Ni's Chinese Medical Center

Patient Information Sheet

Important: Complete all information as thoroughly as possible. Please print clearly **CONFIDENTIAL**

Date	Full Name			Nickname:	
Date of birth: _____/_____/_____	Age	Gender M F	Status: Single Married Widowed Minor Student		
Address			City	State	Zip
Daytime Phone # (home, work, cell - circle one)			Alternate Phone # (home, work, cell - circle one)		
Emergency Contact & Relationship			Phone Numbers of Emergency Contact Primary ( ) Alternate ( )		
Height_____	Weight_____		Language spoken at home:_____		

Reason for visit today: (be specific but brief, ie. headache, back pain,…)

_____

_____

_____

FEMALES:	**(Circle any that apply to your menstrual cycle)**		
Last Period _____		Menstrual Pain	Low backache
Irregular	Painful breast	Heavy bleeding	Pregnant
Water retention	Clotting	Hot flashes	Mood changes

How did you hear about us? Internet, Yellow Pages, Newspaper, Friend, Patient (Please give name)
Other: Name internet site:

Cancellation/Missed Appointment Policy - I acknowledge that I will give at least 24 hours notice of cancellation to avoid a charge for the appointment. This is a courtesy to other patients who need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initial _____

If you will be filing a claim with your health insurance, ask the Front Desk Receptionist to include diagnosis codes on your receipt. Services rendered are to the patient, not to the insurance company. The insurance company is responsible to the patient, the patient is responsible to Bo-Shih Ni, C.A., P.A. d/b/a Ni's Chinese Medical Center.

We provide 24 hour courtesy reminder calls for all upcoming patient appointments. We are asking permission to leave a message on an answering machine or with anyone who answers the phone at the phone # you provide.
Initial here to give your consent _____ Phone #_____

Bo-Shih Ni, C.A., P.A., d/b/a Ni's Chinese Medical Center reserves the right to change pricing at any time.

Bo-Shih Ni is a Board Licensed Acupuncturist in the state of Florida. He received his acupuncture & herbal education in Taipei, Taiwan and has a PhD in Oriental Medicine. He has 30+ years experience in this field of medicine with no disciplinary actions.
Yang-Fen Sun is a Board Licensed Acupuncturist in the state of Florida. She received her acupuncture & herbal education in Orlando, FL. She has 6 years experience in this field of medicine with no disciplinary actions.

Patient/Guardian Signature: _____ Date: _____

Payment must be made in full when service is rendered.

M/C, Visa, Discover, or Cash accepted (PHOTO ID NEEDED)

There will be a $35 fee charged for all returned checks. Checks will no longer be accepted from that patient.

Do you have a Legal Guardian? Yes_____ or No_____
Name of Guardian: _____ Phone: _____
The person who is given Power of Attorney over the patient, must sign these documents, be present at all appointments, and must provide a copy of the Power of Attorney.

3/2022

Ni's Chinese Medical Center

1250 W. Eau Gallie Blvd., Ste L, Melbourne, FL 32935 www.drboni.com

Phone: (321) 757-9731 Email: office.drboni@gmail.com

MEDICAL HISTORY

Have you had acupuncture before? Yes No

Chinese herbal medicine? Yes No

How long have you had your current symptoms? _____

Are you under the care of a physician now? Yes No

If yes, for what? _____

Physician name:

Physician's phone:

Family Medical History (circle any that apply)

Allergies: (list) _____ _____

Asthma
Alcoholism
Depression

Cancer (type) _____

Diabetes (Type:)

Heart Disease
High Blood Pressure
Stroke

Your Medical History

(circle any of the following conditions you currently have, or have had in the past.

AIDs/HIV
Alcoholism
Allergies
Appendicitis
Arteriosclerosis
Asthma
Birth Trauma
(your own birth)
Cancer
Chicken pox
Diabetes (Type:)
Emphysema
Epilepsy
Goiter
Gout
Heart disease
Hepatitis (Type:)
Herpes (Type:)
High Blood Pressure
Measles
Multiple Sclerosis
Mumps
Pacemaker (Date:)
Pneumonia
Polio
Rheumatic fever
Scarlet fever
Seizures
Stroke
Surgery (List)
_____
_____
_____
Thyroid disorders
Major trauma
(car accident, fall,...-list)
_____
_____
_____

Your Diet (circle all that apply)

Appetite: Low Normal High

Coffee/Tea
Soft Drinks/Fruit Juices
Artificial Sweateners

Sugar
Protein Intake: Low High

Thirst for fluids
glasses per day: _____

Average Daily Menu

Morning	Noon	Evening	Snack

Current Medications/Supplements

(Please list all prescription medications and vitamins/supplements that you are currently taking)

Your Lifestyle

Alcohol
Tobacco
Marijuana
Drugs

Regular Exercise

Type: _____ Frequency: _____

Type: _____ Frequency: _____

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INFORMED CONSENT FOR TREATMENT

PLEASE READ BEFORE SIGNING

I hereby request and consent to be treated with Chinese herbal medicine by a physician who is a Licensed and Board Certified Acupuncturist in the state of Florida. If I wish to decline any form of treatment recommended by the physician, I have the right to so.

I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleas effects associated with the consumption of the herbs.

I accept the fact that **no guarantee** is made concerning the outcome of my treatments with herbal medicine.
I accept the fact that each combination of herbs is designed for my needs and my needs only, ***and therefore I cannot receive a refund on any herbs or any services rendered.*** I also understand that I may stop treatment at any time.

I have the right to refuse treatment; however, I must communicate this to the clinical staff **before** any herbal prescription has be filled for me; otherwise I will be obligated to pay for the herbs prescribed.

I will notify the physician if I am or become pregnant.

By signing below I show that I have read, or have had read to me, this consent to treatment, and have had an opportunit 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.

Patient's Name _____

Patient's Signature _____ Date Signed _____

To be completed by the patient's Guardian if the patient is a minor or is physically or legally incapacitated.
The person who is given Power of Attorney over the patient, must sign these documents, be present at all appointments and must provide a copy of the Power of Attorney.

Print Name of Patient Guardian_____

Signature of Patient Guardian_____

Relationship or Authority of Patient_____

Payment must be made in full when service is rendered.

We accept Cash, Mastercard, Visa, and Discover

3/2022

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HIPPA NOTICE OF PRIVACY PRACTICES

Bo-Shih Ni, C.A., P.A. is required by law to maintain the privacy of your **Protected Health Information (PHI)**. This Notice of Privacy Practices tells you how your PHI may be used and disclosed and how you can access this information. Please review it carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPAA," it is our legal duty to safeguard your PHI. Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office. You may also request a copy of this Notice from us, or you can view a copy of it in our office. This Notice will remain in effect until it is replaced or amended.

During the course of our relationship with you, your PHI may be used or disclosed for treatment, payment, and healthcare operations within our office. You may specifically authorize us to use your PHI for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI. This authorization will have an expiration date that can be revoked by you in writing.

Marketing
This office will not use or disclose your PHI for marketing communications without your written authorization. This office may send greeting cards, notice of clinic events, newsletters, and/or appointment reminders.

Disclosure
This office may use or disclose your PHI without your consent or authorization when required by law.

Patient Rights
1. Upon written request, you have the right to review and receive copies of your PHI.
2. Upon written request, you have the right to receive a list of disclosures about your PHI.
3. You have the right to request additional restrictions on the use and disclosure of your PHI, as permitted by law.
4. You have the right to receive all notices in writing.
5. Upon written request, and as permitted by law, you have the right to request that we amend your PHI.

If you have questions about this Notice or any complaints about our privacy practices, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201.

This Notice went into effect on April 14, 2003.

I acknowledge the use of my PHI within this office and my rights.

Signature of patient or patient's Guardian Date

Printed name of patient or patient's Guardian Relationship to Patient

OFFICE USE ONLY

I attemped to obtain the patient's signature on this HIPPA Notice of Privacy Practices, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

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Corporate Office Phone: (321) 757-9731 Email: office.drboni@gmail.com

FEES

INITIAL (NEW PATIENT) PHONE/SKYPE CONSULT	$90
FOLLOWUP PHONE/SKYPE CONSULT	$40

HERBS ARE AN ADDITIONAL COST. PRICES VARY AND WILL BE GIVEN TO YOU BEFORE THE RX IS FILLED. HERBS RANGE FROM $30-$300/WEEK. CREDIT CARD PAYMENT MUST BE MADE BEFORE HERBS ARE SHIPPED. SHIPPING & HANDLING CHARGES ARE BASED UPON WEIGHT OF SHIPMENT AND ARE NOT INCLUDED IN THE PRICE OF HERBS.
THERE ARE NO REFUNDS ON HERBS.

NI'S CHINESE MEDICAL CENTER RESERVES THE RIGHT TO REVISE THEIR FEES AT ANY TIME.

PLEASE SEND A PHOTO ID ALONG WITH YOUR FORMS.

Patient Signature

3/2022

BO-SHIH NI C.A., P.A.
NI'S CHINESE MEDICAL CENTER
MEDICAL PAYMENTS

PRE-AUTHORIZATION FORM

I authorize Bo-Shih Ni, C.A., P.A. to keep my signature on file and to charge my credit card account as indicated below for each recurring treatment.

Check one: ☐ Discover ☐ Mastercard ☐ Visa

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Street Address

_____
City State Zip

_____
Card Number

_____ _____
Expiration Date 3-digit CSC

_____
Cardholder Signature Date

PHOTO ID MUST ACCOMPANY THIS FORM.

Please return this form to the office you are currently communicating with via mail, email, or fax:

Mail: 1250 W. Eau Gallie Blvd., Ste L, Melbourne, FL 32935
Email - office.drboni@gmail.com
Fax: (321) 757-5069

3/2020

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SKYPE/VIDEO/PHONE AGREEMENT & CONSENT

It is important that you understand the following limitations of Skype/video/phone contact, as well as expectations in using it for your consultations.

1. Any internet-based communication is not guaranteed to be secure/confidential. I agree that Dr. Bo-Shih Ni and Ni's Chinese Medical Center should not be held responsible in the event that any outside party passes Skype's security and discovers personal or confidential information.
2. There are precautions that you can take to increase security including:
    a. Ensuring that you are online in a private area.
    b. If possible, connect to the internet directly (as opposed to using Wi-Fi).
    c. Make sure to turn Skype off, not just disconnect from the call when the session is over.
3. Make the same commitment to your online session that you would to an in-office appointment.
    a. Don't be late. A courtesy reminder call will be made to you the day before.
    b. Limit distractions – turn off cell phone, explain to others that you are unavailable for the next 10-15 minutes.
    c. Check the audio/visual in the 'preferences' each time before a session so that you can see what Dr. Ni is seei (and vice versa).
    d. For Skype consultations, send a friend request to hantangni so Dr. Ni can accept and be prepared to make the Skype call as scheduled.
4. A Skype or phone session is subject to a 24-hour cancellation policy. You will be billed at full rate if you miss an appointment or you cancel without providing at least 24 hour notice.
5. Payment for each session is to be made prior to the scheduled session. When you schedule your appointment, the receptionist will request a credit card # to put on file to use for each session. MasterCard, Visa, and Discover are accepted. Health Insurance will not cover online/phone consultations. Your consultation will be charged to your cred card the day your appointment reminder call is made.
6. Before a session can begin, it is necessary to complete and fax, email or mail the Skype/video/phone Agreement & Consent form.
    Melbourne – 1250 W. Eau Gallie Blvd., Ste L, Melbourne, FL 32935 * Fax-321-757-5069
    Email – office.drboni@gmail.com
7. Skype isn't right for everyone. Dr. Ni prefers to have patients, with severe internal disease, physically visit the offic at least twice before conducting Skype/video/phone consultations. If you are experiencing an emergency, call 911 for help.

My signature below indicates that I have read the Skype, video & phone agreement and consent for Dr. Ni to conduct my health consultations via this form of media. I understand and agree to comply with the policies as they are described and acknowledge receipt of this agreement. I also understand that there is no guarantee on the outcome of m treatment using this form of consultation.

Patient Signature and Date

Skype Name or Phone #

3/2020