Healing Roots, LLC
Acupuncture Herbs & Massage

Patient Policies and Billing

Name:______________________________Date of Birth:_______Social Security #:_________

Address:________________________________City:____________State:__Zip:________

Home #:_________________Work #:__________________Cell #:___________________

Email:______________________Occupation/Employer:______________________________

Primary Care Provider:_________________________________#:____________________

Emergency Contact Person:______________________________#:____________________

Please indicate your preferred method(s) of contact for appointment scheduling and rescheduling:
Phone call ( ) Text ( ) Email ( )

Cancellation Policy

****In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked. ****

( ) Cash Patient: I agree to keep my account current by paying at the time of services rendered.

( ) Insurance Patient: I agree to keep my account current and have provided authentic and current coverage information and consent to the billing practices of this office.

( ) PIP / LNI Patient: I agree to keep my account current and have provided authentic and current coverage and authorization information and consent to the billing practices of this office.

****Please let us know if at ANY time you have an open PIP or LNI claim****

Private Insurance Patients

For private insurance billing, please complete the insurance verification form and provide the following information:

Primary Insurance Company::______________________________Phone #:________________

Address:_______________________________City:____________State:__Zip:__________

Policy/ID/Member #:________________________Group/Plan #:________________________

Plan/Program Name:_______________________Name of Insured:_______________________

Insured's Address:____________________________City:_____________State:__Zip:_____

Insured's Phone:____________________Insured's SS#:________________Insured's DOB:______

Insured's Gender:______Insured's Employer:________________Your Relationship to Insured:_________ _Secondary

Insurance Coverage Information:____

PIP Patients:

Please Provide the Following Information IN ADDITION TO the Private Insurance Information:

PIP/Auto Accident Claim #:____________________PIP Insurance Co:_____________________

Date of Accident:_________Claims Adjuster:___________________Phone #:______________

Address for Claims:___________________________City:___________State:__Zip:______

LNI Patients:

Please Provide the Following Information IN ADDITION TO Private Insurance Info:

LNI Claim Number:________________________Employer:___________________________

Date of Injury:__________Claims Adjuster:___________________Phone #:_______________

Is your LNI Claim Department of Labor and Industries or a Self-Insured Claim?_____________________

Billing Address (Self-Insured Claims Only):Attn:____

_______Address:________________________City:______________State:__Zip:_________

Status of Claim (Check One): ( ) OPEN ( ) PENDING ( ) DENIED ( ) CLOSED

Please Carefully Read the Agreements and Sign Below

- I personally accept full financial responsibility for all services rendered to me. I understand that I am financially responsible if my insurance does not cover services rendered, or if I do not provide 24 hours notice when canceling or changing appointments.
- I agree to pay all balances within 30 days of receiving an itemized statement.
- I hereby authorize my insurance company to send payments directly to Rain Delvin, EAMP, MAOM, LMP for services rendered to me.
- I agree to notify the office of Rain Delvin, EAMP, MAOM, LMP in writing if there is any change regarding my coverage or contact information.
- I hereby authorize the release of any medical other information acquired concerning my condition or other disabilities, both to and from Rain Delvin, EAMP, MAOM, LMP which will assist in the payment of any claim on my account.
- I recognize that certain, necessary procedures including Cupping, Moxa, Gua Sha, Herbal and Nutritional Guidance may not be covered by my insurance I hereby agree to pay for those services rendered but not covered by my plan.
- I have received and understand the policies and procedures of this office, including HIPAA Privacy Practices and financial obligations to receiving care. ***We may send you emails or texts regarding your appointments. Please check the following box if you do not wish to receive email or text regarding appointment scheduling.*** **( )**

By signing below, I hereby agree to all of the above agreements, and I request and contract to pay for the services of Rain Delvin, EAMP, MAOM, LMP:

Patient/Guarantor Signature:____________________________Date:__________

Patient Health History

****IMPORTANT: Filling out this form out as thoroughly as possible helps us to determine the best treatment plan for you, and all information you provide is completely CONFIDENTIAL. Please report any health changes, PREGNANCY, changes in insurance, or new PIP or LNI claims to us immediately!****

Name:________________________________Today's date:_______________Cell phone:_________________

Date of Birth:______________Age:_____Height:________Weight:________Gender:_____Marital Status:________

Occupation:________________________How did you find out about Healing Roots?______________________

Have you been treated by Acupuncture, Oriental Medicine, or Massage before?__________________________

When?_______________With whom?______________________For what condition?______________________

Current Health Concerns and Medical History

What is your main goal in seeking treatment?____

Are you looking for help with a chronic condition?____An acute problem?____Preventative Care?____

Which of the available therapies are you seeking: Acupuncture/Oriental Medicine?____Body Work?____

Herbal Medicine?_____Dietary/Lifestyle Counseling?______Other?________________________________

Please list your health concerns (physical, emotional, and psychological) in order of priority:__________________

Concerns	Known Cause	Date of Onset	% of Time	Severity (1 to 10)
1.				
2.				
3.				
4.				

To what extent do these problems interfere with your daily activities?_____________________________________

Are you seeing a Primary Care or other physician for your condition(s)?__________________________________

Dr.'s name and speciality:_____________________________Is this your PCP?____________________________

Dr.'s contact information :____

What is their diagnosis?______________Recommended treatment?_____________________________________

Are you currently using any therapies to remedy your condition?____

____

Please list any medications (prescription or over the counter) and supplements that you are currently taking or have taken during the last two months (Please attach a list if there is not enough space below.) :

Medication/Supplement	Reason for Taking	Dates Taken	Dosage/Frequency
1.			
2.			
3.			
4.			

Do you have any allergies to medications, chemicals, foods, other?______________________________________

Please list all past conditions for which you were hospitalized and/or received surgery (include dates):
These may include, but are not limited to, surgeries, significant trauma, adverse reaction to vaccine or medication, injury, childhood illness, dental work, and occupational stress:

____

____

____

Please indicate if any of the following pertain to you: (indicating "yes" does not make you ineligible for treatment, however, it may restrict some of your treatment modalities):

Cancer	Diabetes	Heart Disease
Hepatitis	HIV	High Blood Pressure
Pacemaker	Seizures	STD's
Pregnancy	Anaphylaxis	Rheumatic Fever
Clotting Disorder	Communicable Disease	Other:

Has anyone in your family suffered from the above conditions or other major illness not mentioned here?
Please indicate which family member and what their condition was: ______________________________________

Gynecological History

Are you currently experiencing any gynecological symptoms or problems?________________________________

How old were you at the onset of first mense?____What was the first day of your last period?________________

Menstrual pattern: Length of cycle?______Length of period?______Predicted ovulation day?_________________

Are you currently trying to conceive?_____________Are you currently pregnant?___________________________

How many pregnancies have you had?____How many births?____Miscarriages?____Abortions?_____________

Are you perimenopausal?______At what age did perimenopause begin?_____Are you on HRT?______________

Do you use birth control?____If yes, what kind and for how long?____

Do you or anyone in your family have a history of cervical, ovarian, or breast cancer?_______________________

Lifestyle and Habits

Do you have a regular exercise program (please describe)?____

Is it rigorous, moderate, or mild?_________Is it daily, weekly, monthly, or irregularly?_________________________

Do you smoke?_______If yes, what?________How much per day?_______Since when?____________________

Do you drink alcohol?______If yes, what?___________How much?______How often?______________________

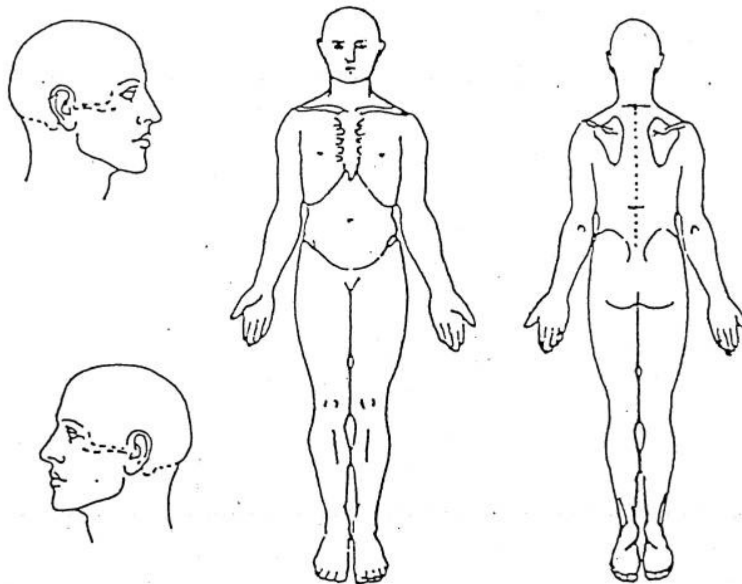
Do you drink caffeine?_______If yes, what?________________How much per day?_________________________

Have you ever been on a restricted diet?____If yes, please describe:____________________________________

Please describe your average daily diet:

Breakfast	Lunch	Dinner	Snacks (time?)

Please indicate painful or distressed areas on the diagram below:



	Pain on Pressure			Swelling			Tension or Weakness			Spontaneous Pain			Pulsing			Temperature			Physical		
Symbol	**x**	**xx**	**xxx**	**)**	**))**	**)))**	**U**		**⋕**	**o**	**oo**	**ooo**	*****	******	*******	**↓**		**↑**	**~**	**R**	**<>**
Reaction	**slight**	**medium**	**severe**	**slight**	**medium**	**severe**	**weak**	**normal**	**tense**	**slight**	**medium**	**severe**	**slight**	**medium**	**severe**	**colder**	**normal**	**hotter**	**sores**	**rashes**	**spasms**

Please check any symptoms that you have had in the last three months:			
General	Glasses	**Respiratory**	Hip pain
Poor appetite	Poor vision	Cough	Other:
Fevers	Cataracts	Bronchitis	**Neuropsychological**
Sweat Easily	Dizziness	Difficulty breathing while lying down	Seizures
Localized weakness	Sinus Problems	Producing phlegm	Areas of numbness
Bleed or bruise easily	Grinding Teeth	What color?	Concussion
Peculiar tastes or smells	Teeth problems	Coughing up blood	Bad temper/mood swings
Strong thirst (hot or cold)	Concussions	Pneumonia	Foggy brain
Thirst, no desire to drink	Eye strain	Asthma	Lack of coordination
Sudden energy drop	Night blindness	Pain with a deep breath	Depression
What time of day?	Blurry vision	Other:	Easily stressed
Poor sleeping/insomnia	Poor hearing	**Gastrointestinal**	Loss of balance
Chills	Nose bleeds	Nausea	Poor memory
Tremors	Facial pain	Constipation	Anxiety
Poor balance	Jaw clicks	Bad breath	Other:
Fatigue	Eye pain	Abdominal pain/cramps	**Genito-Urinary**
Night sweats	Color blindness	Chronic laxative use	Often waking to urinate
Cravings	Earaches	Vomiting	Pain upon urinating
Change in appetite	Spots in front of eyes	Gas/bloating	Urgency to urinate
Weight gain	Ringing in ears	Blood in stools	Decrease in flow of urine
Weight loss	Sores on lips or tongue	Rectal pain	Frequent urination
Skin and Hair	Recurrent sore throats	Diarrhea	Unable to hold urine
Rashes	Other:	Belching	Blood in urine
Itching	**Cardiovascular**	Indigestion	Kidney stones
Dandruff	Pacemaker	Hemorrhoids	Sores on genitals
Change in hair or skin	Blood thinning disease	Bowel movements:	Impotency
Ulcerations	Irregular heartbeat	Frequency:	Urine color?
Eczema	Cold hands or feet	Consistency:	Other:
Hair loss	Blood clots	Other:	**Gynecological**
Hives	Low blood pressure	**Musculoskeletal**	PMS
Pimples	Dizziness	Neck pain	Clots
Recent moles	Swollen hands	Back pain	Vaginal sores
Other:	Phlebitis (inflamed vein)	Hand or wrist pain	Breast lumps
Head, Eyes, Ears,	Chest Pain	Muscle pains	Vaginal discharge
Nose and Throat	Fainting	Muscle weakness	Unusual bleeding
Headaches:	Swollen feet	Shoulder pain	Hot flashes
Where?	Difficulty breathing	Knee pain	Irregular menses
When?	Other:	Foot or ankle pain	Other:

Informed Consent for Acupuncture and Chinese Medicine

If you are pregnant or think that you might be pregnant; have a blood-thinning disorder, take blood-thinning medication, or have a pacemaker; or have any other serious conditions it is imperative that you discuss these with your practitioner BEFORE treatment so that considerations can be made!

Heather Rain Delvin is a NCCAOM certified and licensed Eastern Asian Medical Practitioner (EAMP) in the State of Washington, License #3057, and a Licensed Massage Practitioner (LMP), License #14449. In 1994 Rain began a thirteen-year learning journey, as a Peace Corps Volunteer where she studied at the Buntautuk Traditional Medicine Hospital in Chiang Mai, Thailand. She then completed massage training at the New Mexico School of Natural Therapeutics, her Clinical Herbalist Certification from Michael Moore's Southwest School of Botanical Medicine, worked at Wang Lang Panda Reserve in Sichuan, China, where she informally studied Chinese herbs,, completed clinical observations in internal medicine, strokes, physical medicine, and pediatrics at the Zhejieng College of Traditional Chinese Medicine and achieved her Masters in Acupuncture and Oriental Medicine (MAOM) from the Seattle Institute of Oriental Medicine. She has an extensive theoretical and practical background that she uses to provide her patients the most comprehensive treatment possible.

Acupuncture and Oriental Medicine Treatments That May Be Administered:

Acupuncture: This is a safe treatment involving the insertion of tiny sterile, disposable needles through the skin, which can produce a mild but temporary discomfort at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise without pain. Other possible risks from acupuncture include dizziness and fainting. Extremely rare risks of acupuncture, which when administered properly have a very low occurrence, include nerve damage, organ puncture and infection. I will report to the EAMP any dizziness or lightheadedness that occur during or after an acupuncture treatment. (Initials)_____

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the EAMP of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding., or alongside certain medications. I accept full responsibility to inform the EAMP of a suspected or confirmed pregnancy, if I am a nursing mother, or if my medications change.. The Chinese pharmacopoeia includes several animal derived substances which have no herbal substitutes. While this clinic takes all measures possible to insure that our herbs and supplements come from non-endangered, toxin free & ethically harvested sources, we appreciate that some individuals prefer not to ingest animal-based substances. ***Please check the following box if you DO NOT WANT animal-based products to be administered as part of your herbal formulas.*** **( )** (Initials)_____

Warming Treatment with a TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup or with vacuum cups. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric microcurrent (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

You may request clarification of suggested procedures, verbally consent or choose not to consent to any or all given procedures at ANY time, and your acupuncturist will discuss or adjust your treatment plan accordingly.

By signing below, I show that:

- I have read, or had read to me, the information on this consent form.
- I am aware that potential benefits from these procedures can include the elimination or prevention of my presenting health conditions, relief from my present symptoms, and the improved balance of energy which may improve my overall health.
- I understand the possible risks and complications involved with acupuncture and other treatments. I have had the opportunity to discuss this consent form with my EAMP. I understand that I can request more information at any time.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.
- I realize that no guarantees have been given to me by Rain Delvin, EAMP, LMP regarding cure or improvement of my condition.
- I recognize that certain side effects do occur in a small percentage of patients, and that risks such as temporary aggravation of pre-existing symptoms, discomfort at the site of needle insertion, bleeding, bruising, palpitations, dizziness, and/or weakness do exist.
- I also recognize that these procedures carry the rare but potential risks of needle breakage or infection.

I hereby voluntarily consent to receive Acupuncture and Oriental Medicine treatment for my present and future health conditions. I understand that treatment will be administered by Rain Delvin, (EAMP) East Asian Medicine Practitioner. On occasion, if Rain Delvin_is not available, I consent to treatment by a substitute EAMP, as designated by Rain Delvin and approved by myself.

Patient Name (printed):___________________________________ Date:__________________

Patient/Personal Representative Signature:____

Directions to Healing Roots

From Downtown Olympia:

- Go across the 4th Street bridge heading to the West Side, and take the second exit at the roundabout onto Harrison Avenue.
- Take a right at the light at the top of Harrison hill onto Division, and take the second left-hand turn (away from downtown) onto Jackson Ave NW.
-

From Highway 101:

- Take the Black Lake Blvd. Exit, curving right at the light onto Black Lake Blvd., then go straight through several street lights, continuing past Capitol Mall.
- Continue straight through the light at Harrison (where Black Lake becomes Division), and then take the second left-hand turn (away from downtown) after the light onto Jackson Ave. NW.
-

Upon Arriving at 2020 ½ Jackson Ave. NW:

- Park in the 2nd driveway on the right, in front of the red garage building with a sign for Healing Roots, or in the driveway just to the right of the main house behind Rain's car, or along the street in front of the clinic.
- Go up the steps of the main house, there will be an Open/Closed sign in Chinese and English on the front door.
- **Please feel free to come in and have a seat in the waiting area, and have a cup of tea or water in the waiting area when you arrive. I will be with you shortly!**

Rain Delvin, EAMP, MAOM, LMP
2020 ½ Jackson Ave NW Olympia, WA 98502 Phone: (360) 754-1823 Fax: (877) 244-9677
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