WELCOME

Pinnacle Integrative Health PC
509 Olive Way Ste 803 Seattle WA 98101
206-624-0397

Patient Information

Date:____________________

Name:
Last________________________________ First_____________________________________ MI____________

Email address: ____

Mailing Address: ____
Street City/State/Zip Code

Phone # (C)___________________________ (W) ________________________ (Other) _________________

Can we call you at work? ❑ Yes ❑ No Date of Birth:______________________________ Age:__________

Sex: ❑ Male ❑ Female Identify as ❑ Male ❑ Female SS#:________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Ethnicity: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: ___________________________________ Employer: ______________________________________

Employer Address: ____ Phone: __________________________

How did you hear about our practice? ____

Emergency contact: Name: ____________________ Relation: _______________ Phone #: ______________________

Phone #: (H) _______________________ (W) ______________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ___________

Has it been reported? ❑ Yes ❑ No If yes, to whom? _________________________________

Insurance Information

Policy Holder Name: ____ D.O.B. :____________________________

Relationship to patient (if other than self): ____________________________ Phone # _____________________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ___________________________________
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ___________________________________

NOTE>> PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE** ____________________________

Appointment Cancellation Agreement:

I understand that twenty-four (24) hours notice is not only appreciated, but also required when cancelling an appointment. I understand that I will be charged $60.00 for such missed appointments that are not given 24 hours notice and I agree to pay this fee.

SIGNATURE (X) ____ **DATE** ____________________________

Chief Complaints / Frequency / Duration	*Intensity / Quality*
If you could get rid of any health problems, what would you want to get rid of? List them in order of importance and we'll let you know if we can help.	On a scale of 1-10 please rate the intensity of your chief complaints. (1= **no discomfort**, 10= **extreme discomfort**)
1.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized
2.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized
3.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized
4.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized
5.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized
6.________________ How Long? ______weeks_______month _______years Circle all that apply: Constant Intermittent Random	On **average** your complaint is: 1 2 3 4 5 6 7 8 9 10 At **worst** your complaint is: 1 2 3 4 5 6 7 8 9 10 Circle all that apply: Dull Achey Sharp Burning Radiating Tingling Diffuse Focalized

Please Check to indicate what you have tried doing to resolve these problems that did NOT help?
❑Ibuprofen - dosage?________ ❑Tylenol – dosage?_______ ❑Chiropractic ❑Physical Therapy ❑Massage

Please Check to indicate what you have tried doing to resolve these problems that DID help even if temporarily?
❑Ibuprofen - dosage?________ ❑Tylenol – dosage?_______ ❑Chiropractic ❑Physical Therapy ❑Massage
❑Supplements________________❑Medications ❑Exercise ❑Diet/Nutrition

How did these previous methods help specifically?____

Have you become stressed or discouraged about completely handling this problem(s)?
____
____

When your problem is at it's worst how does it make you feel? ________________________________
____

When it's at it's worst how much older does it make you feel? ________________________________

How does this problem interfere with the following areas of your life?
Work: ____
Family: ____
Hobbies: ____
Activities: ____
Life: ____

What are you concerned that this problem might be or would be affecting if it does not change or if it worsens?
❑Job ❑Income ❑Marriage ❑Sleep ❑Time
❑Kids ❑Finances ❑Freedom ❑Future Abilities ❑ Quality of Life

Are there any health conditions you're worried that this might turn into?
❑Stress ❑Weight Gain ❑Heart Disease ❑Diminished Future ❑Depression ❑Surgery ❑Arthritis ❑Cancer
❑Diabetes ❑Other:_____ ____

Do you know how this problem(s) may have started? (old injury, car accident, chronic stress, toxins, etc.)
____
____

Are you visiting us with the goals of:
A)Resolve my immediate health problem(s)
B) Lifestyle program for restored health, optimized living and longevity
C) Both
D) Other:____

Where do you picture yourself being in the next 3-5 years if this problem(s) is not taken care of? Please be specific:
____
____

What would be different or better without this problem(s)?
❑Diminished Stress ❑More Energy ❑Self Esteem ❑Confidence ❑Sleep ❑Work ❑Outlook ❑Family

If we were to sit down and discuss your life 3 years from now and we were to look back at today, what things would have to take place for you to be happy with your progress for those 3 years? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether family, health, work, finances, travel, marriage or bucket list!)
____
____
____
____

What potential barriers do you forsee that would prevent these things from happening?
____
____
____

Do you feel that it is possible to eliminate or prevent these possible barriers?
____
____

What are your strengths that will help you to accomplish your goals?
____
____

Rate on a scale of 1-10 (10 being the highest level of commitment)
__________Doing what it takes to completely resolve your health concerns?
__________Your willingness to make lifestyle changes?
__________Your teach-ability in being coached or mentored in making changes in order to achieve your goals?

Health History

Who is your primary care physician? (doctor and/or practice) ____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness
❑ Back Pain/Stiffness
❑ Arm/Hand Pain
❑ Leg/Knee Pain
❑ Headaches
❑ Dizziness
❑ Asthma
❑ Pins/Needles in Arms
❑ Pins/Needles in Legs
❑ Fatigue
❑ Sleeping Difficulties
❑ Loss of Smell
❑ Allergies
❑ Blurred Vision
❑ Light Bothers Eyes
❑ Depression
❑ Nervousness
❑ Tension
❑ Cold Sweats
❑ Stomach Problems
❑ Night Pain
❑ Sudden Weight Loss
❑ Loss of Taste
❑ Loss of Memory
❑ Jaw Problems
❑ Constipation
❑ Shortness of Breath
❑ Bowel/Bladder Changes
❑ Nausea
❑ Cold Feet
❑ Chest Pain
❑ Fever
❑ Fainting

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV
❑ Alcoholism
❑ Allergy Shots
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Breast Lump
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Chemical Dependency
❑ Chicken Pox
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ Herniated Disc
❑ Herpes
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Migraines
❑ Miscarriage
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disease
❑ Pinched Nerve
❑ Pneumonia
❑ Polio
❑ Prostate Problems
❑ Prosthesis
❑ Psychiatric Care
❑ Rheumatoid Arthritis
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Other ______________________________
❑ Stroke
❑ Suicide Attempt
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors/Growths
❑ Typhoid Fever
❑ Ulcers
❑ Vaginal Infections
❑ Venereal Disease
❑ Whooping Cough

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain ____________

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_________________________

____

Please list any surgeries and/or hospitalizations you have had (**type & date**): ________________________________

____

____

Please list any allergies: ____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease __________________ ❑ Diabetes __________________
❑ Cancer __________________ ❑ Arthritis __________________ ❑ Other ____________________________

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following: Caffeine ___ cups/day Alcohol ___ drinks/week. Cigarettes ____packs/day

PROVIDER: Reviewed with patient by: ________________________________ Date: __________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ DOB: ___________________
I acknowledge that I have reviewed the Notice of Privacy Practices of __________________.
(Please initial one of the following options and sign below.)
__________ I wish to receive a paper copy of Privacy Notice.
__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.
Please initial below:
__________ I acknowledge that it is the policy of ______________ to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.
__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

______________________________________ ________________________
Signature of Patient/Guardian Date

______________________________________ ________________________
Witness (Office Staff) Dat

Metabolic/Endocrine Function Survey

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

COLON

Feels like bowels do not empty completely	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue of "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

SMALL INTESTINE

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0 1 2 3

STOMACH-pH

Stomach pain, burning, or aching 1- 4 hours after eating	0 1 2 3
Do you frequently use antacids?	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

LIVER

Roughage and fiber causes constipation	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

GALLBLADDER

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed	Yes/No

PANCREAS (blood sugar)

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep yourself going or started	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3
Blurred vision	0 1 2 3

RESPIRATORY

Sinus Congestion	0 1 2 3
Sinus Headaches	0 1 2 3
Wheezing	0 1 2 3
Shortness of breath	0 1 2 3
Post Nasal Drip	0 1 2 3
Sore throat	0 1 2 3
Snoring at night	0 1 2 3
Seasonal Allergies	0 1 2 3
Hoarse voice	0 1 2 3

ADRENAL GLANDS

Wake up during the night, #_______?	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

CORTISOL	
Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3
THYROID-HYPO	
Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face or genitals	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3
THRYOID-HYPER	
Heart palpations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3
PITUITARY	
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3
SKIN	
Hive/Rashes/Urticaria (circle)	0 1 2 3
Skin itchiness	0 1 2 3
Psoriasis	0 1 2 3
Eczema	0 1 2 3

PROSTATE (Males Only)	
Urination difficulty or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3
ANDROPAUSE (Males Only)	
Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintain morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3
MENSES (Females Only)	
Are you peri-menopausal	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 24 days	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne break outs	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3
MENOPAUSE (Females Only)	
How many years have you been menopausal? _______	
Since menopause, do you ever have uterine bleeding?	Yes No
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness or itching	0 1 2 3

Medical Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not cometo the attention of the physician. I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Osseous Manipulation is a science and art which concerns itself with the relationship between the structure (spine) and function (nervous system) as that relationship may affect the preservation and restoration of health. An Adjustment is the specific application of forces to correct and/ or reduce spinal misalignments. Adjustments are usually done by hand but may be performed by handheld instruments. Osseous Manipulation care, like all forms of health care, offers considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with Osseous Manipulation care. The types of complications that have been reported secondary to Osseous Manipulation care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Osseous Manipulation care, occurring at a rate between one per one million to two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

PATIENT SIGNATURE X ______________________________(Date)__________________________

(Or Patient Representative) (Indicate relationship if signing for patient)

Acupuncture Consent to Care

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X ______________________________(Date)________________________________

(Or Patient Representative) (Indicate relationship if signing for patient)

How Do I Check My Insurance Benefits?

My Name: ____ Date of Birth:__________________________
Insurance Name:_____________________________________ Insurance ID:__________________________

Provider's Names:

- Daniel Rasmussen, in-network with: 1st Choice, Aetna, Cigna, KPS, Lifewise, Premera, United, BCBS, Regence
- Nicole Johnson, in-network with: Aetna, Cigna, Group Health, Lifewise, Premera, BCBS, Regence
- Marie Arvola, in-network with: Aetna, Cigna, 1st Choice, Premera
- Elizabeth Quintana, N.D., in-network with: Aetna, Cigna, 1st Choice, Lifewise, Premera, BCBS, Regence

*If your insurance is not on the list, please verify when calling whether the provider is in or out of network. BCBS plans may vary. Please make sure we get a copy of your card.

Our billing department will happily bill your insurance for your visits. However, it is the patient's responsibility to be aware of his/her coverage and co-pay, as well as any deductible and maximums. Please follow the steps below to find out benefits and eligibility.

First, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and then ask the representative the following questions:

Insurance Representative's Name:______________________________ Date Called:__________________

1) What is my **effective date** for insurance coverage:______/______/______

2) Is this a **calendar year**? Yes / No (if no, what is the fiscal year? ____/____ to ____/____)

3) Do I have **in-network** acupuncture benefits? Yes / No
   a. If yes, what is the coverage:
      i. Insurance covers at _____%, patient responsibility _____% **and/or**
      ii. My co-pay is $_____/per treatment
      iii. Maximum number of visits:______, used to date:______
      iv. Does the deductible apply? Yes / No
      v. If yes, my deductible is $_________, amount met so far:________

4) Do I have **out-of-network** acupuncture benefits? Yes / No
   a. If yes, what is the coverage:
      i. Insurance covers at _____%, patient responsibility _____% **and/or**
      ii. My co-pay is $_____/per treatment
      iii. Maximum number of visits:______, used to date:______
      iv. Does the deductible apply? Yes / No
      v. If yes, my deductible is $_________, amount met so far:________

5) Do I have **in-network** medical coverage?
   a. If yes, what is the coverage:
      i. Office visit is covered at _____%, patient responsibility _____% **and/or**
      ii. My co-pay is $_____/per office visit

iii. Can I be seen by an ND? Yes / No
iv. Does the deductible apply? Yes / No
v. If yes, my deductible is $_________, amount met so far:________
vi. Other services are covered at _____%, patient responsibility _____% **and/or**
vii. My co-pay is $_____/per visit

6) Do I have **out-of-network** medical coverage?
   a. If yes, what is the coverage:
      i. Office visit is covered at _____%, patient responsibility _____% **and/or**
      ii. My co-pay is $_____/per office visit
      iii. Can I be seen by an ND? Yes / No
      iv. Does the deductible apply? Yes / No
      v. If yes, my deductible is $_________, amount met so far:________
      vi. Other services are covered at _____%, patient responsibility _____% **and/or**
      vii. My co-pay is $_____/per visit

**** Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.***