

We look forward to meeting with you and working together towards your health goals. Please be aware that we now have THREE locations! If you are unsure of the location of your appointment, please do not hesitate to call us at (207) 775-2059.

Main Office 210 Western Ave, South Portland	Good Medicine Collective 231 York St, Portland	Lotus Family Practice 66 Leighton Rd, West Falmouth
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Information on our South Portland location: The office is located at 210 Western Avenue. We are on the ground floor of a gray/brown three-story building, with plenty of parking.

Information on our Portland location: The office is located on the corner of York and Brackett Streets at 231 York Street, in a building with a “Good Medicine” sign on the front. There is plenty of free parking surrounding the building. Please enter the using the York Street entrance and take a seat on the couch in front of the entrance. The provider will come out and get you at the time of your appointment. Please note that there is no reception at this location which is part of a holistic health collective. Should the provider be running behind, please be patient. We do our best to see clients in a timely manner, but we also find it important to give full attention to our clients and their needs, which means sometimes we do run behind schedule. If you have been waiting more than 10 minutes past your appointment time, please call our main office at (207) 775-2059.

Information on our West Falmouth location: The office is located at 66 Leighton Road. We are located within the offices of Lotus Family Practice, with plenty of parking. There is not a reception desk for Rocky Coast patients in the West Falmouth location, the provider will come out to the lobby to get you at the time of your appointment. If you have been waiting more than 10 minutes past your appointment time, please call our main office at (207) 775-2059.

We require that you check with your insurance company prior to your first visit to find out if you have acupuncture coverage, and if so, what the copay and deductibles are. We do not check coverage for patients. We are able to provide you with receipts suitable for submission to your medical reimbursement account. Should you not have acupuncture coverage under your plan, our fees are \$125 for initial appointments and \$85 for follow-up appointments. We accept payments made via cash, checks, credit cards and online through our patient portal Kareo.

During your initial session we will spend approximately 1½ hours together. This amount of time will allow us to assess your health history and discuss a plan for your care. We will perform a diagnostic assessment using Chinese Medical techniques and we will then share our findings. An acupuncture treatment will be included in this initial visit. All subsequent treatment sessions will last approximately 1 hour.

We understand that this information, including the paperwork to fill out, is quite lengthy and comprehensive, so please do not hesitate to contact us with any questions or concerns. We look forward to meeting with you and working toward your health goals.

Sincerely,

All of us at Rocky Coast Family Acupuncture,

Jason Stein L.Ac., M.Ac.
Beth Herzig L.Ac., M.Ac.
Chris Haskell L.Ac., M.Ac.
Leah Chamberlin L.Ac., M.Ac.
Sarah Belise L.Ac., M.Ac., PHD



FINANCIAL AGREEMENT

CANCELLATION POLICY

It is important that you appear for all scheduled appointments and/or reschedule them in a timely manner of 24 hours from the time of your appointment. Your failure to do so, deprives other patients of an opportunity to visit our office. **Our cancellation policy is as follows:**

- 1. Your first failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be given a warning.
2. Your second failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be charged a fee of \$50.00.
3. Your third failure to appear for a scheduled appointment or provide a minimum of 24 hours notice, you will be charged a fee of \$85.00 and we reserve the right to discharge you from our practice.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I have read, understand and agree to adhere to the cancellation policy stated above.

Signature: _____ Date: _____

PAYER SCENARIO

[] Referred by the VA SSN: _____ - _____ - _____

[] I plan to pay the out of pocket, cash rate of \$125.00 at the initial appointment, \$85.00 at time of follow ups, and/or \$45.00 at the Saturday Clinic. I understand that these charges are due at the day of service. 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.

Signature: _____ Date: _____

[] I plan to bill insurance for my visits. I understand that I am financially responsible for any services that my insurance company does not cover, denies, or processes and transfers to patient responsibility, (copay, amount billed towards deductible, etc.). I demonstrate my understanding of coverage by having completed the required phone call process below.

Subscriber Name: _____ DOB: _____ Relationship: _____

Date of Call: _____ Reference # of Call: _____

Do I have acupuncture coverage? Yes or No Number of Visits Allowed: _____

Do I have to meet a deductible prior to my coverage? Yes or No Amount: \$ _____

Have I met my deductible? Yes or No Current Deductible Amount: \$ _____

What is my copay? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I understand that I am financially responsible for all services that I receive from provider. I authorize payment of medical benefits to the undersigned provider for services that I receive.

Signature _____ Date _____

ROCKY COAST FAMILY ACUPUNCTURE NOTICE OF PRIVACY PRACTICES

Understanding your health records: A record is made each time you visit Rocky Coast Family Acupuncture. 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 Family Acupuncture, 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 Family Acupuncture 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 Family Acupuncture 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 Family Acupuncture, 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. or Dawn Doiron, Office Manager. 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 Family Acupuncture, 210 Western Avenue South Portland, ME 04106 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., Chris Haskell L.Ac. M.Ac., Leah Chamberlin L.Ac. M.Ac. and/or Sarah Belisle Ph.d., L.Ac., M.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 Family Acupuncture 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.

Signature of Person Authorized to Consent Date

Signature of Client Date

CONSENT FOR TRADITIONAL METHODS

I, the undersigned hereby authorize (Jason S. Stein, Beth Herzig, Chris Haskell, Leah Chamberlin 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, strengthens it, and relieves 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 Family Acupuncture and its' providers regarding the cure or improvement of my condition(s). I hereby release Rocky Coast Family Acupuncture 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.

Signature of Person Authorized to Consent Date

Signature of Client Date



ROCKY COAST
FAMILY ACUPUNCTURE

PATIENT DEMOGRAPHICS & HEALTH HISTORY

No information contained herein will be released to third parties without your expressed consent.

Given Name: _____ DOB: _____

Preferred Name: _____ Pronouns: _____

Address: _____

City, State, Zip: _____

Home #: () Work #: () Cell #: ()

Occupation: _____ Employer: _____

Email: _____

Would you like to receive appointment reminder emails? **Yes** or **No**

*EMAIL PRIVACY POLICY: WE DO NOT GIVE OUT EMAILS TO THIRD PARTIES.

Emergency Contact: _____ Phone #: () Relationship: _____

* PATIENTS UNDER 18 YEARS OF AGE, PLEASE PROVIDE NAME OF PERSON WHOM IS FINANCIALLY RESPONSIBLE.

How did you learn of RCFA? _____ May we thank this contact for your referral? **Yes** or **No**

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

Please describe your health goals, questions and/or concerns in seeking acupuncture: _____

Current prescription or over the counter medications 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 the **O** if **you** have been diagnosed with the following:

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism/Drug Addictions | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Hepatitis/Liver Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other |

Do you exercise regularly? **Yes** or **No** If yes, how often? _____
Are you a tobacco smoker? **Yes** or **No** If yes, how often? _____
Are you a cannabis smoker? **Yes** or **No** If yes, how often? _____

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

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

Please **check** the statements that you believe to be true for you:

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

Please **check any of the following** symptoms/statements you have experienced **in the past year**;
Please **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

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

GENITO - URINARY

- Age at first menstrual period
- Currently Pregnant
- Date of last menstrual period
- Date of last normal pap smear
- Date of last GYN examination
- 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
- Number of pregnancies
- Number of children
- Generally satisfied with sexual life

SKIN

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

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

Signature of Patient: _____

Date: _____

Signature of Reviewing Practitioner: _____

Date: _____