Richard Woodward, L.Ac., Dipl.Ac. (NCCAOM)

Three Pillars Acupuncture
6857 S. Hill St.
Littleton, CO 80120-3616

Disclosure Statement

The practice of acupuncture in the state of Colorado is regulated by the Department of Regulatory Agencies. Adjunctive therapies as defined by traditional oriental medical concepts and included under the auspices of acupuncture include tui na, Chinese herbal medicine, fire cupping, bleeding, moxibustion, acupressure, electroacupuncture, plum blossom, gua sha, intradermal needles, auricular acupuncture, ion cord and magnet therapy. As a practitioner of acupuncture and Traditional Chinese Medicine, I comply with the rules and regulations promulgated by the Department of Health and the Department of Regulatory Agencies with respect to C.R.S. 12-29-103. This clinic uses only individually packaged, sterilized, disposable needles, and adheres to the rules regarding the sanitation of acupuncture offices. As a prospective client, you are entitled to receive information about the methods of therapy, the technique used, and the duration of therapy if known. You are entitled to seek a second opinion from another health care provider or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration at the Department of Regulatory Agencies. Please direct correspondence to: The Director of the Division of Registrations, 1560 Broadway #1545, Denver, CO, 80202, or call 303-894-2464.

Fee Schedule*

• Initial Intake Visit (Consultation & Treatment)	$140 + cost of herbs	
• Follow-up Visit, (Consultation & Treatment)	$85 + cost of herbs	
• Out calls	$50 additional	
• Package of 5 Follow-ups Visits	$400	($5 savings per visit)
• Package of 10/20 Follow-ups Visits	$750/$1500	($10 savings per visit)

Education

☯ Externship in Acupuncture & Moxibustion 2006
- International Acupuncture Training Center, State Administration of TCM, Beijing, People's Republic of China

☯ Diploma, Traditional Chinese Medicine 2001
- Colorado School of Traditional Chinese Medicine, Denver, Colorado
- 3 year, 1800 hour professional career program
- An additional 180 hours of direct clinical experience in the Denver community

Ψ Bachelor of Arts, Psychology 1995
- University of Northern Colorado, Greeley, Colorado

Professional Memberships, Certifications, Etc.

- National Certification Commission for Acupuncture & Oriental Medicine (NCCAOM), Diplomate in Acupuncture
- Colorado Department of Regulatory Agencies, Licensed Acupuncturist
- Council of Colleges of Acupuncture & Oriental Medicine, Clean Needle Technique Certification
- Acupuncture Association of Colorado, Former Board Member

note: None of the above licenses or certifications have ever been suspended or revoked at any time.

By signing below, I acknowledge that I have read and understand the information contained in this document.

Patient's Signature _____ Date: _____

* Fees reflect payment received on the same day services are rendered

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Financial Services Agreement

Our goal is to provide you with financial information related to your services in our office on your date of service. **PLEASE NOTE:** It is the patient's responsibility to understand their individual insurance benefits.

Insurance Patients:

Three Pillars Acupuncture is happy to file insurance claims as a courtesy to you and we will collect any and all applicable co-payments at the time of service. It is your responsibility to see that the claims are paid. As stated by your insurance company, **"Verification of benefits are not a guarantee of payment."** If you have insurance and we file a claim with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 90 days.

Three Pillars Acupuncture utilizes an outside billing company for precise billing practices. When submitting a claim for services, we will send procedural codes to the insurance company. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore, any amounts applied to your deductible must be paid in full.

By signing this financial agreement:

1. You are authorizing Three Pillars Acupuncture and its employees and contracted billing company to release any necessary information related to a visit to your insurance company for the purpose of claim payment. You are giving authorization to submit your claims without obtaining your signature on each and every claim submitted.
2. You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to Three Pillars Acupuncture.
3. You are giving Three Pillars Acupuncture and its contracted billing company the right to speak to your insurance company, any third-party insurance company, and/or your attorney regarding your claims and bills.
4. You agree that a photocopy of any document is as valid and effective as the original.

If you prefer that we do not file insurance claims for you, you may pay the time-of-service discounted rate and file your own claim with your insurance carrier. If you choose to submit your own claims, we will provide you with a super bill, but cannot assist you in filing your claims.

Self-Pay Patients:

If you do not have insurance or our services are not covered by your insurance company, you will be considered a "self-pay" patient. Payments for services are due at the time of service. Any discounts or family plans will be applied at time of service and cannot be back-dated.

Financial Services Agreement cont.

Cancellation Policy:

In order to provide you with the best care, please arrive promptly for your scheduled appointment. Late arrival may result in forfeiture and cancellation of the appointment. We require 24 hours' notice of the cancellation or you may be charged a late cancellation fee of $50. Please remember that failure to appear for your appointment prevents others from receiving care.

Collection Activity:

Any account balance(s) that are not paid within 90 days from the date of service may be forwarded to our collection agency. If deemed necessary, Three Pillars Acupuncture reserves the right to forward the account to our collection agency. Any and all contact information including phone numbers, addresses, and emails will be forwarded to the collection agency in regards to any outstanding collection of balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs associated with collection, including, but not limited to, collection fee (up to, but no more than 25% of the outstanding amount owed), attorney's fees plus court costs, and monthly interest at the rate of 18%.

If you have any questions regarding this agreement, please inquire prior to your appointment.

_____

Patient's Name (please print)

_____ _____

Responsible Party or Authorized Person Signature Date

_____ _____

Provider Signature Date

Medical Insurance Billing: A Primer

Dealing with insurance can be a complicated and confusing process. This information is meant to clear up any questions you may have when billing your insurance. This process takes a few steps:

1. We will copy your insurance card and verify your benefits. We will find out if there is a deductible that you must meet before your insurance company will release benefits and if it has been satisfied. We will also find out if you need to pay a copay at the time of service.
2. Once you have been qualified for acupuncture services, our contracted external billing company will file a claim for service with your insurance company on your behalf. Specific legal medical codes designated to the services you receive are used, of which each has an assigned amount of time and a fee. We must abide by these codes and they cannot be changed. The codes dictate the overall price at which the insurance company is charged.
3. Once the insurance company receives the claim for service, they process the claim and either release payment, request additional information, or deny the claim. This information and their decision will be made available to you via mail and come in the form of an **Explanation of Benefits** (EOB). This process usually takes about 1-3 months.
4. If your EOB states that your insurance will cover a percentage of the charges, you will be responsible for paying the difference. This is called co-insurance and is similar, in effect, to a copay.

Your understanding of this process is critical to the working relationship of provider and patient. Thank you for taking the time to read this letter and please inquire if you have any additional questions.

Please retain this copy for your records.

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Notice of Privacy Practices

Roaring Fork Acupuncture & Massage, Inc., (RFAM, Inc.) dba Three Pillars Acupuncture will responsibly use your individually identifiable health information (referred to as "confidential information"). This includes information that is created or received by a health care provider, health plan, or your employer (in the case of Workman's Compensation). It also includes information related to your past, present and future physical and mental health, and payment for the provision of your health care.

RFAM, Inc., may use and/or disclose your confidential information without your authorization for the following purposes:

- Providing treatment, payment, or health care operations.
  - Billing, and getting authorization for treatment from insurance companies and Workman's Compensation.
  - Providing appointment reminders or information about treatment alternatives, other health related benefits, and services.
  - RFAM, Inc., may also use/and or disclose your confidential information without your authorization as permitted or required by law, (i.e. to a public health authority or to the FDA, or for work related illness or injuries, or to the sponsor of a group's health plan, health insurance issuer, or HMO).

Your authorization is required for RFAM, Inc., to release your confidential information to other health care providers or have other individuals receive information about you. You may revoke that authorization in writing at any time.

You have the right to:

- Request an alternate address or method of contacting you.
- Inspect and copy your confidential information.
- Request restrictions on certain uses or disclosures; however, these restrictions are subject to agreement by RFAM, Inc.
- Receive an accounting of the disclosures RFAM, Inc., makes involving your confidential information.
- Amend your confidential information (in limited situations).

RFAM, Inc., will maintain the privacy of confidential information as required by law and by the notice currently in effect. RFAM, Inc., is also required by law to provide this notice of legal duties and privacy practices related to protected health information. This notice is effective April 14, 2003. RFAM, Inc., also reserves the right to make changes or revisions to the terms of this notice, and will make available at the office a new notice if any material changes are made.

If you believe that your rights have been violated, you may contact RFAM, Inc., or the director of the Colorado Department of Human Services. You will not be penalized for filing a complaint. You may send information to either party at the appropriate addresses listed below:

Roaring Fork Acupuncture & Massage, Inc.
6857 S. Hill St.
Littleton, CO 80120

Colorado Department of Human Services
1575 Sherman St.
Denver, CO 80203-1714

By signing below, I certify that I have read this notice and understand my rights in regards to the handling of my confidential information.

Patient's Signature _____ Date: _____

Client Information

Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but the answers affect your diagnosis and treatment. All information is confidential.

First Name _____ Last Name _____ Date _____

Gender: ☐ M ☐ F

Date of Birth _____ Age _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Address _____

City _____ State _____ Zip Code _____

Home Phone _____Work Phone _____ Cell Phone _____

Email _____

Place of Employment _____ Occupation _____

How did you hear about us? (Please circle): Internet Website Print Ad Radio

Friend or Family (Name) _____

Other _____

Major complaints, in order of importance to you:

#1 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#2 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

#3 _____ Severe _____ Moderate _____ Slight _____

Describe your symptoms _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

Treatments you have received for this condition? _____

Do you feel better since the onset of this condition? _____

Please rate your commitment to feeling better (On a scale of 1 to 10): _____

Please list any concerns you may have regarding Chinese Medicine: _____

_____

Personal Medical Health History

Please indicate those that are current health problems for you with a **"C"** and a **"P"** for past problems. Leave blank all those that do not apply.	
AIDS/HIV	
Alcohol	
Anxiety	
Arthritis	
Asthma/Hay Fever/Allergy	
Back issues	
Bursitis	
Cancer	
Constipation	
Depression	
Diabetes	
Digestive Trouble	
Headaches	
Heart Trouble	
Hepatitis	
High Blood Pressure	
Immune Disorder	
Insomnia	
Kidney issues	
Liver issues	
Migraine	
Neck Pain	
Thyroid Disorder	
Tobacco	
Weight Problem	
Other Emotional Problem: _____	
Other: _____	

Please list conditions and surgeries you have had, along with the year diagnosed:

Year	Condition/Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all prescription medication you take, including those you use occasionally such as inhalers, nose sprays, eye drops, etc.

Medication/Dose	Purpose	Length of Time	Last Dose

Please list all supplements you take including vitamins:

Supplement/Dose	Purpose	Length of Time	Last Dose

Please list any allergies (seasonal, environmental, medication, food, etc.):

_____

_____

_____

_____

Please list any occupational concern (stress, computer work, lifting, etc.):

_____

_____

Please tell us about your exercise (regular, minimal, type, etc.):

_____

_____

Symptom Index

Note: For each symptom you currently have, rate its severity on a scale from 1 – 5
(1 being of the least severity and 5 being of the worst severity)
Leave blank if Not Applicable

_____ Irritability / Anger
_____ Depression / Stress
_____ Headache / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Blurred Vision
_____ Dizziness
_____ Gall Stones
_____ Feeling of Lump in the Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping/Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

_____ Urinary/ Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decreased Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Crave / Avoid Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

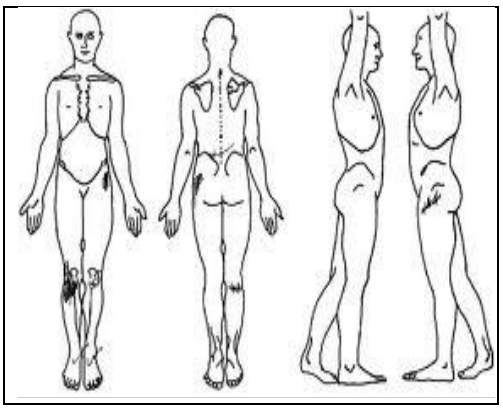
_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infections/Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

ENERGY LEVEL: (Please circle)
Low 1 2 3 4 5 6 7 8 9 10 High

_____ Heaviness in the body
_____ Fatigue / Worse after eating
_____ Hard to get up in the am
_____ Edema (Swelling)
_____ Muscles feel tired often
_____ Easily Bruising or Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Craves Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Fog

_____ Cold Entire Body
_____ Cold Extremities
_____ Hot All Day
_____ Hot Only in Afternoons
_____ Hot Only at Night
_____ Normal Body Temp



Musculoskeletal (Please list areas where you have problems, if any):

Muscle Cramps? _____Tendonitis? _____
Muscle Pain? _____Arthritis? _____
Joint Swelling? _____Bursitis? _____

Please indicate problem areas on diagram at left.

////////// = Tightness
^^^^^^ = Sharp pain
vvvvv = Dull, achy pain
+++++ = Burning pain
xxxxx = Fixed pain
>>>> = Stabbing pain

Personal Information

For Women Only

Have you had a hysterectomy? ☐ Yes ☐ No
Ovaries removed? ☐ Yes ☐ No
Post-menopausal bleeding? ☐ Yes ☐ No
Could you be pregnant now? ☐ Yes ☐ No

Number of: Pregnancies _____ Births _____
Miscarriages_____ Abortions _____

When did your last period end? _____

Number of days in your monthly cycle? _____

Number of days bleeding lasts? _____

Describe your menstrual flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of menstrual flow:
☐ Dark ☐ Bright Red ☐ Slightly Red

Birth Control:
☐ None ☐ Birth Control Pills ☐ IUD
☐ Spermicides ☐ Barriers ☐ Other _____

Do you suffer from:
Cramping? ☐ Yes ☐ No
☐ Before period ☐ During period ☐ After period
☐ Mild ☐ Moderate ☐ Severe

Clotting? ☐ Yes ☐ No
☐ Bright in color ☐ Dark in color

Do you suffer from any of the following:
☐ Bleeding between periods ☐ Infertility
☐ Pelvic Inflammatory Disease ☐ Ovarian Cysts
☐ Endometriosis ☐ Hot Flashes ☐ Mastitis
☐ Breast Cysts ☐ Yeast Infections/Vaginitis
☐ Other _____

Premenstrual Syndrome Symptoms:
☐ Fluid Retention ☐ Breast Tenderness
☐ Cravings ☐ Irritability ☐ Depression
☐ Fluctuating Emotions ☐ Fatigue

For Men Only

☐ Impotence ☐ Testicular Pain/Lump
☐ Weak Erection ☐ Discharge from Penis
☐ Infertility ☐ Prostate Problems
☐ Low Sex Drive ☐ Premature Ejaculation

For Women and Men

Diet Information

Please describe your appetite:
☐ Strong ☐ Normal ☐ Poor
Do you hunger quickly? ☐ Yes ☐ No
Please describe your diet (low-fat, low-carb, vegetarian, etc.):_____
_____
_____

Please list what you ate yesterday:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____

Please describe your thirst:
☐ Strong ☐ Normal ☐ Poor
Do you have a preference for warm or cool drinks?
☐ Warm ☐ Cool ☐ Room Temperature ☐ None
How much water do you drink a day? _____
_____
Other Fluids? _____

If you eat any of the following, please check and list how much per week:
☐ Candy/Chocolate _____
☐ Cookies/Baked Goods _____
☐ White Bread/Flour _____
☐ Soda – Regular/Diet _____
☐ Milk _____
☐ Cheese _____
☐ Ice Cream _____
☐ Yogurt _____
☐ Eggs _____
☐ Pasta _____
☐ Coffee _____
☐ Alcohol _____
☐ Fast Food _____
☐ Protein _____
☐ Dark Green Vegetables _____
☐ Fruit _____
☐ Other _____