



Flowing River Clinic

COMPLEMENTARY ALTERNATIVE MEDICINE

Phone: 510.893.2929 • Fax: 510.893.2928 • 2929 Summit Street, Suite 102, Oakland, CA 94609

Patient Information

Confidential

Patient's Name: Last _____ First _____ Middle Initial _____

Address: _____ Street _____ Email: _____

City _____ State _____ Zip Code _____ Home Phone: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: Male _____ Female _____

Proof of Identity / Patient Security

We do everything we can to safeguard your personal information. We strictly control the staff that has access to your file. We will never share your personal information with anyone without your permission. With medical identity theft becoming a growing problem, we now ask all of our patients for proof of their identity. If you are using insurance to pay for your visit, please provide us with the following:

Social Security Number: _____

Unfortunately, this number is still used by most insurance companies to identify patients.

Driver's License (*Please show the receptionist. We don't need a copy of it unless we don't have your SSN).*)

Other ID: _____

Person Responsible for Service Fee: _____ Relationship to Patient: _____

Patient's Occupation: _____ Employer: _____

Primary Treating Physician: _____ Physician's Phone Number: _____

How did you hear about Rhoda Climenhaga, L.Ac. ?

Yelp Google/Other Search Engine? _____ Friend's Referral _____

Blog/Facebook Doctor's Referral Other: _____

Insurance Information *Please allow us to copy your insurance card*

Is your condition the result of a work injury? Yes No

Is your condition the result of an auto accident? Yes No

**If you checked yes to either, you must provide us with the claim information before receiving care.*

If the insurance is under someone else's name (spouse, parent, etc.), please fill in their information below:

Insured's Name: Last _____ First _____

Insured's Social Security #: _____

Insured's Birth Date: _____ / _____ / _____ Relationship to Patient: _____



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Medical History

Your health history is completely confidential.

Please be thorough. It will help us understand your medical condition and your overall health better.

Name:	Age:	Height:	Weight:
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Chief Complaint / Medical Problem

What health problem are you seeking help with? _____

When did this problem start / how did it develop? _____

What treatment have you received /what medications are you taking for this condition? _____

Other Medical History

Significant Illness – Patient	(Please check all that apply)
--------------------------------------	-------------------------------

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> HIV + | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Fibroids (Uterine) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Blood Disorder/Anemia | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Surgeries: _____ | |

Significant Illness – Family	(Please check all that apply)
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- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibroids (Uterine) | <input type="checkbox"/> HIV + | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Fibroids (Other) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |

What medications do you currently take? _____



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Do you...?

- | | | |
|---------------------------|--|---|
| Smoke | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>how many cigarettes / day:</i> _____ |
| Drink alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>how many drinks / week:</i> _____ |
| Drink coffee | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>how many cups / day:</i> _____ |
| Drink sodas / soft drinks | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>how many glasses / day:</i> _____ |
| Use recreational drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>which drugs and how often:</i> _____ |
| Eat a restricted diet | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>vegetarian? low sodium? etc?</i> _____ |
| Exercise regularly | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>how many times / week:</i> _____ |

Medical History (continued)

Please check any symptoms you currently have or have had in the past 6 months:

General

- Low energy
- Allergies
- Dizziness
- Fainting
- Fevers / Hot flashes
- Difficulty sleeping
- Sweat easily
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Hot or cold easily
- Low sexual energy

Eyes

- Vision problems
- Eye pain/strain
- Red/irritated eye
- Eye discharge

Ears

- Ear ringing or pain
- Ear discharge
- Hearing loss

Nose

- Phlegm / congestion
- Loss of sense of smell
- Nosebleeds
- Sinus Infections

Breathing

- Asthma
- Allergies (nasal)
- Cough
- Shortness of breath

Mouth / Throat

- Hoarseness
- Thirsty often
- Recurrent sore throat
- Cold sores
- Taste loss/change
- Teeth problems
- Foul breath

Chest / Heart

- Chest pain
- Palpitations
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Swelling of ankles
- Varicose veins

Digestion

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea / loose stools

- Bloody stools
- Black stools
- Heartburn / acid reflux
- Indigestion
- Nausea / vomiting

Urination

- Painful urination
- Dark / cloudy urine
- Frequent / urgent urination
- Frequent UTIs

Pain / Numbness

- Head
- Neck
- Shoulders
- Arms
- Hands
- Chest
- Abdomen
- Back
- Legs
- Feet

Skin

- Bruise easily
- Discoloration
- Dry skin
- Acne
- Brittle nails
- Clammy skin

- Dry brittle hair
- Hair loss
- Other skin problems

Emotions

- Irritable / angry easily
- Anxious / fearful
- Sad / depressed
- Worried / fearful
- Forgetful
- Loss of concentration

Women Only

- Abnormal Pap smear
- Bleeding between periods
- Irregular periods
- Heavy periods
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Breast tenderness
- Low sexual energy
- Vaginal discharge/itchy
- Menopausal
- Uterine prolapse
- Fibroids
- Pregnancies _____
- Miscarriage
- Abortion

Do you have other health problems you'd like to discuss? _____



Health Insurance Q & A

Do you accept my insurance plan?

We accept MANY insurance plans... but your insurance might not accept us! Even within the same company, some health plans may cover our services, but some plans may not. The only way to know for sure is to call your insurance company. Only an insurance representative can tell you the exact details of your plan: what services are covered, and how much is covered.

Why didn't my insurance pay for my visits? I thought I had coverage!

Many weeks after your visit, you might receive a letter stating that your insurance has refused to pay for all or part of your fees. This can happen for many reasons:

- The insurance company made a mistake.
- Your plan has a deductible which has not yet been met.
- Your insurance company only pays for a percentage of your fees.
- Your insurance company limits the number of visits per year.
- Your insurance benefits changed since the last time you checked.
- Our clinic made a mistake in billing.

We will do our best to help you with any of these situations. Many times, a simple call from our staff can straighten things out. Other times, you may have to pay for part of your fees that your insurance company will not cover.

Why does the insurance bill look so different from your cash fee schedule?

We offer discounted rates to patients who pay in-full at the time of treatment. The cash fee schedule is all-inclusive. Insurance companies require us to bill separately for each treatment performed. Insurance companies also routinely delay 1 – 2 months in reimbursing us for services. We sometimes wait over one year to be paid. For these reasons, insurance bills are often significantly higher than the discounted rate available to patients who pay at the time of treatment.

Why did I receive a bill from your clinic?

If your insurance company refuses to pay for your care, our clinic will send you a bill for the services you have received. If you receive a bill from us, please call us and we will be happy to explain the situation and help you deal with the insurance company.

What's the best health insurance company?

One of the worst things about all health insurance is that it places someone else between the patient and the doctor--- someone in an office far away often decides the medical care you should receive. We don't feel this is right as it compromises the doctor/patient relationship, but more, it takes control away from the patient. In our view, health insurance should be considered protection against unexpected medical emergencies – not the only source of payment for routine healthcare and wellness. We strongly recommend that our patients use tax-free health savings accounts (HSA) to pay directly for medical care. Matched with a high-deductible insurance plan to cover you in case of medical emergencies, HSAs can give you complete control over all the routine medical care for your family. This is a very inexpensive solution to rising healthcare costs, and it gives you control over your health decisions. You won't need to ask anyone's permission to do what's right for you and your family.

If you have other questions about health insurance, or any problems with your bill, please call us. We will be happy to help you, explain things to you, or direct you to someone at the insurance company who can.

Patient's Initials: _____

Rhoda Climenhaga, L.Ac.

Financial Policies

Please read carefully

We want to provide you with excellent care, and we want to make all financial arrangements as easy and reasonable as possible. You can help us by providing complete personal and insurance information on these forms, and by reading these financial policies carefully.

To avoid interruptions in your care, please ask us if you don't understand any of the following:

Health Insurance: Rhoda Climenhaga accepts most insurance – including many health plans, auto insurance, and worker's compensation insurance. Please give us all insurance information before your first visit so that we can explain your coverage limits, deductibles, and co-pays. All deductibles and co-pays are due at the time of treatment.

Methods of payment: Fees not covered by insurance are payable by cash, check, or credit card and are due on the day of your visit.

Discounts: We aim to make treatment affordable for everyone. We offer discounted fees for payment at the time of service that are lower than our insurance rates. Discounted fees for advance payment of treatments are also available. Low income patients who receive MediCal, MediCare, or other government assistance may qualify for additional discounts. Please ask us for more information.

Missed appointments: Please let us know at least 24 hours in advance of a cancellation, so that we can make your time slot available to someone else. If you miss an appointment without 24 hours notice, you will be charged \$50.00.

Returned checks: A service charge of \$25.00 will be charged for all checks returned without payment.

Understanding of Responsibility:

I authorize Rhoda Climenhaga, L.Ac. to release all information needed to process insurance claims, and I authorize payment of medical benefits to my treating practitioner for services provided.

I understand that I am responsible for the cost of all care provided to me, and I accept full responsibility for these charges if my insurance company denies coverage. I agree to make full payment to Rhoda Climenhaga, L.Ac. within 30 days of any denial of coverage.

I understand the above policies and agree to abide by them. I agree to talk with the staff at Flowing River Clinic about any financial problems that may interfere with my medical care.

Patient's Name

Signature

Date

Treating Practitioner: _____

Rhoda Climenhaga, L.Ac.



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Informed Consent – Acupuncture & Massage

Please read carefully

Acupuncture is a safe and effective method of treatment, but like all medical treatments it is not without risk. Sterile and disposable needles are used. The needles are very fine, and little pain is typically experienced during treatment. Acupuncture can occasionally cause slight bleeding that resolves with pressing a cotton ball on the skin. Minor bruising may also occur. Patients may experience sensations of warmth, tingling, or mild pain at the site of needle insertion. On very rare occasions, acupuncture may cause temporary flare-ups of pain.

Cupping, which involves localized suction with small glass cups, may be used to stimulate healing and promote circulation. This technique leaves temporary local bruises that typically resolve within 4-5 days.

Massage is a safe and effective method of treatment, but it is not without risk. During certain techniques, patients may experience moderate local pain as muscles are stretched and manipulated. Patients may also experience slight muscle soreness after treatment.

I have read the information above and understand the possible risks involved. I hereby request and consent to acupuncture, cupping, and massage treatment provided by Rhoda Climenhaga, L. Ac..

I understand that it is my responsibility to fully communicate my health history, signs and symptoms, and other pertinent information, to help my treating practitioner make informed decisions about my treatment plan.

I understand that I have the right to refuse or discontinue treatment at any time.

Patient's Name

Signature

Date