Lotus Healing Arts, LLC

2610 Post Road ~ P.O. Box 908 ~ Plover, WI 54467
715-345-0655 ~ Fax 715-345-0904

Mark Ensweiler, D.C., L.Ac.

I General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____ May we contact them? Y/N

Have you had Acupuncture or Oriental medicine before? Y/N

Are your presently under a doctor's care? Y/N Who and for what? _____

Are there any other therapies which you are involved? Y/N Who and for what? _____

II Insurance Information

Insurance Company _____ Contact # _____

Group/Plan # _____ Co-pay $ _____ Visit # _____ Referral Y/N Covered % _____ Ded.(?) _____

Date called _____ Contact Name _____

III Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____

What are your health goals? _____

List any past or future surgeries. _____

_____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) _____

_____

List exercise and sport activities you have been or are currently involved in: _____

_____

IV Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

V Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N Is your cycle painful? Y/N Have you ever been pregnant? Y/N

Birth control? Y/N How long? _____ ❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

VI Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

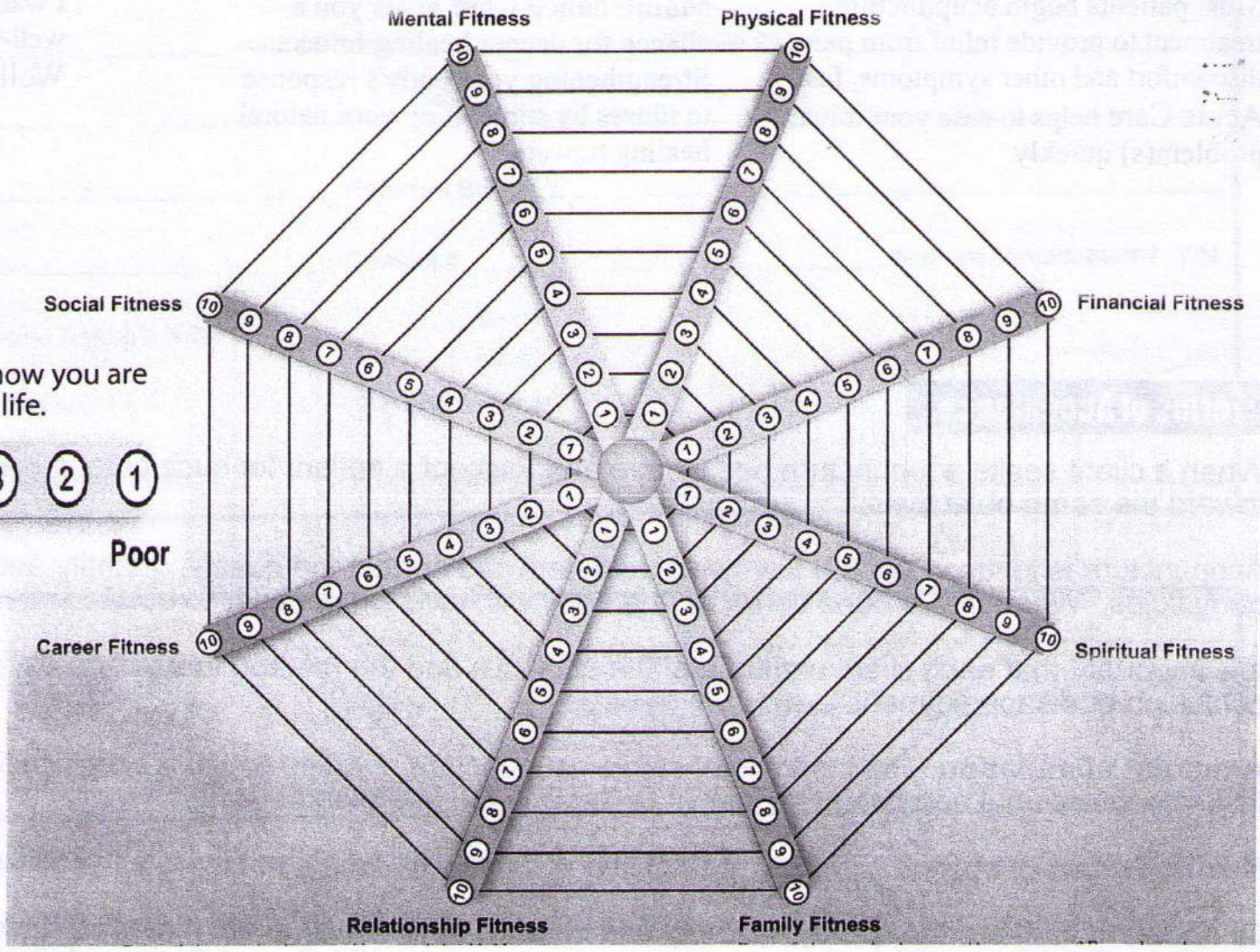
Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

Rate yourself by choosing from 1-10 how you are feeling in each aspect of your life.

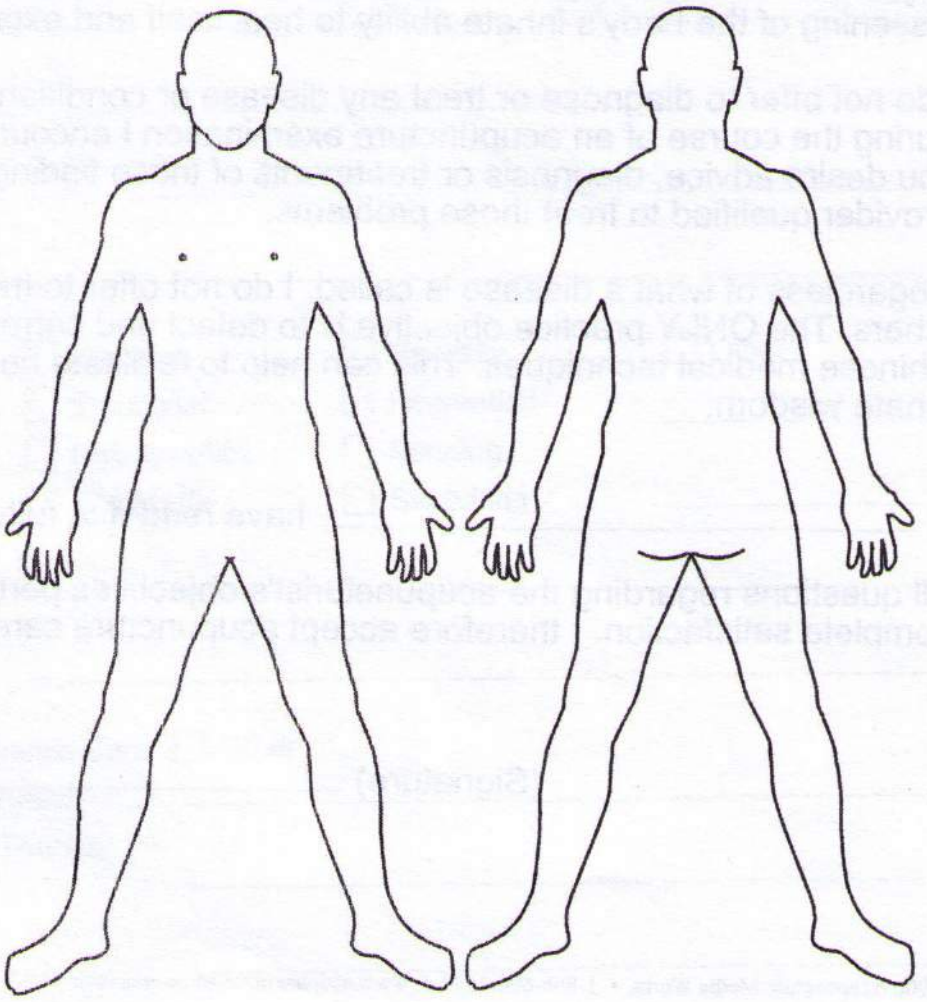
10 9 8 7 6 5 4 3 2 1

Excellent **Poor**



VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.



Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit

Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentialiy lead to a full expression of your body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

(Signature) _____ (date) _____

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac. • Charity Millard, D.C.

P.O. Box 908, 2610 Post Road, Plover, WI 54467 • (715) 345-0655

ACUPUNCTURE & HERBAL THERAPIES

INFORMED CONSENT

Acupuncture - It is important to acknowledge the differences between the health care specialties of Acupuncture, Chiropractic and Medicine. Acupuncture can be defined as "the art and science of promoting, maintaining or restoring health. It includes diagnosing and treating disease based on traditional Oriental medical concepts of treating specific areas of the human body, known as acupuncture points on meridians (pathways), by performing any of the following practices: 1) Inserting acupuncture needles; 2) Moxibustion; 3) Applying manual, thermal, or electrical stimulation or any other secondary therapeutic techniques." The law in Wisconsin also allows for the Acupuncturist to use the following related modalities: Acupressure, low level laser therapy*, and herbal medicine.** (Wisconsin Statues-Chapter 451.01)

Although acupuncturist and herbalists are trained to differentially diagnose a wide variety of health disorders, they are not trained as internal medical specialists. As such, every acupuncture/herbal patient needs to be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your acupuncturists may express an opinion as to whether or not you should take this step (referral to a licensed M.D. for further diagnostic evaluation), but you are responsible for the final decision.

A patient, in coming to an Acupuncturist, gives the Acupuncturist the permission and authority to care for the patient in accordance with Acupuncture analysis and guidelines. Acupuncture treatments, including needle insertion, and adjunctive clinical procedures are considered to be safe and conservative treatment. These forms of treatment are usually safe and conservative treatment. These forms of treatment are usually beneficial and seldom cause any problems, however, in rare instances a patient may experience some pain or minor bruising at the site of needle insertion, mild nausea during or after treatment, and there is also and extremely remote possibility of a broken needle. (If this should happen, the appropriate specialist would be consulted immediately to remove the needle). The Acupuncturist, of course, will not render acupuncture service in cases where it would be inappropriate. The Acupuncturist provides a specialized, non-duplicating health service. The Acupuncturist is licensed in a special practice and is available to work with other types of providers in your health care regime.

Mark S. Ensweiler, D.C., L. Ac. is duly licensed in the state of Wisconsin to practice as a Chiropractor and Acupuncturist. He is certified as a National Board Diplomate in bother Acupuncture and Chinese Herbal Therapies by the N.C.C.A. (National Commission for the Certification of Acupuncturists).

*Low level (wattage) laser therapy is a safe and relatively simple treatment modality used with or as a substitute for acupuncture needles. This treatment involves the use of low powered red light to be utilized over specific acupuncture points on the body. It must be understood that while this device is currently considered as experimental by the F.D.A., there are no known risks associated with this device except for the potential risk of eye injury if the beam was directed into the eye and stared at for a prolonged period of time.

**Medicinal/therapeutic herbs are utilized for the restoration and maintenance of health and are prescribed as bulk formulas for teas, pills/capsules, powders, and liquid tinctures. Only time-tested and GRAS (generally regarded as safe) herbs are utilized or recommended at this office.

Please feel free to discuss any questions or concerns you may have with the Doctor/Acupuncturists before signing this statement of policy.

I have read and understand the foregoing.

_____ _____

Signature (Parent or guardian if a Minor) Date

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac.
Charity Millard, D.C.
P.O. Box 908, 2610 Post Road, Plover, WI 54467
(715) 345-0655

_____ _____
Name Date

Financial Agreement

I have read and signed the payment policy sheet and understand the financial responsibilities that I have undertaken in receiving professional health care services at Lotus Healing Arts. The services rendered to me (or _____, under 18 years old) will be compensated by:

_____ I will be paying (cash, check, Visa/MasterCard) on the same day that I receive these services.

_____ I have private health insurance that will reimburse for a portion of the professional fees. I have checked my policy and know that specific professional chiropractic and acupuncture services are covered. (We need a copy of your card.)

_____ I have <u>not</u> yet met my deductible for this year and will be paying 100% for services rendered, at the time of service, until my deductible has been met in full and other arrangements are made.

_____ My policy may pay for a <u>percentage</u> of professional services offered. I will pay the remaining percentage that I am responsible for at the time services are rendered. This percentage is _____.

_____ I have been involved in a reported and documented work-related injury while on the job and will be or have filed a Workmen's Compensation claim. The insurance carrier is responsible for professional services.

_____ I have been involved in an automobile or personal injury accident where my insurance company (or the other party(s) involved will be reimbursing Lotus Healing Arts directly upon receiving current billing and clinical documentation.

_____ I have consulted with an attorney and my medical/chiropractic bills will not be reimbursed until there is a final settlement.

_____ I am under Medicare-Part B. I agree to pay for professional services rendered and will be reimbursed for chiropractic services directly from Medicare.

_____ Additional services not covered by Medicare will be paid at the time services are rendered.

_____ I am not paying for professional serviced rendered at the time of service, in full, for the following reasons:

_____

_____

_____

_____

_____ If so, how and when would I plan on paying for professional services rendered at Lotus Healing Arts?

_____

_____

_____

_____

_____ I understand that unpaid balances at Lotus Healing Arts (beyond 45 days) will be charged interest at the rate of 1-1/2% per month, unless other arrangements have been made. Please note that all nutritional and herbal supplements supplied through Lotus Healing Arts are payable when picked up at our office.

_____ _____

Patient/Client
(Parent or guardian if under 18 years old)

Date

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac. • Charity Millard, D.C.
Debrah Ensweiler, Ms. T.
P.O. Box 908, 2610 Post Road, Plover, WI 54467
(715) 345-0655

Professional Fees, Insurance, and Payment Policies

The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this geographic area. As certified and licensed health care providers, our fee structure is based on the types of services rendered and the amount of time that is spent with each patient/client to render a particular service or procedure.

Ideally, payment for health care services and recommended supplements or supplies at our office is an expression of an investment in one's health and well-being and, while we accept a wide variety of insurance plan payment options, not all people have insurance policies that will pay for the health care services and products rendered to you at Lotus Healing Arts. If you have an insurance plan that will re-imburse for part or all of the services rendered at our office, we are happy to do all of the necessary paperwork for you. If you do not have options to receive insurance re-imbursement, you will be expected to pay for professional services rendered at the time of your visit. We accept cash, personal check, Visa and MasterCard. If you cannot pay for services rendered at the time of the visit, please let us know ahead of time what your plans are for payment for services. To avoid misunderstandings, we invite early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. We offer certain discounts for same-day payments, senior citizens, and a sliding-fee scale for those with current and proven financial hardships.

The highest quality health care can be provided only on the basis of mutual understanding. We, therefore, encourage our patients and clients to discuss any questions that you might have regarding our policies.

At our office we accept assignment for a number of health and auto accident policies and for all workmen's compensation injuries that have been appropriately reported to one's employer. If you would like your health insurance to cover all or part of your fees, you will need to first check with your plan and/or insurance representative to see what your actual coverage is and the status of your deductible, if any.

Patients who have health insurance need to know that professional services are rendered and charged to the patient and not to the insurance company, unless your particular policy involves a "managed care" contract (PPO, HMO, etc.) and this office has contracted with that insurance company to accept their payment as complete and full.

Insured patients are expected to take care of their fees as services are rendered unless previous arrangements have been made. This would include timely payments for unmet deductibles, co-insurance payments, etc. It is important that you understand the provisions of your insurance policy/plan. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, this does not relieve the financial obligation to our office that you have incurred. (Exceptions to this rule might be seen, however, with various "managed care", PPO, HMO contracts that this of fice has contracted with.)

Our office does participate with Medicare and Medicaid for the professional services that they cover. We have a senior citizen discount rate and payment is due as services are rendered unless other arrangements are made. We perform all the necessary paperwork for Medicare re-imbursement at no extra charge to you and they will re-imburse you, the patient, directly.

Our office location, staff, and equipment are chosen to provide you with quality health care services in a pleasant and efficient atmosphere. Should you have any questions with regards to our services, credentials, fees, etc., please let us know. Our ultimate goal is to provide appropriate professional health care services to you in a personal and individual manner and we invite any questions that you may have.

I have read and understand the above mentioned policies and procedures.

_____

Patient (Parent or guardian if under 18 years old) **Date**

_____

Witness

[Lotus Healing Arts]

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that *Lotus Healing Arts* has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Lotus Healing Art's Privacy Notice.

_____ _____

Print Name **Unique Identifier**

_____ _____

Patient's Signature **Date**

For office use only:
Patient Name: _____
Medical Record #: _____
Date of Admission: _____
Filed electronically: ___Yes ___No
Forward completed form to HIS to file in patient's chart: ____Yes ___No

[Name of Covered Entity] staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and *[Name of Covered Entity]* efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available
[ ] Patient/Legal Representative Left before Signature Obtained
[ ] Emergency Admission/Patient Not Present for Registration
[ ] Patient bypassed Registration – Not Available
[ ] Other: _____

3. Completed by:

_____ _____ _____

Workforce Member Signature Title Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____