NW Alternative Healing Center, Inc.
Dr. Yixiong Wang
3316 NE 125th Street
Seattle, WA 98125
206-528-1038

I, _____ acknowledge that I have had the opportunity to read the Notice of Privacy Practices for the NW Alternative Healing Center. I understand this notice describes how medical information about me may be used and disclosed and how I can get access to this information. I also understand that I can have my own copy of this notice at my request.

Signature: _____ Date: _____

PATIENT HISTORY INFORMATION

PATIENT NAME (PLEASE PRINT) _____

PHONE: HOME (___)_____ WORK (___)_____ CELLULAR (___)_____

ADDRESS _____ CITY _____ STATE ___ ZIP _____

BIRTHDATE _____ AGE ____ SEX _____ MARITAL STATUS _____ SS# _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ REFERRED BY _____

MAIN PROBLEM(S) YOU WANT HELP WITH: _____

_____

WHEN DID THIS/THESE PROBLEM(S) BEGIN? _____

HAVE YOU BEEN GIVEN A DIAGNOSIS/DIAGNOSES FOR THIS/THESE PROBLEM(S)? _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____

NAME OF INSURANCE PLAN _____ GROUP # _____

MEMBER # _____ AUTO INSURANCE CLAIM # _____

PATIENT IS: SUBSCRIBER ☐ SUBSCRIBER'S SPOUSE ☐ SUBSCRIBER'S DEPENDENT ☐

IF YOU ARE SUBSCRIBED UNDER YOUR SPOUSE'S INSURANCE PLAN, PLEASE COMPLETE THE NEXT LINE:

SPOUSE'S NAME _____ SS# _____ BIRTH DATE _____

SUPPLEMENTAL INSURANCE PLAN _____ GROUP # _____

MEMBER # _____ AUTO INSURANCE CLAIM # _____

PATIENT IS: SUBSCRIBER ☐ SUBSCRIBER'S SPOUSE ☐ SUBSCRIBER'S DEPENDENT ☐

ADDITIONAL PATIENT INFORMATION

CONDITION IS RELATED TO: AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER ☐

DATE OF MOST RECENT SYMPTOM/INJURY _____ CAUSE _____

IN EMERGENCY CALL _____ PHONE # (____)_____

(NEIGHBOR, FRIEND OR RELATIVE WHO CAN BE REACHED DURING OFFICE HOURS)

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

1) I ACCEPT FINANCIAL RESPONSIBILITY FOR MY TREATMENT.
2) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO NW ALTERNATIVE HEALING CENTER, INC.
3) I AUTHORIZE RELEASE OF MEDICAL RECORDS TO MY PRIMARY CARE PHYSICIAN IF REQUESTED.
4) I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY IF REQUESTED.
5) I UNDERSTAND THAT A SERVICE CHARGE OF 1% PER MONTH WILL BE CHARGED ON BALANCES MORE THAN 60 DAYS OLD.

SIGNATURE OF PATIENT OR PATIENT'S PARENT _____ DATE _____

Office Use Only: Diagnosis Code

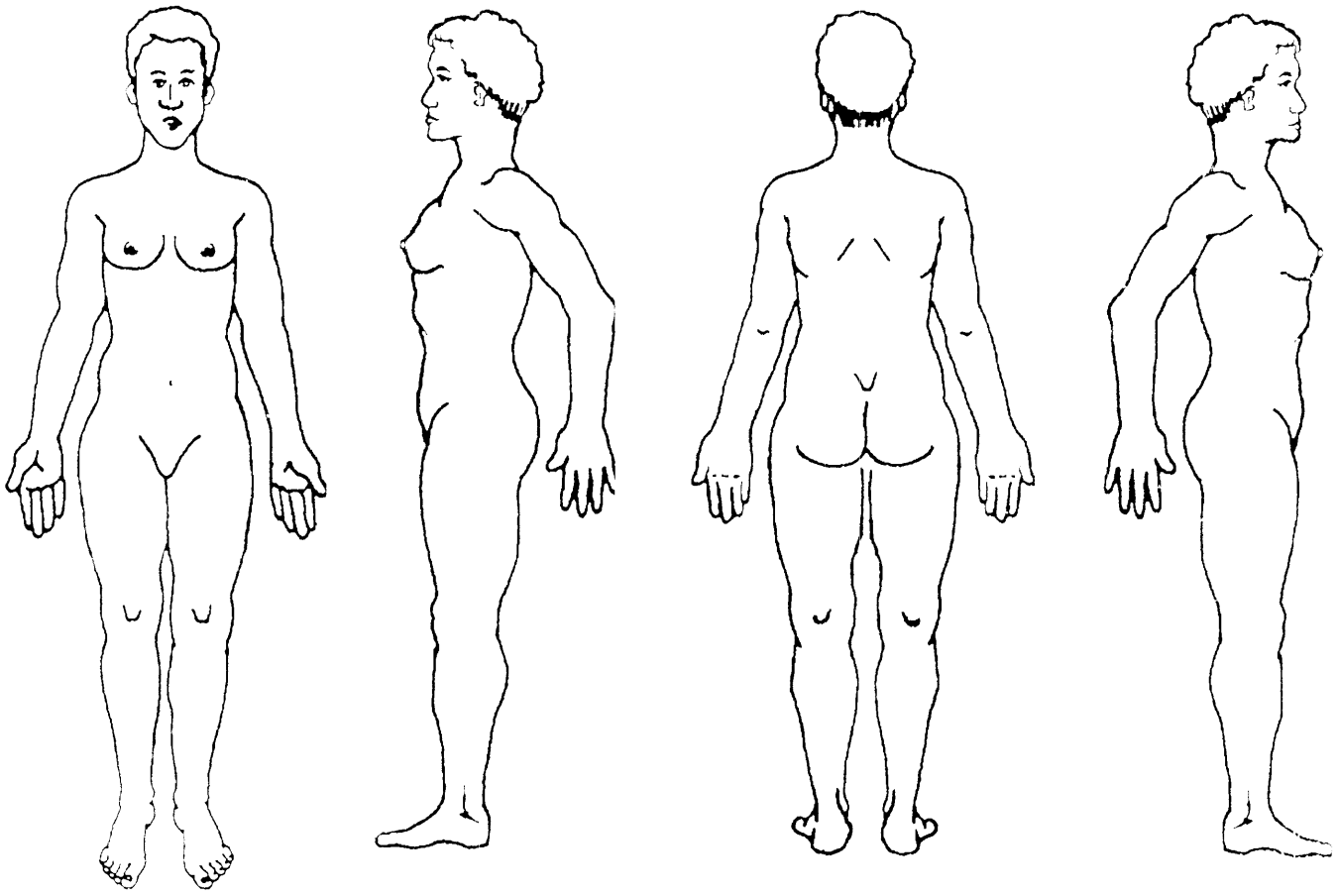
PERSONAL STATUS REPORT

Name _____ Date: _____

Identify **CURRENT** symptomatic areas in your body by drawing the symbols on the figures below.

KEY:

- ◯ Circle areas of **PAIN**
- X "X" over areas of **JOINT AND MUSCLE STIFFNESS**
- ≋ Draw a squiggly lines along the areas of **NUMBNESS OR TINGLING**
- ⫴ Mark **SCARS, BRUISES** or **OPEN WOUNDS**



Additional comments: _____

CONSENT FORM
FOR TRADITIONAL METHODS

I, the undersigned, hereby authorize Yixiong Wang, a national and Washington state certified acupuncturist, to perform the following specific procedures:

Acupuncture: Insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.

Cupping: A technique to relieve symptoms cups made of glass, bamboo or other materials to put on the skin with a vacuum created by heat or other device.

Plum blossom or seven star hammer: A light tapping of an area of the body with a small sterile hammer which has seven points.

Gua sha: A rubbing on an area of the body with a blunt, round instrument.

Moxa: Indirect burning on an acupoint using stick, ball or string moxa to relieve symptoms.

Wonder cookie: Heating or an herbal wafer and placing this wafer on an area or acupuncture point to gently warm it.

Special electromagnetic heat lamp: Direct therapeutic heat of a specific area of the body.

Tuina: An ancient hands-on form of therapy used to treat a wide variety of common disharmonies.

I recognize the potential risk and benefit of these procedures as described below.

Potential risks: Discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of skin and even an aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: Drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Yixiong Wang regarding cure or improvement of my condition.

I authorize Yixiong Wang to utilize for research or teaching purposes clinical or other medical information contained in my medical record resulting from the above mentioned procedures. I hereby release Yixiong Wang from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____

Signature of Patient Date

or

_____ _____

Signature of person authorized to consent Date