SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

ACUPUNCTURE INTAKE

UPDATED 2026 – ONLINE

DATE: ____ / ____ / _____

CHART #: _____

PLEASE CHECK ONE: ☐ MR. ☐ MRS. ☐ MS. ☐ DR. ☐ REV. ☐ FR. ☐ SR. ☐ PR.

FULL NAME: _____ DATE OF BIRTH: ____ / ____ / _____

AGE: _____ SSN: ____ - ____ - _____ GENDER: _____ MARITAL STATUS: _____

ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT: _____ PHONE #: _____

BEST SOURCE OF COMMUNICATION: (CHECK ONE) ☐ TEXT ☐ EMAIL ☐ CALL

HOW DID YOU HEAR ABOUT US? _____

PREFERRED LANGUAGE: _____ RACE: _____ ETHNICITY: _____

SMOKING STATUS: (CHECK ONE) ☐ CURRENT ☐ FORMER ☐ NEVER

EMPLOYERS NAME: _____

OCCUPATION: _____ WORK PHONE: _____ EXT: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

RELATIONSHIP TO INSURED: (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

IF SELF; SKIP TO BOTTOM OF FORM. IF SPOUSE, CHILD OR OTHER BE SURE TO FILL OUT ALL OF THE HOLDERS INFORMATION.

NAME OF INSURANCE HOLDER: _____ DATE OF BIRTH: ____ / ____ / _____

ADDRESS: _____

SSN: ____ - ____ - _____ EMPLOYER: _____ PHONE: _____

Authorizations: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE: _____ DATE: ____ / ____ / _____

GUARDIAN'S SIGNATURE: _____ RELATIONSHIP: _____

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DATE: ____ / ____ / _____

PATIENT NAME: _____ CHART #: _____

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Allergies/Hay Fever
- ☐ Concussion
- ☐ Dry mouth/nose
- ☐ Ear aches
- ☐ Excess phlegm
- ☐ TMJ Syndrome /Jaw Pain
- ☐ Headaches /Migraines
- ☐ Red, dry and/or itchy eyes
- ☐ Spots in eyes
- ☐ Sinus issues
- ☐ Ringing in ears

RESPIRATORY & CARDIOVASCULAR

- ☐ Asthma
- ☐ Frequent colds
- ☐ Chronic cough
- ☐ Emphysema or COPD
- ☐ Heavy/tight chest
- ☐ Anemia
- ☐ Easily bruised
- ☐ Poor circulation
- ☐ Blood clots
- ☐ Fainting
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart palpitations
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Stroke
- ☐ Heart Disease
- ☐ Other: _____

GASTROINTESTINAL/URINARY

- ☐ Normal Stool
- ☐ Loose stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn/acid reflux
- ☐ Abdominal pain
- ☐ Bloating /Gas
- ☐ Nausea /vomiting
- ☐ Hernia
- ☐ Liver Disorder
- ☐ Ulcer
- ☐ Frequent Bladder infections
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Prostate Disorder
- ☐ Kidney stones
- ☐ Kidney Disease
- ☐ UTI
- ☐ Other: _____

GYNECOLOGICAL

- ☐ Menopause
- ☐ Breast lumps
- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Fibroids or cysts
- ☐ PMS
- ☐ Heavy Periods
- ☐ Light periods
- ☐ Irregular Periods
- ☐ # Pregnancies _____
- ☐ # Miscarriages _____
- ☐ Genital burning, itching, discharge or swelling

Days between periods _____ # Days of period _____

NEUROLOGICAL & PSYCHOLOGICAL

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Stressed
- ☐ Epilepsy/Seizure Disorder
- ☐ Parkinson's Disease
- ☐ Poor memory
- ☐ Vertigo/Dizziness
- ☐ Other: _____

Any other health concerns you would like to share?

_____

207 777 3333 | 416 Sabattus Street, Lewiston, ME 04240 | SassevilleChiropractic.com | hello@sassevillechiropractic.com

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DATE: ____ / ____ / _____

FULL NAME: _____ CHART #: _____

Please list any medications you are currently taking and why:

_____

_____

_____

_____

Please list any vitamins or supplements you are currently taking:

_____

_____

_____

Please list any Family History Medical Conditions and Who they Relate to:
(Refer to Medical Conditions Above — Example: Mom: high blood pressure)

_____

_____

_____

_____

Have you had any Auto or other accidents? ☐ Yes ☐ No *If yes, please describe below:*

_____

Who is your Primary Care Physician? _____ Date of Last Exam? ____ / ____ / _____

Are you pregnant? ☐ Yes ☐ No How many weeks? _____ Due Date: ____ / ____ / _____

Who is your Midwife/Obgyn? _____

Do you smoke? ☐ Yes ☐ No Packs per day? _____ Do you use other drugs/substances? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Drinks per day? _____

Do you drink caffeine? ☐ Yes ☐ No Drinks per day? _____

Do you Exercise? ☐ Yes ☐ No *If yes, please describe what forms and how often below:*

_____

_____

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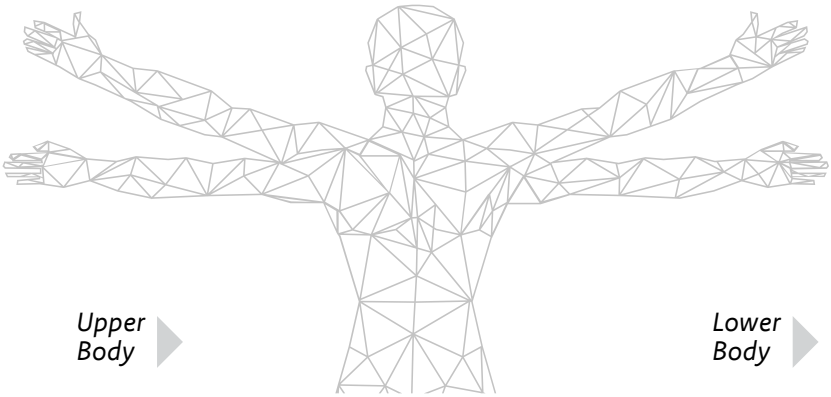
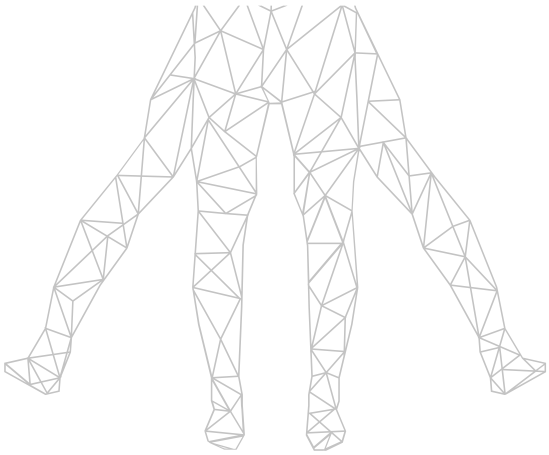
DATE: ____ / ____ / _____

FULL NAME: _____ CHART #: _____

Please mark your areas of pain on the diagram(s) below:



Upper Body



Lower Body

What is your MAJOR complaint? _____ Date problem began? ____ / ____ / _____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? ☐ Right ☐ Left ☐ Both ☐ Center

Have you had this condition in the past? ☐ Yes ☐ No

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Describe the nature of your symptoms:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

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DATE: ____ / ____ / _____

FULL NAME: _____ CHART #: _____

What is your SECOND complaint? _____ Date problem began? ____ / ____ / _____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? ☐ Right ☐ Left ☐ Both ☐ Center

Have you had this condition in the past? ☐ Yes ☐ No

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Describe the nature of your symptoms:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

PREVIOUS CHIROPRACTIC CARE?

Have you ever had chiropractic care? ☐ Yes ☐ No Where: _____ When: ____ / ____ / _____

Why? _____

_____

_____

Were X-rays taken? ☐ Yes ☐ No When was your last adjustment: ____ / ____ / _____

CHART #: _____

Release Form for individuals involved in care of Patient

I, _____ , give SCWC permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from SCWC. I also allow the following people to discuss information about my appointments.

This consent is valid until such time as I provide SCWC written revocation of it.

PATIENT NAME: _____ DOB: _____

SCWC may speak with:

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

By signing this form, I authorize Sasseville Chiropractic Wellness Cetner to share my personal health information listed above to the person(s) or organization(s) I named on this form. I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

PATIENT NAME: _____ DATE: ____ / ____ / _____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

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WELLNESS CENTER

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DATE: ____ / ____ / _____

PATIENT NAME: _____ CHART #: _____

I do not wish to receive office notes for each of my chiropractic visits. I understand that by signing this document I am allowing Sasseville Chiropractic Wellness Center to omit asking if I need my office notes each time I come in.

I also understand that by signing this document that I will need to let Sasseville Chiropractic Wellness Center know if I need office notes for any future visits as they are available any time I need.

PATIENT/GUARDIAN SIGNATURE: _____

SCWC REPRESENTATIVE SIGNATURE: _____

SASSEVILLE
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CHART #: _____

Cancellation / No Show Policy / Emergency Appointments

1. Cancellation/No Show Policy for Appointments

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. Typically there are patients on a wait list for these services that could have been scheduled if given appropriate advanced notice.

If an appointment is not cancelled at least 24 hours in advance, *you will be charged a $100 fee*; this will not be covered by your insurance company.

After 3 no call no show/missed appointments in a row, the patient is released from active care.

2. Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We expect patients to arrive at least 5 minutes prior to their scheduled appointment.

If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment. This will be considered a last minute cancellation and will result in a missed appointment, *you will be charged a $100 fee*; this will not be covered by your insurance company.

3. After hours and Emergency Appointments

If the need arises for you to be seen by a SCWC provider outside of their normal SCWC hours, you will be charged an after-hours/emergency fee. "Outside of normal SCWC hours care" refers to any care provided by a provider that is scheduled outside of their typical schedule hours. Our office is closed every Thursday, weekends, and all major holidays.

If you need emergency or after hours care, *there will be an additional $150 fee along with any service charges from your treatment*; this fee will not be covered by your insurance company.

PATIENT NAME PRINTED: _____ DATE: ____ / ____ / _____

PATIENT SIGNATURE: _____

CHART #: _____

HIPAA Omnibus Notice of Privacy Practices

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 condition and related health care services.

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, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider 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, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

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, employee review, training of medical students, licensing, fundraising, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.(this could be done by phone, email or mail). We use closed treatment rooms but you may still be in ear shot of other patients. Your initial and follow up evaluation notes will be sent to your Primary Care Physician.

If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death. 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 and safety as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Mainecare Benefits. In the event that Sasseville Chiropractic Wellness Center is sold or merged with another organization, your health information/records will become the property of the new owner.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the 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.

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

ACUPUNCTURE INTAKE

UPDATED 2026 – ONLINE

CHART #: _____

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications –You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Changes to this Notice of Privacy Practices: we reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that is maintains. Until such amendment is made, Sasseville Chiropractic Wellness Center is required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact us.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office Contact: Katrina Morin Phone: 207-777-3333 Email: katrina@sassevillechiropractic.com

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign below acknowledging your receipt of this notice.

PRINT FULL NAME	SIGNATURE	DATE
_____	_____	____ / ____ / _____

SASSEVILLE
CHIROPRACTIC
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UPDATED 2026 – ONLINE

CHART #: _____

Billing Policy

Please be sure to contact your insurance company for specific benefit information. Although the chiropractor may participate with your insurance company, they may not be covered. ***Some out-of-state policies do not reimburse for services provided by Doctors of Chiropractic (DC) since they do not credential them independently***.

- We will submit your claim for you. Co-payments are due at the time of service.
- Please direct any coverage, benefit or participation questions directly to your insurance company.
- Be sure to give your insurance company the name of the provider you will be seeing.
- ***Effective 9/19/2021 SCWC no longer participates in State of Maine Medicaid programs.***

Services denied as not covered by your insurance company are your responsibility.

We appreciate timely payment on patient statements. Payment in full is due on each statement. If payment in full can not be made, please contact our billing department at 777-3333 to discuss payment options. It is important to us that we work with you to ensure continuity of care.

Patient balances are payable within 30 days of original invoicing. If the patient account balance is still outstanding after 90 days, the account will be submitted to our collection agency.

- ***The patient will be responsible for any reasonable collection cost, including attorney fees if incurred.***

Who is responsible for this account? This should be the holder of the insurance plan. May we discuss your account with the Responsible Party listed below? (Please check one): ☐ ***YES*** ☐ ***NO***

NAME OF RESPONSIBLE PARTY _____ SSN ___ – ___ – ____ RELATIONSHIP _____

ADDRESS / CITY / STATE / ZIP _____

It is your responsibility to keep us informed of any changes in your insurance coverage. Most plans have a filing limit, so any delay in the submission of claims may result in the denial of a claim. A delay caused by lack of information will be billable to you.

We accept cash, credits card, and personal checks.

I acknowledge awareness of the billing policies of Sasseville Chiropractic Wellness Center and agree to their terms. I agree to be financially responsible for services provided to me today and in the future at Sasseville Chiropractic Wellness Center.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ DATE ____ / ____ / _____

SASSEVILLE
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CHART #: _____

Payment Policy

Payments are expected at each appointment and can be paid via credit/debit card deductible. Please fill out the form below with credit/debit card information and choose the type of payments you authorize.

PATIENT NAME: _____

Please initial to Agree to:

_____ Payment for copay or estimate cost per visit at each appointment.

_____ Automatically pay any outstanding balances after claims process through Insurance.

I agree that Sasseville Chiropractic Wellness Center may charge my credit card on file for the balance due when they receive a copy of the EOB from my Health Insurance carrier. This authorization relates to all balances not covered by my insurance company for services provided by Sasseville Chiropractic Wellness Center. This could be amounts resulting from balances of copayment, deductible, co-insurance, non-covered or denials for no coverage, however is not limited to these scenarios.

I understand that this authorization is valid until such time as I provide a 30-day written notice to cancel the authorization. Written notice must be submitted to the address below for processing.

CHECK ONE: ☐ MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER

CREDIT CARD #: _____ EXP. DATE: ____ / ____ / _____

PRINTED NAME ON CARD: _____

PATIENT SIGNATURE: _____ DATE: ____ / ____ / _____

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DATE: ____ / ____ / _____

Non-Medicare Advanced Beneficiary Notice (ABN)

PATIENT NAME: _____ DOB: _____ CHART #: _____

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Services below may NOT be payable by your medical plans and would need to be Paid At Time of Service.

Appropriate copays need to be ***paid at time of service***.

Items below list the estimated cost that will be billed to your insurance company. Any of these services provided that do not get paid by your insurance, will be considered ***Patient Responsibility***.

TREATMENT	EST. COST
Acupuncture	Up to $400
After hours/emergency care	$150
Consultations	Up to $175
Distraction	$30
Kinesiotape/Posture Rehab/Tex	$55
MT/NMR Therapy	$110-$210
Muscle Stimulation Therapies	Up to $50

TREATMENT	EST. COST
New Patient Exam	Up to $350
Orthotics	$85-$500
Re-evaluations	Up to $250
Spinal Adjustments	$55-$125
Extra Spinal Adjustment	$50
Wellness Care	Up to $500
X-rays	$80-$150

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Please draw a line through any service you DO NOT want performed.
- Recognize that by signing below, this covers any and all visits from January 1 to December 31, 2026.

Additional information: If you have a managed care plan (HMO), you will need a referral from your primary care provider (PCP). Any unpaid services are your financial responsibility.

Signing below means that you have received and you understand this notice.

PATIENT SIGNATURE: _____ DATE: ____ / ____ / _____

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CHART #: _____

Dear Patient:

We are always happy to submit a claim to your insurance company for services rendered. However, your insurance company may not cover any service, unless you obtain a referral from your Primary Care Physician. (Please consult your member handbook regarding referrals from your Primary Care Physician)

It is your responsibility to obtain a referral. Your signature below indicates that if you receive specialty care without consent of your Primary Care Physician, you will assume financial responsibility.

Thank you.

PATIENT NAME: _____ DATE: ____ / ____ / _____

PATIENT/GUARDIAN SIGNATURE: _____

SCWC REPRESENTATIVE SIGNATURE: _____

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

ACUPUNCTURE INTAKE

UPDATED 2026 – ONLINE

DATE: ____ / ____ / _____

Acupuncture & Traditional Chinese Medicine Intake Form

CHART #: _____

Please complete this questionnaire carefully. The information you provide will assist us in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / _____

Have you ever had Acupuncture before? ☐ Yes ☐ No

What is your primary reason(s) for treatment today?

_____

Have you visited a medical doctor for this condition? ☐ Yes ☐ No

If yes, did you receive a diagnosis? ☐ No ☐ Yes: _____

Are you currently receiving any other treatments for this condition? ☐ Yes ☐ No

If yes, please describe treatments and how effective they have been: _____

FEMALES ONLY Are you pregnant? ☐ No ☐ Yes: How many weeks? _____ Due Date: ____ / ____ / _____

Do you have a contagious disease at this time? ☐ No ☐ Yes: _____

Do you have any of the following?

☐ Pacemaker ☐ Hemophilia ☐ HIV ☐ Metal Allergy ☐ Epilepsy ☐ Fear of Needles

☐ Latex Allergy ☐ Surgical implants ☐ Hepatitis ☐ Nut Allergy ☐ Other _____

GENERAL HEALTH QUESTIONNAIRE

How much do you consume per day of:

Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____

What are your typical sleeping habits? Hours slept/night: _____

☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Frequent dreaming

☐ Disturbing dreams ☐ Wake at same time every night ☐ Other _____

How would you describe your energy levels?

☐ High ☐ Low ☐ Normal ☐ Lethargic ☐ Hyperactive ☐ Changes from day to day

MUSCULOSKELETAL

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Body heaviness ☐ Joint pain ☐ Limited motion

☐ Muscle pain /cramps ☐ Scoliosis ☐ Strains/Sprains: _____ ☐ Broken Bones: _____

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

ACUPUNCTURE INTAKE

UPDATED 2026 – ONLINE

DATE: ____ / ____ / _____

PATIENT NAME: _____ CHART #: _____

Patient Consent to Treatment — Acupuncture and Associated TCM Modalities

1. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment.
2. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including, but not limited to: numbness or tingling, dizziness or fainting, minor swelling, bleeding or bruising. I will immediately notify the acupuncturist if I experience any symptoms or problems before, during or after treatment. I freely accept the risks involved with my procedure
3. I understand that I should not make significant controlled movements while the needles are being inserted, manipulated, retained, or removed as this may result in pain, a bent, stuck or broken needle.
4. Additional treatment methods may include: the electrical stimulation of needles, cupping, gua-sha or acupressure. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given. I understand that if cupping or gua-sha treatments are used, that there will be marks left on the skin that look similar to bruises and may last up to 1 week.
5. I will give my practitioner full and accurate information about my health during the initial consultation and continue to inform my practitioner if I develop any new health issues, including but not limited to: developing new allergies, infectious diseases, surgical interventions or if I become pregnant.
6. I understand that I must let my practitioner know, and treatment may be withheld, if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, tuberculosis and Hepatitis.
7. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not usually provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases, my symptoms may temporarily worsen before they begin to improve.
8. By signing this form, I, (Print Name) _____, give my informed consent for Acupuncture treatment. I realize I may withdrawal my consent at any time.

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE:____ / ____ / _____

For office use: I confirm that I have discussed the above with the client during the initial intake.

PRACTITIONER SIGNATURE: _____ DATE: ____ / ____ / _____