Bladder/ Kidney infections
- ◯ Sexually transmitted diseases

GENITO — URINARY

_____
Age at first menstrual period

_____
Date of last menstrual period

_____
Date of last normal pap smear

_____
Date of last GYN examination

_____
Number of pregnancies

_____
Number of children

- ◯ Currently pregnant
- ◯ Regular menstrual cycle
- ◯ Irregular menstrual cycle
- ◯ Painful periods
- ◯ Heavy bleeding with periods
- ◯ Bleeding between periods
- ◯ Vaginal discharge
- ◯ Breast lumps
- ◯ Discharge from nipples
- ◯ Breast soreness before/with periods
- ◯ Bloating before/with periods
- ◯ Mood changes before/with periods
- ◯ Endometriosis
- ◯ Ovarian cysts
- ◯ Infertility
- ◯ Challenges with breastfeeding
- ◯ Uterine prolapse
- ◯ Vaginal dryness
- ◯ Hot flashes
- ◯ Generally satisfied with sexual life

_____ _____ _____ _____
Client/Authorized Person's Signature | Date | Reviewing Practitioner's Signature | Date