Tom Etges, MD, LLC

INTEGRATIVE FAMILY MEDICINE
MEDICAL ACUPUNCTURE
PROLOTHERAPY

Please check all that apply: ☐Primary Care ☐Prolotherapy / Injection Therapy
☐Medical Consult ☐Medical Acupuncture

Full Name: _____
First MI Last Preferred

Date of Birth: _____ Age:_____ SSN# (For billing):_____

Gender (Check ALL that apply):
☐Male ☐Female ☐Non-binary ☐Transgender FTM ☐Transgender MTF
☐Other (please specify): _____ ☐Decline to answer
What pronouns do you prefer that we use when talking about you? (check all that apply)
☐She/her/hers ☐He/him/his ☐They/them/theirs ☐Other: Please specify: _____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Best daytime phone for us to call? ☐Cell ☐Home ☐Work

Employment: ☐F/T ☐P/T ☐N/A ☐Student Employer/Title_____

Relationship Status: ☐M ☐S ☐D ☐P ☐W Other

Spouse/Partner's Name: _____ Contact Number_____

Name of an Emergency Contact not living with you:_____

Relationship to you:_____ Phone:_____

How did you hear about us?_____

Is this treatment work related?(circle) Y / N If yes, what was the date of injury?_____
If we are billing one of the insurances below, please allow us to copy your card. **You are responsible for verifying your insurance benefits.**

If it is **NOT** one of the insurances listed, then please leave this blank as we are unable to bill any other carriers. We are considered out-of-network. Please pay in full for your visit today.

☐Lifewise ☐MODA Health ☐PacificSource ☐Regence BC/BS ☐Providence ☐Meritain
☐Auto Accident ☐Workmans Comp

Insurance:_____ Plan Name:_____
Member ID#:_____ Group #:_____

Name: _____ DOB:_____/_____/_____

Office Billing Policy

I understand that it is my responsibility to provide the office with current, accurate billing information at the time of check in and to promptly notify the office of any changes to the information I provide.

We bill Lifewise of Oregon, MODA Health, PacificSource, and BC/BS insurance companies, as well as auto accident and worker's compensation insurance with an open claim and claim number.

For other commercial insurance carriers, payment is expected on the date of service. We will provide you with documentation of your visit for you to submit to your insurance carrier for possible reimbursement.

Because this office is not a participating provider for Medicaid, or OHP plans, I am unable to bill for services for patients covered by these programs.

Assignment of Insurance Benefits:

By my signature below, I authorize Tom Etges, MD and his agents to submit claims to my insurance carrier on my behalf and I authorize direct payment to him for all services rendered. I also authorize my personal health information to be released to my insurance carrier for billing purposes.

Payment Policy:

If you have insurance that we are billing, your copayment or coinsurance, or any outstanding deductible portion is due at the time of service. It is a contractual agreement between your insurance carrier, you (the enrollee), and Tom Etges, MD to collect these fees on the day of service.

I understand that Tom Etges, MD, or his staff will obtain any necessary prior authorizations prior to my treatment. I also understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier. If we are unsuccessful at collecting payment from your insurance carrier for any reason, you are ultimately responsible for any balance due.

If time permits, and as a courtesy, we will verify your insurance eligibility, benefits, and patient financial responsibility amounts prior to your visit. We request you confirm your benefits with your insurance carrier since insurance benefits are a contract between you and your insurance carrier and you are ultimately financially responsible for payment of all services rendered to you.

I understand that I will be billed for any outstanding amounts due by me, and that I have a financial responsibility to pay these amounts within 30 days. Two (2) statements will be provided for any balance due and if payment is not received prior to the second mailing, then the second statement will be marked "Final Notice" and may be sent to an outside collection service if payment is not received within 10 days of the final notice. I also agree that I will be responsible for any collection, interest, or legal expenses associated with the collection of my debt.

Cancellation Policy/ Fees:

If you are unable to keep a scheduled appointment, please contact us with a minimum 24 hour notice. If calling after hours, please leave a message in our secure voicemail system. If you miss your appointment, or do not give 24 hour notice of cancellation, you will be charged a fee of $85, which is **not** billable to insurance and must be paid by you.

I understand and agree that if I present an NSF check for payment, I will be charged an NSF fee of $35 and it is not billable to insurance. The $35 fee, plus the outstanding balance, must be paid in full immediately by cash, money order, or valid credit card. I further understand that my account will be converted to a cash account and no more personal checks will be accepted by the office of Tom Etges, MD, LLC.

I understand that any request for Tom Etges, MD, to complete disability or medical program participation paperwork associated with my care will have a $20 fee to complete the paperwork and is not billable to insurance. This fee is due before the paperwork will be completed.

My signature below confirms that I have read and understand these billing policies and my financial obligation as they pertain to Tom Etges, MD, LLC.

Privacy policy: I have received a copy of Tom Etges MD, LLC's "Notice of Privacy Practices," (hard copy upon request).

Consent to treat:

Legal signature / Relationship to patient / Date

_____/_____/_____

Name: _____ DOB:_____/_____/_____

Please list major and minor surgeries (with year or age)

1._____ 3._____

2._____ 4._____

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?

Please list significant traumas/accidents:

Please list all medications you take and their dosage, attach a separate sheet if needed:

Please list all Vitamin/Mineral/Herbs/Nutritional supplements you take and their dosage:

Please list any drug, food, or environmental allergies you have:

What are your health concerns in order of importance?

1._____ 3._____

2._____ 4._____

How do your health concerns affect your everyday living?

What do you feel needs to happen for you to get better?

When was the last time you felt well?

How much change are you willing to make (at this time) for improving your health?

☐Minimal ☐Some ☐Complete

Place a mark on the line that best describes you currently. (Use the last 3 months for reference)

Mood

Extremely Depressed |----------|----------|----------|----------|Very Happy

Overall Health

Near Death |----------|----------|----------|----------| Extremely Healthy

Name: _____ DOB:_____/_____/_____

For the following, please indicate your average (A) and worst (W) levels. (Use either the last 3 months or since there has been a problem, whichever is shorter).

Energy Level- None |----------|----------|----------|----------| Extremely Energetic

Pain Level- None |----------|----------|----------|----------| Worst Pain Imaginable

Stress Level- None |----------|----------|----------|----------| Extreme Stress

Main Complaint? _____

Did your main complaint come on: (circle) Gradually / Suddenly

Is it getting: ☐better ☐worse ☐staying the same

When did symptoms begin?_____ What was the cause?_____

What makes it better?_____

What makes it worse?_____

Have you had this problem in the past? ☐Yes ☐No If Yes, when? _____

Have you had acupuncture in the past? ☐Yes ☐No For what reason? _____

Have you had X-Rays, MRI, or CT Scan? ☐Yes ☐No If yes, on which body part? _____

Does this problem interfere with sleep?☐Yes ☐No _____

FAMILY HISTORY

Father Health: ☐ Good ☐ Poor ☐ Deceased Mother Health: ☐ Good ☐ Poor ☐ Deceased

Age: _____ Cause of Death: _____ Age: _____ Cause of Death: _____

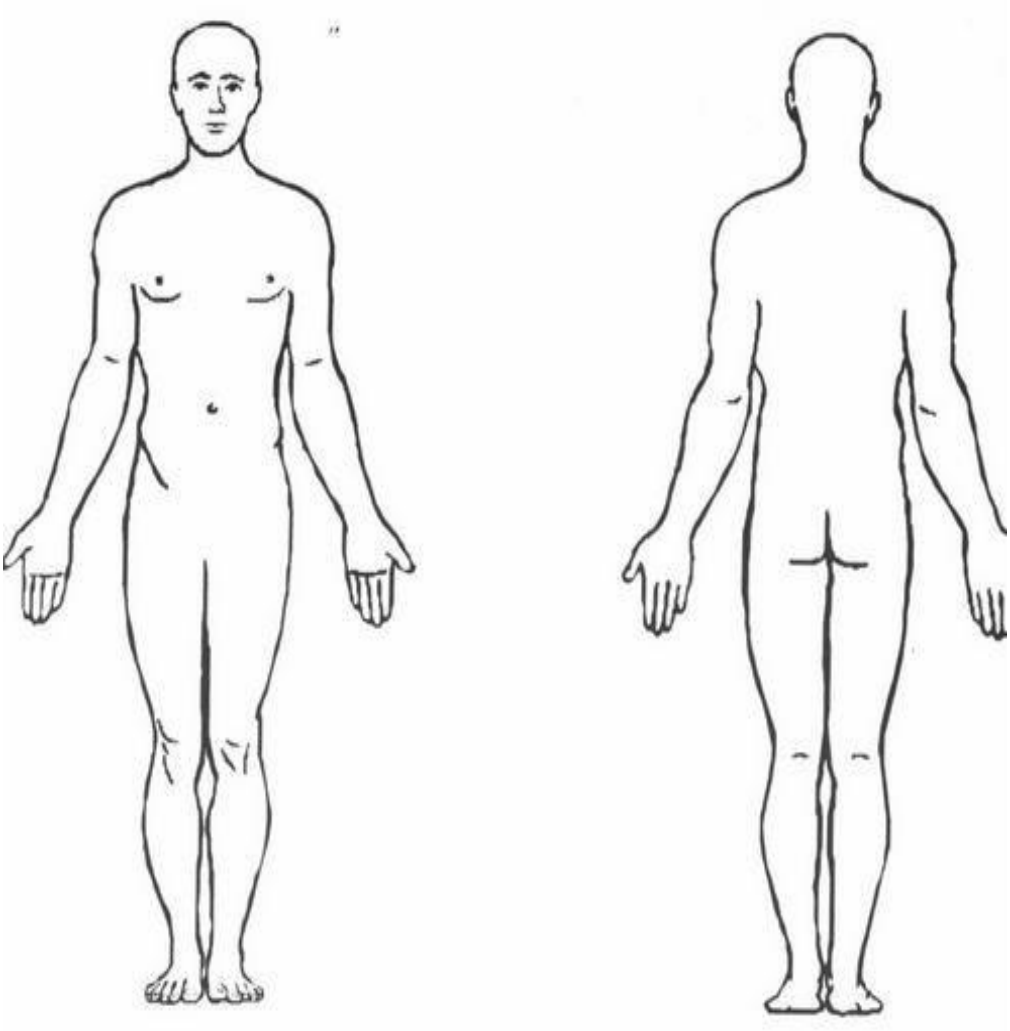
Check the box for any of the following conditions that you or your family members have experienced:

Cancer	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Diabetes	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Heart Disease	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
High Blood Press	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Stroke	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Epilepsy	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Mental Illness	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Asthma	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Hay Fever/Hives	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Anemia	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Kidney Disease	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Liver Disease	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Gallbladder Disease	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Ulcer	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Tuberculosis	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Goiter	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Arthritis	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Heart Murmur	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Cataracts	☐ self	☐father	☐mother	☐sibling	☐child	☐ other
Glaucoma	☐ self	☐father	☐mother	☐sibling	☐child	☐ other

Name: _____ DOB:_____/_____/_____

Body Diagram

Rate each pain on diagram on a scale of 1 (slight) to 10 (extreme)



Please Circle below: C= currently, P= in the past, N= never

Headache C P N
Migraine C P N
Neck Pain C P N
Mid-Back Pain C P N
Lower-Back Pain C P N
Shoulder Pain C P N
Hip Pain C P N
Knee Problems C P N
Ankle Problems C P N
Feet Problems C P N
Fatigue C P N
Gout C P N
Constipation C P N
Diarrhea C P N
Urinary Problems C P N
High Blood Pressure C P N
Depression C P N
Seizures C P N
Paralysis C P N
Muscle Weakness C P N
Numbness or Tingling C P N
Vertigo or Dizziness C P N
Loss of Balance C P N
Stroke C P N
Loss of Smell C P N
Fainting C P N
Cancer C P N
Varicose Veins C P N
Osteoporosis C P N
HIV C P N
Hypoglycemia C P N
Arthritis C P N
Diabetes C P N
Pregnant C P N

Name: _____ DOB:_____/_____/_____

Review of Systems

GENERAL
Weight _____
Maximum weight _____
When? _____
Height _____

Rate your energy on a scale
Of 1 to 10 _____
Time of day most
Energized? _____

MENTAL

Depression	C	P	N
Mood Swings	C	P	N
Anxiety/Nervousness	C	P	N
Considered Suicide	C	P	N
Tension	C	P	N
Poor Concentration	C	P	N
Easily Stressed	C	P	N
Memory problems	C	P	N

ENDOCRINE

Hypo/hyperthyroid	C	P	N
Heat/cold intolerance	C	P	N
Hypoglycemia	C	P	N
Diabetes	C	P	N
Excessive thirst	C	P	N
Excessive hunger	C	P	N
Fatigue	C	P	N
Seasonal Depression	C	P	N

IMMUNE

Vaccination reactions	C	P	N
Recurrent infection	C	P	N
Swollen glands	C	P	N

NEUROLOGIC

Seizures	C	P	N
Muscle weakness	C	P	N
Paralysis	C	P	N
Muscle weakness	C	P	N
Numbness or tingling	C	P	N
Vertigo or dizziness	C	P	N
Loss of balance	C	P	N
Fainting	C	P	N

SKIN

Rashes	C	P	N
Eczema Hives	C	P	N
Acne Boils	C	P	N
Itching	C	P	N
Color Changes	C	P	N
Perpetual Hair Loss	C	P	N
Lumps	C	P	N
Night Sweats	C	P	N

HEAD

Headaches	C	P	N
Head Injury	C	P	N
Jaw Pain/ TMJ	C	P	N

NECK

Lumps	C	P	N
Swollen Gland	C	P	N
Goiter	C	P	N
Pain	C	P	N

EYES

Spots in Vision	C	P	N
Cataracts	C	P	N
Impaired Vision	C	P	N
Glasses or Contacts	C	P	N
Blurriness	C	P	N
Eye pain/strain	C	P	N
Color blindness	C	P	N
Tearing or dryness	C	P	N
Double Vision	C	P	N
Glaucoma	C	P	N

EARS

Impaired hearing	C	P	N
Ringing	C	P	N
Earaches	C	P	N
Dizziness	C	P	N

NOSE/SINUSES

Frequent colds	C	P	N
Nosebleeds	C	P	N
Stuffiness	C	P	N
Hay fever	C	P	N
Sinusitis	C	P	N

MOUTH/THROAT

Frequent Sore Throat	C	P	N
Gum problems	C	P	N
Sore tongue	C	P	N
Dental cavities	C	P	N
Hoarseness	C	P	N

RESPIRATORY

Cough	C	P	N
Coughing blood	C	P	N
Asthma	C	P	N
Pneumonia	C	P	N
Emphysema	C	P	N
Pain on Breathing	C	P	N
Tuberculosis	C	P	N
Sputum	C	P	N
Wheezing	C	P	N
Bronchitis	C	P	N
Pleurisy	C	P	N
Difficulty Breathing	C	P	N
Shortness of Breath	C	P	N

CARDIOVASCULAR

Heart Disease	C	P	N
High/Low Blood Pressure	C	P	N
Blood Clots	C	P	N
Phlebitis	C	P	N
Rheumatic Fever	C	P	N
Swelling in Ankles	C	P	N
Angina	C	P	N
Murmurs	C	P	N
Fainting	C	P	N
Palpitations/Fluttering	C	P	N
Chest Pain	C	P	N

GASTROINTESTINAL

Heartburn	C	P	N
Trouble Swallowing	C	P	N
Change in thirst/appetite	C	P	N
Nausea	C	P	N
Vomiting	C	P	N
Blood in Stool	C	P	N
Pain or cramps	C	P	N
Belching or passing gas	C	P	N
Black stools	C	P	N
Jaundice (yellow skin)	C	P	N
Liver Disease	C	P	N

Bowel Movements:
how often _____
Is this a change? _____

Constipation	C	P	N
Diarrhea	C	P	N
Gallbladder disease	C	P	N
Ulcer	C	P	N
Hemorrhoids	C	P	N

URINARY

Pain on Urination	C	P	N
Increased Frequency	C	P	N
Frequency at night	C	P	N
Frequent infections	C	P	N
Kidney stones	C	P	N
Inability to hold urine	C	P	N

MUSCULOSKELETAL

Joint pain or stiffness	C	P	N
Broken bones	C	P	N
Muscle spasms or cramps	C	P	N
Arthritis	C	P	N
Weakness	C	P	N
Sciatica	C	P	N

BLOOD

Easy bleeding or bruising	C	P	N
Deep leg pain	C	P	N
Varicose Veins	C	P	N
Anemia	C	P	N
Cold Hands or Feet	C	P	N
Thrombophlebitis	C	P	N

Name: _____ DOB:_____/_____/_____

MALE REPRODUCTIVE

Hernias	C P N	Prostate Disease	C P N
Testicular pain	C P N	Testicular Masses	C P N
Venereal Disease	C P N	Are you sexually active:	□ Yes □ No
Discharge or sores	C P N	Sexual Orientation:	
Impotence	C P N	☐ Heterosexual	
Premature ejaculation	C P N	☐ Bisexual	
Discharge or sores	C P N	☐ Homosexual	

Birth Control Used C P N Method:_____

FEMALE REPRODUCTIVE

Age you started to have periods: _____ years Are your periods regular? □ Yes □ No

On average, how many days between periods? _____days How long do your periods last?_____ days

Menstrual flow: □ Normal □ Light □ Heavy Pain with your periods? □ None □ Mild □ Mod □ Severe

Pain not associated with your periods? □ Yes □ No Clotting? □ Yes □ No Discharge? □ Yes □ No

Date of last menstrual period _____ Bleeding between periods? □ Yes □ No

Are you sexually Active: □ Yes □ No Painful sex: □ Yes □ No

Birth Control Used: Current:_____ Past:_____

Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Homosexual

Venereal Disease: □ Yes □ No Date: _____ Type:_____

Do you do self-breast exams: □ Yes □ No Date of last exam:_____

Breast pain / tenderness: □ Yes □ No Breast discharge: Yes □ No Breast Lumps: □ Yes □ No

Abnormal Pap: □ Yes □ No Date of last pap:____/____/_____

Abnormal Mammogram: □ Yes □ No Date of last mammogram:____/____/_____

Date:	Outcome:	Comments / Complications:
	Miscar / Vaginal/ Cesarean / Tubal / Abortion	
	Miscar / Vaginal/ Cesarean / Tubal / Abortion	
	Miscar / Vaginal/ Cesarean / Tubal / Abortion	
	Miscar / Vaginal/ Cesarean / Tubal / Abortion	

Name: _____ DOB:_____/_____/_____

Medical Acupuncture

Patient Information and Consent Form

*Please read this information carefully. *Ask your practitioner if there is anything you do not understand.*

What Is Acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is Acupuncture Safe?

Acupuncture is generally very safe. Serious side effects are very rare, less than one per 10,000 treatments.

Does Acupuncture Have Side Effects?

You need to be aware that:
Drowsiness occurs after treatment in a small number of patients. If affected, you are advised not to drive.
Minor bleeding or bruising occurs after acupuncture in about 3% of patients.
Pain during treatments occurs in about 1% of patients.
Symptoms can get worse after treatment. Usually less than 3% of patients.
You should tell your practitioner about any symptoms that worsen, but it is usually a good sign.
Fainting can occur in certain patients, particularly with the first treatment.
In addition, if there are particular risks that apply to your treatment, Dr. Etges will discuss these with you.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:
If you have experienced a fit, faint, or funny turn
If you have a pacemaker or any other electrical implants
If you have a bleeding disorder
If you are taking anticoagulants or any other medication
If you have damaged heart valves or have any other particular risk of infection
If you are pregnant or might possibly be pregnant

*Note: ONLY single-use, sterile, disposable needles are used in this clinic for acupuncture treatments.

1. No form of therapy "cures" every ailment and acupuncture is no different. The number of treatments required before one experiences lasting results is usually related to the length of time the problem has existed. For longstanding conditions, 6-12 weekly sessions are usually recommended. For acute injuries or illness, treating within the first 24-48 hours is optimal and may initially be treated 1-2 times per week.
2. Initial acupuncture sessions can cause fatigue. Please avoid scheduling major activities the evening following your first few acupuncture appointments.
3. Initial response to your acupuncture treatments can include: no perceptible change, an improvement, or sometimes a temporary (usually less than 24 hours) worsening of symptoms. Please do not be discouraged if this transient worsening occurs. It may indicate that Qi, the body's vital energy, has been affected, which often results in subsequent improvement in symptoms.
4. During a treatment, you will be provided with a button that activates a wireless chime. Please press the button if discomfort from electrical stimulation occurs, positional fatigue develops, or if a needle becomes uncomfortable, preventing you from relaxing.
5. Traditionally, it is recommended the following be avoided for 12 hours following an acupuncture treatment: alcohol, concentrated sweets, intense exercise, heavy or very rich foods, and sexual activity. The reasoning behind this is to encourage the free flowing of Qi generated during the acupuncture session to continue.
6. It is not unusual for an acupuncture point to remain sensitive for a few days. Local swelling and/or sometimes bruising can occur but is usually quite mild. Should symptoms become more severe or persist, please don't hesitate to call the office. If you have any questions, please ask.
7. For additional information, I highly recommend the American Academy of Medical Acupuncture website: www.medicalacupuncture.org. At the bottom of the home page, listed under the Medical Acupuncture Learning Center, is a link entitled, "Doctor, what's this acupuncture all about?" This information goes into even more detail about the style of acupuncture I practice.

Statement of Consent:

I confirm that I have read and understand the above information, and I consent to having acupuncture treatment. I understand I can refuse treatment at any time. I understand Tom Etges is a medical doctor with training in acupuncture. He is not a licensed acupuncturist.

Full Printed Name: _____

Legal Signature: _____ Date:_____

Name: _____ DOB:_____/_____/_____

Primary Care Provider Information

In an effort to provide your primary care physician (PCP) with updates about your progress with acupuncture, please provide us with the following information:

Name of current PCP: _____

Phone number of PCP: _____

Address (or street): _____

Name of other specialists and/or clinics where you have been or are currently receiving medical care:

Name:	Location:

If there is any other information about previous care you have received that you would like us to know about, please elaborate here:

_____

_____

_____

_____