Anita Tadavarthy, LAc
7110 SW Fir Loop, Suite 205
Tigard, OR 97223
503.819.2904
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www.metisacupunctureclinics.com

Registration

Name: ____ Date: ______________
(first) (middle) (last)

Home Address: ____
(city) (state) (zip code)

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email: ____________________________ Employer: ____________________________

Work Address: ____
(city) (state) (zip code)

Date of Birth: ____________ Age: ____________ Gender: M / F Marital Status: ____________

Emergency Contact: ____________________ Relationship: ____________________ Phone: ____________________

Context of Care

Why do you come to see me?

____

What do you know about our approach?

____

What three expectations do you have from this visit?

____

____

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What long-term expectations do you have from working with our clinic?

____

____

What expectations do you have of me personally?

____

____

What is your present level of commitment to address any underlying causes of your signs & symptoms that relate to your lifestyle (circle 0 to 10, 10 being 100% committed)?

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits?

____

____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we may be sharing with you?

____

____

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Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you may be making?

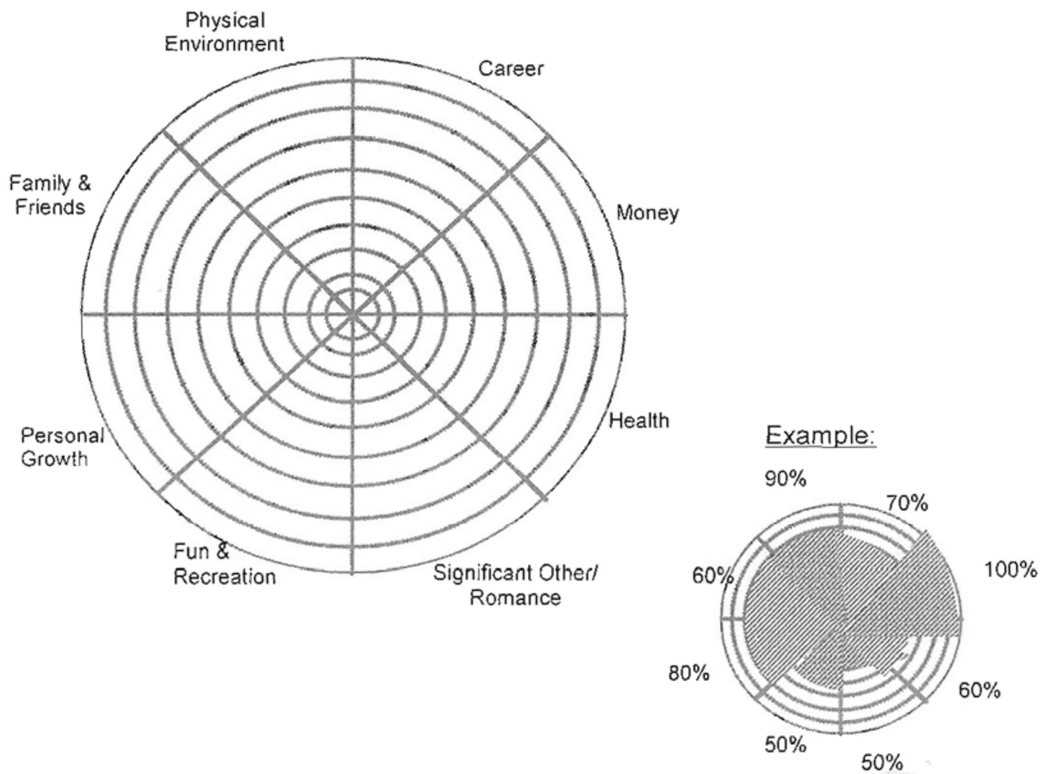
____

What do you love to do?

____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.



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Health History

When and where did you last receive health care?

____

For what reason?

____

In order of importance, identify the health concerns that have brought you to see Anita Tadavarthy, LAc.

Condition	**Past Treatment**
a. ______________________	______________________

How does this condition affect you?

____

b. ______________________	______________________

How does this condition affect you?

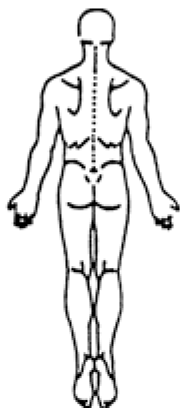
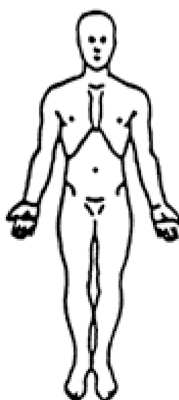
____

c. ______________________	______________________

How does this condition affect you?

____

Body Pain (circle / shade areas of pain, ache, burning, and/or numbness)

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Height: ____________ Weight: Currently: ___________ Past Max: __________ When? ___________

Blood Pressure: Most recent blood pressure reading? ______/_______

When was this reading taken? __________

List any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

List any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking: ____

____

Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? ____

(Pregnant patients will need a letter from her physician stating that she can receive acupuncture)

Do you have any infectious/contagious diseases? Y N If yes, please identify:

____

List any childhood illnesses that you have ever had:

____

List any hospitalizations that you have ever had (list reasons & dates):

____

X-Rays / CAT Scans / MRIs / NMRs / special studies (list reasons & dates):

____

Family History

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child(ren)
Age (if living)						
Health G = good P = poor						

List the chronic conditions in your family:

____

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Review of Systems

In the last six months, which of the following symptoms have you experienced?

	Never	Sometimes	Often
Difficult to stop bleeding?			
Easily bruised / Slow wound healing			
Fatigue			
Tendency to faint easily			
Sudden weight loss			
Lack of appetite			
Excessive appetite			
Digestive problems			
Vomiting or nausea			
Belching or burping			
Heartburn			
Feeling of food retention			
Loose stools or diarrhea			
Constipation			
Colitis / Diverticulitis			
Hemorrhoids			
Blood in stools			
Black tarry stools			
Cough			
Bronchitis			
Tendency to catch colds easily			
Intolerance to weather changes			
Shortness of breath			
Asthma			
Decreased sense of smell			
Nasal problems			
Allergies			
Hayfever			
Skin problems			
Feeling of claustrophobia			
Recent use of antibiotics			
Low back pain			
Sciatica			
Knee problems			
Hearing problems			
Kidney stones			
Decreased sex drive			
Hair loss			
Night sweats			
Feeling hot or cold			
Urinary problems			
Edema			

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	Never	Sometimes	Often
Insomnia, difficulty sleeping			
Nightmares			
Mentally restless			
Laughing for no apparent reason			
Heart palpitations			
Chest pain			
High blood pressure			
High cholesterol			
Eye problems			
Hepatitis			
Jaundice (yellowish eyes or skin)			
Light colored stools			
Difficulty digesting oily foods			
Gallstones			
Cold hands & feet			
Mood swings			
Nervousness			
Mental tension			
Anxious			
Easily angered or agitated			
Soft or brittle nails			
Spasms or twitching of the muscles			
Dizziness / Vertigo			
Stroke			
Paralysis			
Male Reproductive:			
Sexual difficulties			
Prostate problems			
Testicular pain / swelling			
Penile discharge			
Female Reproductive / Breasts:			
Premenstrual problems			
Irregular cycles			
Painful periods			
Heavy flow			
Bleeding between cycles			
Clotting			
Vaginal discharge			
Breast lumps / tenderness			
Nipple discharge			
Difficulty conceiving			
Menopausal symptoms			

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Menstrual / Birthing History:

Age of First Menses:	Birth Control Type:	# of Abortions:
___________	___________	________________
# of Days of Menses:	# of Pregnancies:	# of Live Births:
___________	______________	_______________
Length of Cycle:	# of Miscarriages:	
______________	_____________	

Lifestyle

Do you typically eat at least three meals per day? Y N If no, how many? ________________

Exercise routine:

____

How many hours per night do you sleep? ________ Do you wake rested? Y N

Nicotine/Alcohol/Caffeine Use:

____

Have you experienced any major traumas? Y N Explain: __________________________

____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? __________

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Metis Clinics LLC, Anita Tadavarthy, LAc - Consent Form

Primary Care & Medical Records: I do hereby voluntarily consent to be treated with acupuncture and/or substances from Anita Tadavarthy, LAc, a licensed acupuncturist. I understand that acupuncturists in the state of Oregon are not primary care providers. Anita Tadavarthy, LAc, recommends that all patients have a regular primary care physician. All patients must provide medical records from a primary care provider upon request.

Group Treatment: Treatment may be administered in a group setting in a large room. It is possible that other individuals in the room may hear or see case and treatment information.

Acupuncture/Moxibustion: Acupuncture is performed by the insertion of needles through the skin and/or by the application of heat to the skin at points on or near the surface of the body to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. There may occasionally be adverse side effects such as: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely lung puncture (pneumothorax).

Direct Moxibustion: With this therapy, there is a risk of burning or scarring.

Electro-Acupuncture: Electro-acupuncture may be administered with the acupuncture. There may be certain adverse side effects such as: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: Chinese herbs and substances may be recommended to treat bodily dysfunction or diseases or to modify or prevent pain perception and to normalize the body's physiological functions. Patients must follow the directions for administration and dosage. There may occasionally be adverse side effects such as: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. With any problems associated with these substances, patients should suspend taking them and call Anita Tadavarthy, LAc, as soon as possible.

Acupuncture-Massage: Acupuncture-massage is used to modify or prevent pain perception and to normalize the body's physiological functions. There may be certain adverse side effects such as: muscle soreness or achiness and the possible aggravation of symptoms existing prior to the treatment.

All of the above information has been explained to me by Anita Tadavarthy, LAc. I have had my questions answered.

- I consent to treatment with acupuncture and Oriental Medicine from Anita Tadavarthy, LAc.
- I understand that there are no guarantees concerning treatment.
- I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician.
- I understand that I am free to refuse or stop treatment at any time.

Patient Signature: ____ **Date:** ________________

Printed Name: ____ **Date of Birth:** ____________

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Acknowledgement of Receipt of the
Notice of METIS CLINICS LLC Privacy Practices

I have received the NOTICE OF METIS CLINICS LLC PATIENT PRIVACY PRACTICES from Anita Tadavarthy, LAc, which describes how METIS CLINICS LLC may use and disclose my protected health care information to carry out treatment, payment of services, health care operations, and other purposes that are allowed by law. This Notice also describes my patient rights and METIS CLINICS LLC requirements to protect my health information.

METIS CLINICS LLC reserves the right to change the privacy practices that are described in the NOTICE OF METIS CLINICS LLC PATIENT PRIVACY PRACTICES. All changes will be posted at METIS CLINICS LLC. I understand that I may request a copy of this notice at any time and discuss its contents with the Privacy Officer, Anita Tadavarthy, LAc.

The most current copy of this notice will be posted in the clinic.

______________________________	______________________________
Signature of Patient or Personal Representative	Date
______________________________	______________________________
Printed Name of Patient or Personal Representative	Description of Personal Representative's Authority

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The Health Insurance Portability and Accountability Act (HIPAA) – Revised: February 18, 2008
Metis Clinics LLC, 7110 SW Fir Loop, Suite 205, Tigard, OR 97223

METIS CLINICS LLC PATIENT PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may gain access to this information. Metis Clinics LLC, will ask you to sign an Acknowledgement that your received this Notice of Metis Clinics LLC Patient Privacy Practices. In accordance with the HIPAA Privacy Regulation, this Notice describes how Metis Clinics LLC may use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. This notice also describes your rights and Metis Clinics LLC requirements to protect your health information.

Treatment, Payment, and Health Care Operations

For purpose of treatment: We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. Your treatment may include acupuncture, massage, and herbs. We may also, for the purpose of treatment, disclose your protected health information to another health care provider when needed by the provider to render treatment to you.

For payment services: We will your health care information to receive payment for services and products. We will bill you and/or a third party payor for the cost of treatment and herbs provided to you. The information on or accompanying the bill may include your identification, as well as the herbs you are taking.

For health care operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal Privacy Regulations. For example, we may use information in your health record to monitor the quality of our acupuncture associates and to train acupuncture personnel.

Other uses and disclosure of protected health information permitted or required by regulation.

The following is a description of other possible ways we may use and/or disclose your protected health care information:

Friends and family: We may disclose your protected health care information to friends and family in the case of an emergency to the extent necessary to help with your health care or with payment of your health care. Using our judgment as health care professionals, our acupuncture staff may disclose protected information with a family member, other relative, close personal friend, or any person your identify as being involved in your health care.

Reminder calls: We may contact you to provide reminders of herbal refills or appointments or other health related services that may be of interest to you.

Other covered entities: We may disclose protected health information to another covered entity to conduct health care operations in the area of quality assurance activities, certification, licensing, or credentialing.

Disclosure to the U.S. Department of Health & Human Services: When the U.S. Department of Health and Human Services is investigating or determining our compliance with the federal Privacy Regulations, we are required to disclose your protected health information to the DHHS.

Abuse or neglect: We may disclose your protected health care information to appropriate authorities if we believe that you may be a possible victim of abuse, domestic violence, neglect, or other crimes.

Serious threat to health or safety: We may disclose your protected health information if we believe that disclosure is necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person.

Public health or safety: We may release your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. For example, we may use information in your health record to the Food & Drug Administration relative to adverse events regarding drugs, foods, supplements, and other health products or to post marketing surveillance to enable product recalls, or replacements.
Law enforcement: We may disclose to law enforcement agencies in response to a court order, subpoena, discovery request, administrative order, or other lawful process by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health care information.

Other required or permitted disclosures: We may disclose your health care information to the following entities under given circumstances:

- To a correctional institution or its agents, if a patient is or becomes an inmate of such an institution, when necessary for the patient's health or the health and safety of others;
- To notify, or assist in notifying a family member, personal representative, or another person responsible for the patient's care, or the patient's location, or general condition;
- To the military authorities under certain circumstances when the patient is a member of the Armed Forces;

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- To the authorized federal officials for intelligence, counterintelligence, and other national security activities

Authorized use & disclosure
We will obtain your written Authorization before using or disclosing your protected health care information for purposes other than those listed above or otherwise permitted or required by law. You may revoke an Authorization in writing at any time. Upon receipt of this revocation, we will stop using or disclosing your protected health care information except to the extent that we have already taken action in reliance of the Authorization.

Patient Rights
Requests for Restrictions: You have the right to request that we restrict how your protected health information is used or disclosed in carrying out treatment, payment, or health care operations. Such requests must be made in writing to the Privacy Office at Metis Clinics LLC (see address above). In your request tell us: (1) the information of which you want to limit our use and disclose and (2) how you want to limit our use and/or disclose of the information. We are not required to agree to the requested restrictions, but if we do, we will abide by our agreement except in an emergency.

Access to protected health information: You have the right to look at or obtain a copy of your protected health information. You must make a request in writing to the Metis Clinics LLC, Privacy Office (see address below) to obtain access to your protected health information. If you request copies, we may charge you a reasonable fee for copies and postage (if you want them mailed). We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed.

Accounting of Disclosures: We will provide the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information (PHI), a description of the PHI we disclosed, the reason for the disclosure, and certain other information.

Amendments to Health Care Information: You may request that we amend your protected health information if you feel that it is incomplete or incorrect. Your request must be in writing, and it must explain why the information should be amended. If we did not create the information you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide you with a written explanation. If denied you have the right to file a statement of disagreement with the decision.

For More Information or to Report a Problem
If you would like additional information or have questions about our privacy practices, you may contact the Metis Clinics LLC, Privacy Office at 503-819-2904 or by writing to the Privacy Office at the address above. You may also file a written complaint to this address. If you believe your privacy rights have been violated, you may file a complaint with Metis Clinics LLC, or with the Department of Health & Human Services. We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health & Human Services.

Metis Clinics LLC HIPAA Compliance & Privacy Office

Privacy Officer:	Anita Tadavarthy	Address:	7110 SW Fir Loop, Suite 205 Tigard, OR 97223
Telephone:	503-819-2904	Email:	anita@metisclinics.com

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Metis Clinics LLC, Anita Tadavarthy, LAc – Financial Policy

Payment & Fees: Payment is due in full at the time of service. We accept cash, checks, debit & credit cards. We accept Visa, MasterCard, & Discover Cards. Make checks payable to Metis Clinics. Each treatment is $55. At the first visit, there is a one-time $10 evaluation fee. Additional fees may apply for extended treatment time.

Insurance: We offer a Superbill. We provide you with a receipt for you to receive reimbursement from your insurance company. You pay Metis Clinics directly and then submit a receipt to your insurance company to seek reimbursement.

When seeking reimbursement from your insurance company, you should ask four main questions:

1) **Ask your insurance company if they cover out-of-network providers.** If they do, then you will be able to receive reimbursement for services offered at Metis Clinics
2) **Ask your insurance company what your acupuncture allowance is –** most acupuncture allowances range from $500 - $1,500 per year. At Metis Clinics, each treatment is currently $55. Acupuncture is a therapy and multiple treatments will greatly help you to achieve a long-term solution
3) **Find out what your co-pay is** – with this information, you will know what reimbursement you will receive from your insurance company
4) **Find out reimbursement time** - with this information, you can better manage your personal finances

Many insurances offer acupuncture benefits; however, you will have to check with your insurance company on your specific acupuncture benefits / reimbursements. At Metis Clinics, it is the patients' responsibility to seek reimbursement, from their insurance company, for services offered at our clinics.

Cancellation Policy: If you need to cancel an appointment, call Metis Clinics at 503.819.2904 at least 24 hours in advance. Appointments cancelled without 24-hour notice will be charged a $25 cancellation fee.

Patient Signature: ____ **Date:** ____________

Printed Name: ____ **Date of Birth:** __________

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