Piper Dunlap, L.Ac.
1118 Lawrence Street
Port Townsend, WA 98368
Phone (360) 385-3882
Email: Piper@PiperDunlap.com

Today's Date _____

Payment Information

Fees for Services:	Regular Rates	Pay-at-time of service Rates	
Initial acupuncture visit	$125.00	$120.00	(90 minutes)
Follow-up acupuncture visit	$95.00	$85.00	(60 minutes)
Initial herbal consultation	$95.00	$85.00	(60 minutes)
Follow up consultations (In person or phone)	$35.00	$30.00	(15 minutes, $1.00 each additional minute)

Forms of Payment Accepted:

Cash, Check, Venmo, and PayPal accepted. Insurances listed below will be processed. Payment in full for herbs and services rendered due at the time of service.

Insurance Policies currently being accepted:

Premera Blue Cross	Regence Blue Shield
Lifewise Health Plan of Washington	TriWest for Veterans

If your plan is not on this list, please ask, and we will provide a superbill for you to submit to your insurance provider.

Preferred method of Payment:

□ Cash or check (a $30.00 service fee will be charged for all returned checks)

□ Insurance

If you would like us to bill your insurance, please fill out the form on the other side.

Payment Disclaimer:

I agree to pay for all herbs and services rendered at the time of service. In the event that insurance does not pay a claim within 180 days, or does not cover a service, I understand that I am personally responsible for all charges. I agree to the release of any medical and billing information necessary to process payment. I assign medical benefits payable directly to Piper Dunlap, L.Ac.

I understand that if I cancel an appointment with less than 24 hours notice or fail to show up for an appointment, a $50 fee will be charged directly to me. I understand insurance will not pay for a missed appointment fee.

_____ _____

Signature of patient (or guardian if patient is a minor) Date

Insurance Information

Full name: _____ Date: _____

Name of insured: _____ Insured's date of birth: _____
(If other than you)

Address of insured: _____ Relationship to insured: _____
(If different from address on page 3)

_____

Insurance plan: _____ Ins. ID#: _____

Claims phone number: _____ Group #: _____
(Should be on the back of your card)

For office use only

Eligibility Notes: _____

_____

_____

_____

Patient Information

Please Print!

Name: _____ Sex: M F Birth date: _____ Age: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Email: _____

Would you like to receive a quarterly newsletter? _____

Occupation: _____ Emergency contact: _____

Parent's name if under 18: _____ Emergency contact phone #: _____

How did you hear about Piper's practice? _____

Name of your primary health care provider:

_____

Have your complaints previously been given a particular medical diagnosis? If so, please explain.

_____

_____

Are you currently taking any prescribed medications, vitamins, supplements, and/or herbs? Please list.

_____

_____

Present Complaint: Symptoms, when and how problem started, anything that makes your symptoms worse or better, etc.

_____

_____

_____

_____

Please tell me about any previous treatments you have tried for your condition (acupuncture, homeopathy, massage, nutrition, M.D., etc.) and the results.

_____

_____

_____

_____

Please check any of the following that apply to you:

DIABETES _____ HEPATITIS a, b, c _____ HYPERTENSION _____ PREGNANCY _____ TB _____

CHEMO/RAD _____ SEIZURES _____ HEMOPHILIA _____ PACEMAKER _____ HIV/AIDS _____

Describe your…

General energy level: _____

Time of day you feel best and worst: _____

What is your history for major…

Illnesses: _____

_____

Surgeries: _____

_____

Childhood illnesses: _____

_____

Daily habits (how much of the following substances do you consume daily?)

Cigarettes/tobacco: _____

Alcohol (in what form): _____

Coffee/tea/caffeinated beverages: _____

Sugar: _____

Dairy products (milk, cheese, etc.): _____

Meats/fish/poultry/eggs: _____

Bread & grains: _____

Cooked vegetables: _____

Raw fruit/vegetables: _____

Specific food/flavor cravings: _____

Describe the exercise you get on a regular basis: _____

_____

Which of these environments affect you adversely? (please circle)

cold heat damp dry windy humidity foggy

Which of these environments make you feel better? (please circle)

cold heat damp dry windy humidity foggy

Do you have an intolerance to hot or cold (food, drink, or areas of the body that are hot or cold)?

_____

_____

Please provide me with your family's brief medical history. Include any incidence of tuberculosis, cancer, skin disease, hypertension, nervous disorders, diabetes, arthritis, heart disease, stroke, seizures, asthma, allergies, alcoholism/substance abuse, etc.

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

WOMEN

Age when periods began: _____ Last PAP:_____ Results:_____

Length of cycle: _____ days Duration of flow:_____ days Is your cycle regular?_____

Any spotting? _____ Pain? _____ PMS? _____ Vaginal discharge? _____

Difficulties during teens (pain, flow, regularity, cramps, etc.): _____

_____

Birth control history (method & duration of use): _____

_____

Obstetric history (pregnancies, births, abortions, miscarriages, etc.): _____

_____

Menopause: _____

STD's (herpes, warts, etc.): _____

_____

MEN

History of impotence, premature ejaculation, fertility difficulties, discharge from penis, vasectomy, etc.

_____

_____

STD's (herpes, warts, etc.): _____

_____

Please mark present conditions with a ✓ and significant past conditions with an **X**.

- ☐ Abdominal Pain
- ☐ Ache in low back and/or knees
- ☐ Acid regurgitation
- ☐ Allergies
- ☐ Alternating chills/fever
- ☐ Always cold
- ☐ Always hungry
- ☐ Awaken to urinate _____ times/night
  time: _____
- ☐ Back pain
  where?_____
- ☐ Bad breath
- ☐ Bearing down sensation
  in groin/scrotum
- ☐ Belching, hiccups
- ☐ Bladder/kidney stones
- ☐ Bleeding
  where?_____
- ☐ Bruise easily
- ☐ Bloating of the stomach/abdomen
- ☐ Blood clots
- ☐ Bloody urine
- ☐ Blurry vision/floaters
- ☐ Brittle nails
- ☐ Bronchitis
- ☐ Burning sensation in anus/rectum
- ☐ Burning urination
- ☐ Chest/arm pain
- ☐ Chest fullness
- ☐ Chills and fever
- ☐ Clearing the throat often
- ☐ Cloudy urine
- ☐ Cold body and limbs
- ☐ Constipation
- ☐ Convulsions
- ☐ Cough or asthma
- ☐ Coughing up mucus
  color: _____
- ☐ Dark scanty urine
- ☐ Deafness/low-pitched
- ☐ Decreased/poor appetite
- ☐ Depression
- ☐ Descending or sinking
  sensation in abdomen
- ☐ Diarrhea – chronic or acute
  (please circle)
- ☐ Dislike of wind
- ☐ Dizziness
- ☐ Dry eyes and nose
- ☐ Dry mouth and throat
- ☐ Dry skin
- ☐ Dry stools
- ☐ Dull and dry hair
- ☐ Easily frightened

Emotions:

- ☐ Anxiety
- ☐ Irritability
- ☐ Grief/sadness
- ☐ Feelings of fear
- ☐ Mania

- ☐ Emotional prior to period
- ☐ Excessive dreaming
- ☐ Fatigue easily
- ☐ Feverish
- ☐ Flushed cheeks
- ☐ Forgetfulness
- ☐ Frequent colds
- ☐ Frequent urination
- ☐ Hair loss
- ☐ Hard to project voice
- ☐ Headache
- ☐ Heaviness
- ☐ Heavy menses
- ☐ Hemorrhoids
- ☐ High-pitched ringing in the ears
- ☐ Hoarse voice
- ☐ Hot palms of hands/soles of feet
- ☐ Hysteria
- ☐ Impotence
- ☐ Incontinence of urine
- ☐ Indecisiveness
- ☐ Indigestion
- ☐ Infertility
- ☐ Insomnia
- ☐ Intermittent dull pain
- ☐ Irregular heartbeat
- ☐ Joint pain
  where?_____
- ☐ Other joint/bone problem? _____
- ☐ Large red spots under skin
- ☐ Localized sharp pain
  where?_____
- ☐ Loose stools
- ☐ Low sex drive
- ☐ Lumps, mass or tumors
- ☐ Memory loss
- ☐ Migraine headaches
- ☐ Muscle pain
- ☐ Nasal congestion
- ☐ Nausea
- ☐ Neck pain
- ☐ Night sweats
- ☐ No thirst
- ☐ Nocturnal emission
- ☐ Numbness
- ☐ Organ prolapse
- ☐ Pale face
- ☐ Palpitations
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Poor memory
- ☐ Poor vision
- ☐ Premature ejaculation
- ☐ Premature gray
- ☐ Red face
- ☐ Red, painful eyes
- ☐ Red, painful skin eruption
- ☐ Rib or side pain
- ☐ Right trunk pain
- ☐ Seizures
- ☐ Sensation of object stuck in throat
- ☐ Shortness of breath
- ☐ Sighing
- ☐ Skin problems: _____
- ☐ Sleep a lot
- ☐ Sneezing
- ☐ Sore throat or mouth
- ☐ Spasms or tremors
- ☐ Stiffness
- ☐ Stomach pain
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Sweat easily
- ☐ Swollen painful gums
- ☐ Symptoms relieved by heat
- ☐ Thirsty
- ☐ Tired all the time
- ☐ Tongue sores/ulcers
- ☐ Tooth loss
- ☐ Urgent urination
- ☐ Vertigo
- ☐ Vomiting
- ☐ Vomiting bitter fluids
- ☐ Waking between 3-5 a.m.
- ☐ Water retention
- ☐ Weight gain
- ☐ Wheezing
- ☐ Yellowing of skin