Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____ Sex: F ☐ M ☐

Home Address: _____
Street Apt# City State Zip code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Marital Status: Single ☐ / Married ☐ / Other ☐ Email Address:_____

Employer: _____ Title: _____ Phone: (_____) _____

Employer's Address: _____
Street Suite# City State Zip Code

Family Physician: _____ Phone: (____) _____

Spouse Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____ Sex: F ☐ M ☐

Phone Number: (_____) _____

Referring Physician name and number:
_____

Referring friends name:_____

Found us on: Internet: _____ Insurance website:_____

This will constitute authorization for treatment by Sharareh Daghigihi, L.Ac for my child/ward or me. In the event of default, patient responsible party agrees to pay all collections and attorney fees. I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance. A copy of this authorization shall be considered as valid as the original.

Signature: _____ Date: _____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Medical History Questionnaire

Please complete the following as accurately as possible

Name: _____ Date: ____/____/_____

Present Illness:

What is your chief complaint?

_____

_____

_____

When did this condition begin?

_____

_____

What treatments have you received already?

_____

_____

Medical History:

What surgeries have you had? When did you have them?

_____

Do you have any known allergies (food or medications)?

_____

What medications are you currently taking?

_____

What supplements are you currently taking?

_____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Have any of your blood relatives had any of the following?

Stroke	☐	Heart Disease	☐	High BP	☐
Cancer	☐	Bleeding disorders	☐		
High Cholesterol	☐	Diabetes	☐		

For Female patients please complete the following:

Age of your first period	Emotional changes with your period
Are you pregnant?	Menstrual blood clots
Date of last period	Excessive bleeding
Length of your cycle	Breast pain with your period
Color of Blood	Vaginal discharge
Menstrual cramps	Menopausal symptoms
Night sweats/Hot flashes	Vaginal yeast infections

Shareareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

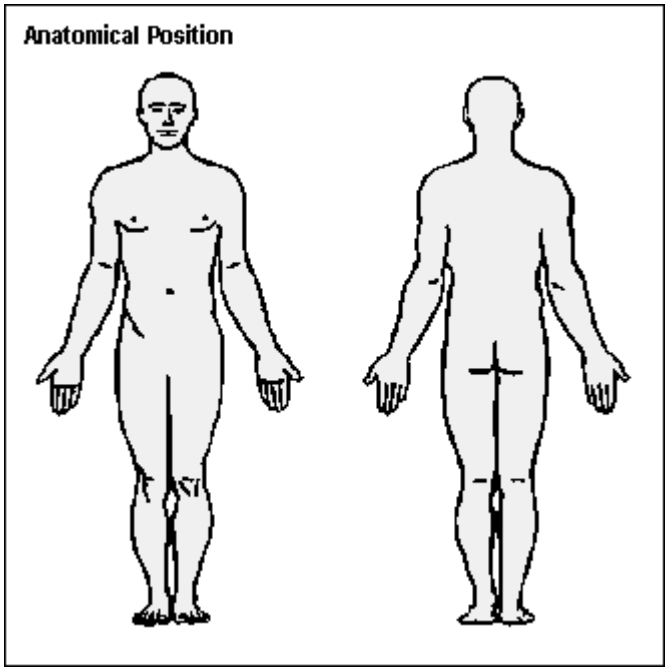
Please complete the following as accurately as possible:

Indicate if you have any of the followings:

Headache	☐	Palpitation	☐	Infertility	☐
Dizziness	☐	Dry eyes	☐	Premature ejaculation	☐
Fainting	☐	Indigestion/gas	☐	Prostate problem	☐
Epilepsy & convulsion	☐	Heart burn	☐	Sexually transmitted disease	☐
Stroke	☐	Constipation	☐	Indicate	
Loss of memory	☐	Diarrhea	☐	Sores that don't heal	☐
Loss of any five senses	☐	Irritable bowl Syndrome	☐	Cancer (indicate)	☐
Tinnitus/ear ringing	☐	Peptic ulcer	☐	Insomnia	☐
Thyroid problem	☐	Jaundice	☐	Skin disease (indicate)	☐
Asthma	☐	Fatty liver	☐	Arthritis	☐
Pneumonia Emphysem	☐	Pancreatitis	☐	Osteoarthritis	☐
Cough	☐	Gallstone	☐	Osteoporosis	☐
Tuberculosis	☐	Diabetes	☐	Lupus	☐
Frequent colds	☐	Hepatitis	☐	Rheumatic Arthritis	☐
High blood pressure	☐	Hernia	☐	Herniated disk	☐
High Cholesterol	☐	Kidney stones	☐	Muscle spasm	☐
Heart Disorder	☐	Frequent urination	☐	Numbness & tingling	☐
Cardiac pacemaker	☐	Urinary track infection	☐	Fibromyalgia	☐
Anemia	☐	Impotence	☐	Chronic fatigue syndrome	☐

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Mark X where you feel pain or discomfort



Please write down the affected locations:

_____

_____

Pain Intensity from 1-10: _____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____
HEALTH INSURANCE ID (or Social Security#) _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this Organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:
• A basis for planning care and treatment.
• A means of communication among the many healthcare professionals who contribute to care.
• A source of information for applying diagnostic and medical information to a bill.
• A means by which a third-party payer can verify that services billed were actually provided.
• A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
• To object to the use of health information for directory purposes.
• To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
• To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient/Legal Representative signature: _____

Witness signature: _____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Date: _____

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Sharareh Daghighi Acupuncture/Acuwellness Center. We strive to render excellent medical care to you, your family and all of our patients. In order to be consistent with this philosophy, Acuwellness Center uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 818-642-3512.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice we will consider this to be a missed appointment and a $50.00 fee will be assessed to you.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

If you have any questions regarding this policy, please contact Sherry Daghighi at the above address or phone number and he will be glad to clarify any questions you may have. We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

_____

Signature (Parent / Legal Guardian) Relationship to Patient

_____ _____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Printed Name

By signing this authorization, I authorize you to use and/or disclose certain protected health information (PHI) about me to:

Sharareh Daghighi, DAOM, L.Ac.
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
Phone: 818-642-3512
Fax: 818-789-8890

Dear Dr, _____

I authorize you to release a copy of the medical records of:

Patient name: _____ Date of birth: _____

Social Security #: _____ covering the period of _____to _____

Please fax the records to above address.

The specific information requested is the office visits, labs, x-ray, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make informed decision whether to allow release of the information.

The authorization will expire on _____

I release you from all legal responsibility or liability that may arise from this authorization.

Please release my medical records, including:

All of my medical records (excluding HIV testing)

My entire medical records (Including HIV testing)

Please exclude the followings: _____

Patient's signature: _____ Date: _____

Patient's name: _____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Please note:
1- Your health insurance does NOT cover all the services which our office provides.
2- Your Insurance might only cover part of your Acupuncture treatments and for only specific diagnosis.
3- You are responsible for your deductible and co-insurances.
4- Other services such as Heat/Cold therapy, Cupping, Herbs, Nutritional Supplementation, Herbal consultation are NOT covered by your insurance therefore your responsibility.
5- Eligibility verification is not a guarantee of payment. Coverage is subject to all of the terms and conditions of the member's description of benefits.

Please ask us for pricing or if you have any questions.

Patient Name: _____

Patient Signature: _____

Date:_____

Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com