Kay Fields L.Ac.
Acupuncture & Herbal Clinic 1962 NW Kearney #L103 Portland, OR 97209 Phone: (503) 295-7600 www.kayfields.com

MOTOR VEHICLE ACCIDENT

PATIENT INFORMATION

Date ____________________

Patient Name ____

Date of Accident ______________________________ Time of Accident ______________ a.m / p.m.

Please describe the accident in your own words: ______________________________

____

____

____

____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?___

ACCIDENT SITE

Road/Street Name ______________________
City/State ______________________
Nearest intersection with road/street ______________________
Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other
Which direction were you headed? ______________________
Speed you were traveling? ______________________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder
Was vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate properly? ☐ Yes ☐ No
Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Low ☐ Midposition ☐ High

OTHER VEHICLE
(if applicable)

Make and model of other vehicle ______________________

Which direction was other vehicle headed? ______________________

Speed other vehicle was traveling ______________________

IMPACT

Did your car impact another vehicle? YES / NO
Did your car impact a structure? YES / NO
If yes, explain

Did any part of your body strike anything in the vehicle?
☐ Yes ☐ No If yes, explain,

Was impact from:
☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other:_____
At the time of the impact were you:
☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up
Were both hands on the steering wheel? YES / NO
If no, which hand was on the wheel? Right / Left
Was your foot on the brake? YES / NO
If yes, which foot was on the brake? Right / Left
Were you: ☐ Surprised by impact
☐ Braced for impact

POLICE

Did the police come to the accident site? YES / NO

Were there any witnesses? YES / NO

Was a police report filed? YES / NO

Was a traffic violation issued? YES / NO
If yes, to whom?______________________

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?___________

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital

Diagnosis

Treatment received

X-rays taken

SYMPTOMS / INJURIES

Have you been able to work since this injury? Yes / No How many days of work have you missed?

Prior to the injury were you able to work on an equal basis with others your age? Yes / No

If you have had any of the following symptoms since your injury, please check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficultly
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Where do you continue to have pain, numbness, or tingling?

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain:				
	☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
	☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
	☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Bending ☐ Standing ☐ Lying down ☐ Walking

I certify that the above information is correct to the best of my knowledge.

Patient signature ______________________________ Date ______________

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PERSONAL INFORMATION:

Patient Name:______________________________ Age:________ M / F Date:____________________

Address:______________________________ City:__________________ State:________ Zip:________

Home Phone:_________________________ Cell Phone:________________________ Work Phone:________________________

Birth Date:______________________________ Marital Status: Married Single Divorced Widowed Partnered

Email:______________________________ Referred by:______________________________

Insurance? No / Yes Insurance Name:______________________________

Policy/ID #:______________________________ Group #:__________________ Social Sec.#:_______________

Emergency Contact:______________________________ Phone:____________________ Relationship:___________________

CURRENT HEALTH HISTORY

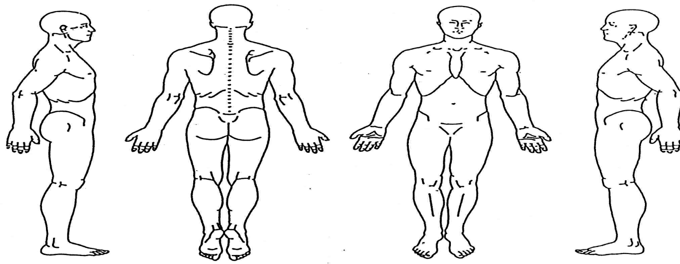
What are the main conditions you would like to be helped with?

1.____

2.____

3.____

Please mark painful or distressed areas:



How is your sleep?____

How is your digestion?____

How long has it been since you have had a complete medical exam?______________________________

CURRENT MEDICATIONS & SUPPLEMENTS

Please list all medications, over the counter supplements, and/or herbs taken and why

____

____

HEALTH HISTORY….CONTINUED

Check conditions you have or have had in the past. Circle those you PRESENTLY have (last few weeks).

GENERAL
Headache
Fever
Chills or Sweats
Fainting or Dizziness
Imbalance
Seizures or Epilepsy
Sleeping Difficulties
Quality of Sleep.
Sleep_______hrs/night
Fatigue or Feel run-down
Hypoglycemia
Nervousness/Anxiety
Panic Attacks/Phobias
Depression
Mental Disorder
Alcohol/Drug Problems
Diabetes
Neuralgia
Anemia
Cancer
Memory Loss
Weight Loss______lbs
Weight Gain______lbs

EAR, NOSE & THROAT
Eye Strain/pain
Failing Vision
Blurred Vision
Glaucoma
Sensitivity to Light
Hearing Problems
Ear noises
Ear infections
Sinus Infections/frequent colds
Nose Bleeds
Sore Throat
Thyroid conditions
Mouth Sores
Gum Disease
Teeth Grinding
Jaw Pain
Tonsillitis
Enlarged Glands
Hay Fever
Allergies

SKIN
Rashes
Skin Eruptions
Eczema
Itching
Bruise Easily
Dark Circles Under the Eyes
Boils
Moles
Varicose Veins
Hair Loss

RESPIRATORY
Asthma
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Chronic Cough
Spitting Blood/Phlegm
Chest Pain
Difficulty Breathing
Shortness of Breath

CARDIOVASCULAR
Rapid/Slow/Irregular Heartbeat
Blood Clots
High or Low Blood Pressure
High Cholesterol
Pacemaker
Hardening of Arteries
Swelling of ankles
Poor Circulation
Stroke/TIA

MUSCLE & JOINT
Stiff neck
Backache
Arthritis
Swollen Joints Bursitis
Tendonitis
Muscle or Joint weakness or pain
Muscle spasms or cramps
Foot Trouble
Spinal Curvature
Osteoporosis

GENITOURINARY
Frequent Urination
Night Urination
Painful Urination
Blood/Pus in Urine
Kidney Infection or stones
Bed Wetting or Incontinence
Prostate Trouble
Hernia
STD
Sexual Dysfunction

GASTROINTESTINAL
Trouble Swallowing
Bad Breath or Body Odor
Indigestion/Heartburn
Nausea
Poor Appetite
Belching or passing gas
Excessive Hunger
Cravings
Hypoglycemia
Eating Disorder
Vomiting Blood
Pain Over Stomach
Ulcers
Distension of Abdomen
Constipation
Diarrhea
Appendicitis
Tiredness after meals
Gurgles in Stomach
Alternating constipation/diarrhea
Hemorrhoids
Parasites
Hepatitis
Gall Bladder Trouble
Bloating After Meals
Liver trouble
Hard/Compact Stools

WOMEN ONLY
PMS
Painful Menstrual Period
Excessive Flow
Bleeding Between Cycles
Irregular Cycle
Cramps or Backache
Endometriosis
Ovarian Cysts
Uterine Fibroids
Abnormal PAP
Vaginal Discharge
Breast Pain/Tenderness
Lumps in Breast
Menopausal Symptoms
Hot Flashes

IS YOUR LIFE:
Satisfactory
Boring
Demanding
Unsatisfying

DO YOU WORRY OVER:
Home Life
Marriage
Children
Job
Finances

DO YOU OFTEN:
Feel Upset or Cry
Feel Anxiety or Have Irrational Fears
Feel Depressed
Feel Things Always go Wrong
Feel Shy or Inferior
Feel Angry

HAVE YOU:
Seriously Considered Suicide
Attempted Suicide
Suffered Abuse (physical, sexual, or emotional)

This information on this form is correct to the best of my knowledge.

Signature____ **Date**____________________

Would you like to sign up for our free E-mail Newsletter? Yes / No
Our newsletter provides information about the benefits of Acupuncture and Chinese Medicine.

HIPAA Notice of Privacy Practices

1962 NW Kearney #L103 -Portland, OR 97209 – (503) 295-7600

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

____________________________ Date

____________________________ Signature

____________________________ Print Name

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Acupuncture and Planetary Medicine Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Kay Fields, a licensed acupuncturist. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed
physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Dietary Therapy: I understand that if I receive dietary recommendations as a part of therapy, I am not obligated to follow these recommendations. In this instance I understand my condition may not improve if these guidelines are not adhered to.

Therapeutic Exercise: During a treatment plan I understand I may be recommended specific exercises for my ailment. I understand if the exercise aggravates my condition to stop immediately.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Kay Fields, LAc j as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: ________________________________ **Date:** ______________________

Printed Name: ______________________________

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OFFICE POLICIES

Patient Initials:

- Making Appointments: For healing to be most effective, a series of visits is usually suggested. We advise that you schedule in advance to ensure continuity of appointments. For your convenience you may schedule your appointments online 24 hours a day 7 days a week at www.kayfields.com. ________
- **Cancellation Policy: Missed appointments without prior notification is subject a FULL VISIT FEE. A 48-hour advance cancellation notice is required so other patients can be helped in that time slot. Please, note that if your bill is currently paid by insurance of any type, they will not pay for this fee. You will be personally responsible for it.** ________
- Payment Policy: We charge for services provided. Payment is due at the time of service for insurance co-payments, deductibles, medicinaries, and cash payments. We offer a discount to patients who pay in full at the time of service. Any visit that is not paid for in full at the time of service will be billed at the regular fee. Due to rising bank charges, we must charge a $10 fee for all returned checks. Cash or check is accepted. Administrative costs, such as insurance processing, are one of the components used in an equation developed by the Health Care Financing Administration to arrive at reasonable fees providers may charge for the services they provide. The elimination of this component results in monetary remuneration shared throughout the health care industry, and is realized in the form of a courtesy discount to patients or third-party payors who make prompt payment AT THE TIME SERVICES ARE RENDERED. ________
- We do not bill for medicinaries and typically insurance companies will not cover them under their policies. We do not accept returns on any products. Please be sure before you buy. This policy is in effect for your safety. ________
- Motor Vehicle Accidents: Please notify us if you are in an accident. We will be happy to bill under your PIP coverage.
- Collection Policy: We may charge interest of 1.5% per month (up to 18%) on unpaid balances. If an account is over six month in arrears, it will be subject to legal collection. The key to avoid this situation is communication. WE WILL WORK WITH YOU! Just talk to us. ________
- Childcare Policy: We do not offer childcare in this clinic. Please do not leave children unattended. ________
- Please notify us when your address and/or your phone number changes as soon as possible. ________
- Cell Phones: Please turn off all cell phones before entering the treatment rooms. ________

"PAYMENT AT TIME OF SERVICE OPTION" AGREEMENT

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED. A written copy of the fees for specific services provided in this office is available to each patient by mail on request and all fees are subject to change without notice.

- ☐ I elect to use this prompt payment option. I will pay in full at the time services are rendered.
- ☐ I do not choose to use this payment option as I elect to have Kay Fields, LAc bill my insurance carrier/third party payor for their portion of the services covered by them. I understand that any discounts do not apply. I agree to pay my scheduled co-payment and/or the percentage not covered by my insurance policy.

INSURANCE PATIENTS ONLY

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges of all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with. I understand the benefits and risks of Acupuncture and its related modalities and give my consent for these services. I will consult with my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature:____ Date:____

OUR POLICY ON INSURANCE

Most insurance companies do cover acupuncture however each insurance company processes and pays claims according to the patient's benefits and their individual administrative policies. It is important to understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, and their insured. We do accept insurance in this clinic. Most insurance companies require a yearly deductible, and a co-payment. The co-payment is determined by the percentage of the visit that the insurance will cover.

We will continue to bill insurance for our patients and verify insurance benefits as a courtesy to our patients. Due to the complexity of the insurance processing procedures, we are informing you that this is not a guarantee of benefits. You must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. Any amount authorized to be paid directly to Kay Fields, LAc. will be credited to your account upon receipt.