Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other ______________________			
Cardholder Name (as shown on card): ______________________				
Card Number: ______________________ CVV_____				
Expiration Date (mm/yy): ______________________				
Cardholder ZIP Code (from credit card billing address): ______________________				

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE
Clark Mollenhoff takes pride in the quality of care he offers his patients. In order to do this he has a strict cancellation policy. Mollenhoff Acupuncture requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the credit card we have on file.

I, ______________________ authorize Mollenhoff Acupuncture to charge the credit card on file for payment, late cancellation fees, insurance co-payments and other related and agreed upon charges.

______________________ ______________________
Customer Signature Date

Mollenhoff Acupuncture

Clark Mollenhoff M.Ac., L.Ac.
www.mollenhoffacupuncture.com
240-481-7692

Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name ______________________________ Gender ❏ M ❏ F Date ______________

Address ______________________ City ______________ State ________ Zip ______________

Email ____

Phone: ❏ Home ______________ ❏ Work ______________ ❏ Cell ______________
(please indicate preferred contact number)

Occupation ______________________ Employer ______________________

Date of Birth ______________ Age ____________ Height ____________ Weight ____________

❏ Single ❏ Married ❏ Partnered ❏ Widowed ❏ Separated/Divorced

Emergency contact ______________________________ Relation ______________

Emergency contact number: Home ______________________ Cell ______________

Name of physician ______________________________ Phone number ______________
(No contact will be made without your permission)

Insurance companies accepted are the as follows: Blue Cross, United, and Cigna. If you have already sent me your insurance information you can leave the insurance section blank.

PRIMARY INSURANCE Insurance Phone Number (back of the card)______________________

Name of Insurance Co. ID#. Group#
____

Name of Insured Relationship to Patient: Self ☐ Spouse☐ Parent ☐
____

Secondary Insurance Name of Insured
____

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

____
Patient Name (print) Patient Signature Date

GOALS — What health concerns would you like to address through treatment

____

____

____

____

LIFESTYLE HABITS

Alcohol (drinks per week) ____________ Coffee/Tea (cups per day) ____________ Soda (regular or diet) ____________

Cigarettes (packs per day) ____________ Drug use (recreational) ____________

Exercise ❏ Yes ❏ No How often? ____________

What kind of exercise? ____________

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

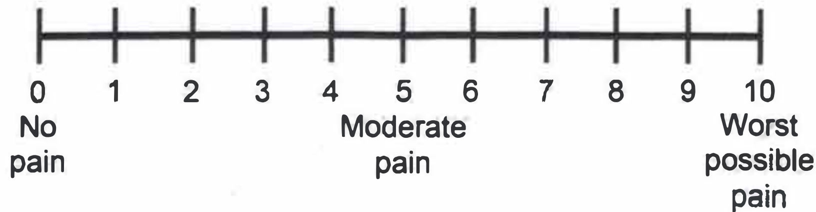
Medications	Dosage	For what condition?

Vitamins & Supplements	Dosage	For what condition?

PRIMARY COMPLAINT

0–10 Numeric Pain Rating Scale

Please indicate on the scale below the level of pain that you are experiencing today.

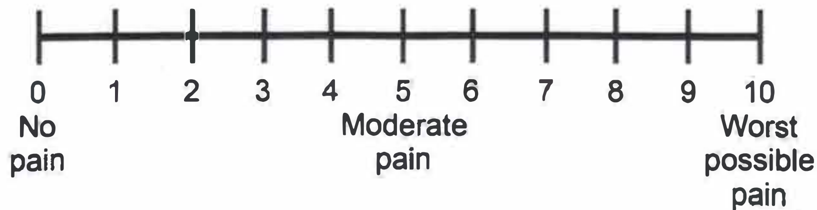


SECONDARY COMPLAINT

(If Applicable)

0–10 Numeric Pain Rating Scale

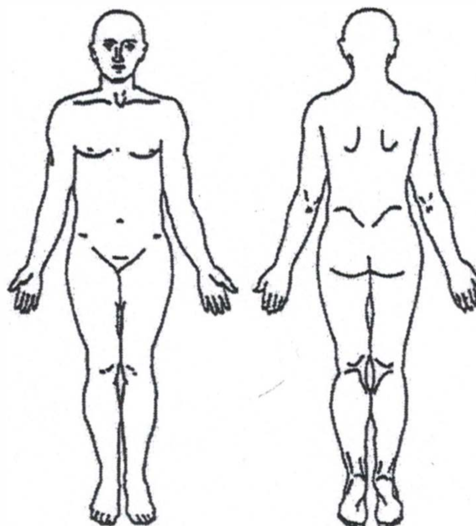
Please indicate on the scale below the level of pain that you are experiencing today.



Where is Your Pain?

Please mark on the drawings below, the areas where you feel pain.

"S"-Sharp/Stabbing "B"-Burning "D"-Dull "T"-Tingling "P"-Pain (General)



CONDITIONS/SYMPTOMS — Please mark any condition you have experienced in the past or currently.

Temperature (Kidney)

past	current	
❑	❑	Cold hands
❑	❑	Cold fingers
❑	❑	Cold feet
❑	❑	Cold toes
❑	❑	Sweaty hands
❑	❑	Sweaty feet
❑	❑	Hot overall
❑	❑	Cold overall
❑	❑	Afternoon flushes
❑	❑	Night sweats
❑	❑	Heat in the hands, feet, and chest
❑	❑	Hot flashes
❑	❑	Thirsty
❑	❑	Perspire easily
❑	❑	Lack of perspiration
❑	❑	Take water to bed

Energy (Lung/Kidney)

past	current	
❑	❑	Shortness of breath
❑	❑	Difficulty keeping eyes open during day
❑	❑	General weakness
❑	❑	Easily catch colds
❑	❑	Low energy
❑	❑	Feel worse after exercise

Blood (Liver/Spleen/Heart)

past	current	
❑	❑	Dizziness
❑	❑	See floating black spots

Heart Function

past	current	
❑	❑	Palpitations
❑	❑	Anxiety
❑	❑	Sores on the tip of the tongue
❑	❑	Restlessness
❑	❑	Mental confusion
❑	❑	Chest pain traveling to shoulder
❑	❑	Pacemaker
❑	❑	Frequent dreams
❑	❑	Wake unrefreshed

Lung Function

past	current	
❑	❑	Nasal discharge, color: ________________
❑	❑	Cough
❑	❑	Nose bleeds
❑	❑	Sinus Congestion
❑	❑	Dry mouth
❑	❑	Dry throat
❑	❑	Dry nose
❑	❑	Dry skin
❑	❑	Respiratory allergies, to what? ______________
❑	❑	Alternating chills & fever
❑	❑	Sneezing
❑	❑	Headache, location: ______________
❑	❑	Overall achy feeling
❑	❑	Stiff neck
❑	❑	Stiff shoulders
❑	❑	Sore throat
❑	❑	Difficulty breathing
❑	❑	Sadness
❑	❑	Melancholy

Spleen Function

past	current	
❑	❑	Low appetite
❑	❑	Abrupt weight gain
❑	❑	Abrupt weight loss
❑	❑	Abdominal bloating
❑	❑	Abdominal gas
❑	❑	Gurgling In stomach
❑	❑	Fatigue after eating
❑	❑	Prolapsed organs (diagnosed): ___________
❑	❑	Easily bruised
❑	❑	Hemorrhoids
❑	❑	Pensive
❑	❑	Over-thinking
❑	❑	Worry

Spleen, Stomach, Large Intestine Function

past	current	
❑	❑	Loose stool
❑	❑	Constipated
❑	❑	Incomplete evacuation
❑	❑	Diarrhea
❑	❑	Blood In stools
❑	❑	Mucous In stools
❑	❑	Undigested food in stools

Dampness

past	current	
❑	❑	General sensation of heaviness
❑	❑	Mental heaviness
❑	❑	Mental sluggishness
❑	❑	Mental fogginess
❑	❑	Swollen hands
❑	❑	Swollen feet
❑	❑	Swollen joints
❑	❑	Chest congestion
❑	❑	Nausea
❑	❑	Snoring

Stomach Function

past	current	
❑	❑	Burning sensation after eating
❑	❑	Large appetite
❑	❑	Bad breath
❑	❑	Mouth (canker) sores
❑	❑	Bleeding, swollen or painful gums
❑	❑	Heartburn
❑	❑	Acid regurgitation
❑	❑	Ulcer (diagnosed)
❑	❑	Belching
❑	❑	Hiccups
❑	❑	Stomach pain
❑	❑	Vomiting

Eyes (Liver Function)

past	current	
❑	❑	Itchy
❑	❑	Bloodshot
❑	❑	Hot
❑	❑	Dry
❑	❑	Watery
❑	❑	Gritty
❑	❑	Blurry vision
❑	❑	Decreased night vision
❑	❑	Near-sighted
❑	❑	Far-sighted

Liver/Gall Bladder Function

past current

- ❑ ❑ Alternation diarrhea & constipation
- ❑ ❑ Chest pain
- ❑ ❑ Tight sensation in chest
- ❑ ❑ Bitter taste In mouth
- ❑ ❑ Anger easily
- ❑ ❑ Frustration
- ❑ ❑ Depression
- ❑ ❑ Irritability
- ❑ ❑ Frequently unable to adapt to stress; cause of stress: ____________________
- ❑ ❑ Skin rashes
- ❑ ❑ Headache: at top of head
- ❑ ❑ Tingling sensation
- ❑ ❑ Numbness
- ❑ ❑ Muscle spasms
- ❑ ❑ Muscle twitching
- ❑ ❑ Muscle cramping
- ❑ ❑ Seizures
- ❑ ❑ Convulsions
- ❑ ❑ Lump in throat
- ❑ ❑ Neck tension
- ❑ ❑ Neck: limited range-of-motion
- ❑ ❑ Shoulder tension
- ❑ ❑ Shoulder: limited range-of-motion
- ❑ ❑ High-pitched ringing in ears
- ❑ ❑ Gall stones
- ❑ ❑ Sexually transmitted disease (s); specify: ____________________

Kidney/Urinary Bladder Function

past current

- ❑ ❑ Frequent cavities
- ❑ ❑ Easily broken bones
- ❑ ❑ Sore knees
- ❑ ❑ Weak knees
- ❑ ❑ Cold sensation in knees
- ❑ ❑ Low back pain
- ❑ ❑ Memory problems
- ❑ ❑ Wake frequently to urinate
- ❑ ❑ Low-pitched ringing in ears
- ❑ ❑ Kidney stones
- ❑ ❑ Bladder infections
- ❑ ❑ Lack of bladder control
- ❑ ❑ Fear
- ❑ ❑ Easily startled
- ❑ ❑ Excessive hair loss

Urination

past current

- ❑ ❑ Normal color
- ❑ ❑ Dark yellow
- ❑ ❑ Clear
- ❑ ❑ Reddish
- ❑ ❑ Cloudy
- ❑ ❑ Scanty
- ❑ ❑ Profuse
- ❑ ❑ Strong odor
- ❑ ❑ Blood
- ❑ ❑ Painful
- ❑ ❑ Discharge
- ❑ ❑ Difficult
- ❑ ❑ Urgent
- ❑ ❑ Frequent

Male — Genital

past current

- ❑ ❑ Impotence
- ❑ ❑ Premature ejaculation
- ❑ ❑ Nocturnal emission
- ❑ ❑ Pain/itching of genitalia
- ❑ ❑ Lumps in testicles
- ❑ ❑ Increased libido
- ❑ ❑ Decreased libido
- ❑ ❑ Other (describe) ____________________

Women — Gynecology

past current

- ❑ ❑ Menopause
- ❑ ❑ Irregular periods
- ❑ ❑ Menstrual cramps
- ❑ ❑ Excessive blood flow
- ❑ ❑ Menstrual blood clots
- ❑ ❑ Abnormal pap smear
- ❑ ❑ Vaginal infections
- ❑ ❑ Vaginal pain/itching
- ❑ ❑ Uterine fibroids
- ❑ ❑ Endometriosis
- ❑ ❑ Breast tenderness
- ❑ ❑ Breast lumps, cysts
- ❑ ❑ Increased libido
- ❑ ❑ Decreased libido
- ❑ ❑ Other (describe) ____________________

Currently pregnant: trimester ________

Past pregnancies:

# of live births: ______________

# of miscarriages ______________

# of abortions ______________

Other Information

____

____

____

____

____

____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: CLARK MOLLENHOFF M.Ac., L.Ac. Mollenhoff Acupuncture

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE