寿康
FEIFEI LIU
TRADITIONAL
CHINESE MEDICINE
WWW.FLTCM.COM

FEIFEI LIU, A.P.
TRADITIONAL
CHINESE MEDICINE
830 E State Road 434
Longwood, Fl 32750
PHONE: 407-951-7841 FAX: 407-951-7843
Website: www.fltcm.com **Email:** info@fltcm.com

Please fill in the following information as completely as possible. In order for us to verify your insurance benefits, we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Date_____

Name _____ **Home Phone (____)**_____
Last First Middle

Address_____ **Business Phone: (____)**_____
Number, Street

_____ **Zip Code:**_____
City State

E-mail address_____ **Cell Phone (_____)**_____

Occupation_____ **Social Security#**_____

Birthday_____ **Sex: M , F Height**_____ **Weight**_____**Age**_____**Marital Status** _____ **Children**____

Place of Employment _____

Work Phone _____ **Best # To Reach You** _____

Have you had an auto accident within the last two years? If yes, When_____ **Yes No**
How did you learn about our office?_____

1. Have you ever had Hepatitis? If yes, When_____ **Yes No**
2. Do you have AIDS or HIV infection ? How long? _____ **Yes No**
3. Have you ever had any surgery? Please list type and year below **Yes No**

_____

_____

4. Have you ever had heart problems or symptoms? Please explain:_____ **Yes No**

_____

5. Are you taking any medications or pain pills at this time? List below: **Yes No**

_____

_____

6. Are you taking any nutritional supplements at this time? List below: **Yes No**
(vitamins, minerals, etc) _____

_____

7. Are you pregnant? If yes, What month are you in ? _____ **Yes No**
8. Have you had Acupuncture before? For what problem:_____ **Yes No**
Previous doctor /acupuncturist's name:_____ **Yes No**
9. Do you have any problems with needles , dizziness, nausea, or fainting ? **Yes No**
10 .Reason for your visit:_____

_____

_____

We accept the following forms of payment. Please circle the method of payment you plan to use today.
VISA MAST CARD CASH

_____

FEIFEI LIU TRADITIONAL CHINESE MEDICINE

PATIENT QUESTIONAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____
_____
_____

II. Please list the family members or significant others whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name _____ Phone Number: _____

Name _____ Phone Number: _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, if other than your home.

_____
_____
_____
_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked ***CONFIDENTIAL*:**

YES _____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments or other health care information, if other than your home phone number:

_____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voice mail?

YES _____ NO_____

PATIENT NAME _____ (Guardian, if under 18 years)
(Please print)

SIGNATURE _____ DATE _____
(Patient OR Guardian's Signature)

FEIFEI LIU TRADITIONAL CHINESE MEDICINE

PATIENT PROFILE

Name: _____ Date: _____

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.

Please indicate with one check (**X**) any conditions that you sometimes experience; use two checks (**XX**) for those which often occur and three checks (**XXX**) for symptoms that are a major concern.

Water Element

_____ Hearing Loss
_____ Dizziness
_____ Lower Back Pain/Neck Pain
_____ Sinus Congestion
_____ Edema
_____ Darkness under the eyes
_____ Emotional instability
_____ Aversion to cold
_____ Hair thinning or loss
_____ Premature aging
_____ Frequent urination
_____ Kidney stones
_____ Perspire very easily
_____ Weakness of the Legs/Knees
_____ Rapid Weight Change
_____ Asthmatic Cough
_____ Loose teeth
_____ Reduced sexual energy
_____ Thyroid Problems
_____ Diabetes

Wood Element

_____ Headache
_____ Migraines
_____ Ringing in the ears
_____ Poor eyesight
_____ Eye infections
_____ Dry eyes
_____ Eczema
_____ Shingles
_____ Herpes Simplex
_____ Warts
_____ Nervousness
_____ Convulsions/Spasms
_____ Irritability
_____ Constipation
_____ Hemorrhoids
_____ Hepatitis
_____ Irregular Menstruation
_____ Painful Menstruation
_____ Ulcer
_____ Vomiting
_____ Gallstones
_____ Indecisiveness
_____ Fullness below ribs
_____ Shoulder/neck tension
_____ Insomnia 11pm-3am

Fire Element

_____ Dry Scalp
_____ Skin eruptions, rashes
_____ Cysts, tumors
_____ Ear infections
_____ Sore throat, tonsillitis
_____ Lymphatic swelling
_____ Hot palms and soles
_____ Heart palpitations
_____ Aversion to heat
_____ Bitter taste in mouth
_____ Gum problems
_____ Nose bleed
_____ Facial redness
_____ Itching/burning skin
_____ Hot hands/ feet
_____ Thirst
_____ Dark urine
_____ Night sweats

Earth Element

_____ Indigestion
_____ Flatulence
_____ Food Allergy
_____ Stomach ache/ulcer
_____ Diarrhea
_____ Anemia
_____ Hallitosis
_____ Mouth sores
_____ Heartburn
_____ Strong appetite
_____ Weak appetite
_____ Nausea
_____ Abdominal bloating
_____ Low body weight

Metal Element

_____ Bronchitis
_____ Asthma
_____ Shallow breathing
_____ Cough
_____ Sinus congestion
_____ Nasal infections

Other

_____ Fatigue
_____ Arthralgia
_____ Sciatica / nerve pain
_____ Cold hands/ feet
_____ Tendonitis
_____ Bursitis

Pain (please describe):

_____
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Other Comments:

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FEIFEI LIU TRADITIONAL CHINESE MEDICINE

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

_____
_

This Consent was signed by:_____
Printed Name - Patient or Representative

_____
_
Signature

Relationship to Patient (if other than patient):_____
Date:___ /___ /___

Witness:_____
Printed Name - Practice representative
Date:___ /___ /___

FEIFEI LIU TRADITIONAL CHINESE MEDICINE

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, MASTERCARD, AND VISA.

Regarding Insurance

We always require full payment of herbs and the Office Visit fee portion of your bill at the time of service. We do not bill the insurance company for herbs. MEIAN,LLC. is not responsible for verifying eligibility and benefits coverage prior to treatment. However, MEIAN,LLC. will file appropriate insurance claims as a courtesy to you. Once verification of insurance coverage is obtained and the insurance company has demonstrated payment, we may require no payment for the Office Visit fee, or we may require only your copayment/coinsurance of the Office Visit fee. In the event that your insurance company demonstrates payment and then later stops making payments, or demands a refund of payments made to us, you are responsible to pay any unpaid balances of the Office Visit fees.

Our fees are determined by the complexity of the particular case and the different services used during treatment. We cannot bill your insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits, we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some, and at times, perhaps all of the services provided may be “non-covered” services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full of the office visit fee regardless of any insurance company’s arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor’s guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X_____DATE_____

Signature of Patient or Responsible Party

FEIFEI LIU TRADITIONAL CHINESE MEDICINE

To: Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visit, which will be modified, any of these procedures used during your treatment will be reduced to $0.00, and you will be responsible for the office visit fee only.

97810-52 Acupuncture 1st 15 min
97811-52 Acupuncture 2nd 15 min
97010-52 Heat therapy
97014-52 Elec. Stim (Unattended)
97032-52 Elec. Stim. (Attended)
99070-52 Needles
97813-52 Acupuncture w/Elec.stim1st 15 min
97814-52 Acupuncture w/Elec Stim 2nd 15 min
97140-52 Manual Therapy
97530-52 Kinetic Activities
97110-52 Therapeutic Exercises

The fee for the New Patient office visit (code 99203) is $ 125.00
The fee for each office visit after the initial visit (code 99213) is $ 75.00

I have read and understand the information contained therein.

_____ **Date** _____
Patient's Signature

Yours in Health,

Feifei Liu, AP
Acupuncture Physician

FEIFEI LIU TRADITIONAL CHINESE MEDICINE

TREATMENT CONSENT FORM

I, _____, hereby consent to be treated with acupuncture and herbal medicines by Feifei Liu, AP or whomever she designates in her absence.

I understand that acupuncture is performed by the insertion of fine needles into specific points on the body with the intent of improving body functions and/or relieving pain. I understand that only pre-sterilized, disposable needles will be used. I further understand that the needles may cause some temporary localized pain, bruising, or light headaches. "Moxibustion" a.k.a. heat therapy may also be used and natural herbal medicines may be prescribed.

I am in full compliance with the fact that in the event I decide to seek treatment from a health practitioner outside this clinic and patient records need to be transferred, all herbal prescriptions/acupuncture points on the records are copyrighted, the exclusive property of **THIS** clinic and may not be used without express written permission from **THIS** clinic. Any request of patient records by me or any other health practitioner I decide to transfer to for purposes of using copyrighted herbal/acupuncture prescriptions of **THIS** clinic without permission is strictly prohibited.

I accept the fact that there is no guarantee concerning the outcome of my acupuncture or herbal treatments and I understand that I may stop treatment at any time. I also accept that there are **NO REFUNDS** on any services, including herbal medicines.

Payment must be made in full at the time of treatment.

_____ _____

Signature of Patient or Guardian Date

The employees of Feifei Liu Traditional Chinese Medicine to maintain your confidentiality to the best of their ability. If you have any questions or concerns regarding the privacy of your records, please contact the office manager.