Moon and Lotus, LLC

Acupuncture, Chinese Herbs, Heartmind Counseling

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541-345-2220

Appointments are scheduled during the following hours:
Tuesday— 9:00 am —4:30 pm

Payment at Time of Service Rates
The amount you will be charged is determined by whether you are a new or returning patient, and the complexity and amount of time of your visit. Your initial visit is 75-90 minutes. Most return office visits are one hour in length, however more time may be needed if we are doing follow up assessments, nutritional and herbal counseling, or more focused bodymind exploration.

Health assessment & first acupuncture treatment: $150

One hour follow-up visit: $98

75 minute follow-up: $125

90 minute follow-up $150

Herbs: separate charge

Insurance Policy
Please bring your insurance card with you to your first visit. We will bill insurance if we are in-network provider. If not, we will give you the information you need to send to your insurance company to get reimbursement. After we receive payment from your insurance company, we will send you an invoice for the amount that you owe. If you have a set co-pay, we ask you to pay that at each visit. Payment for herbs is also requested at time of service.
With insurance billing, the fee schedule differs from the discounted “time of service” rates above. We do not bill OHP or Medicare Advantage programs currently.

Payment Policy
I accept cash and checks. You can pay with MasterCard and Visa, including debit cards, but there is a $3 fee charged. A reasonable charge will be added for any returned checks to cover my bank costs.

Missed Appointments/Cancellation Policy

If you reschedule or cancel your appointment, please give me at least 24 hours advanced notice so that I may give that spot to another person who needs it. I reserve the right to charge you for the office visit if you cancel in less than 24 hours or are late for an appointment by more than half the time scheduled.

Thank you for entrusting me with your health care, and for understanding the need for these charges per the amount of time we spend together. This allows to me provide the best possible service to you.

As always, please don't hesitate to talk with me, if you have any questions or concerns.

The office phone number is 541-345-2220. You can leave messages for me there. This is the best way to get a hold of me to schedule, cancel or reschedule appointments.

I have read and agree to the above information.

_____

Signature Date

Name: _____ Date of Birth _____

Address: _____

Email address: _____

Best phone: _____

Emergency contact:_____

Reason for visit: _____

Other doctors who have treated you for your condition_____

_____

How did you hear about me?

_____

Please answer the following questions briefly. Information you provide is completely confidential.

Past Medical History

Significant illnesses: (please choose all that apply and include dates)

High Blood Pressure •Cancer Diabetes Heart Disease

Thyroid Disease Seizures Hepatitis Rheumatic Fever Venereal Disease

HIV+ •AIDS

Other_____

Surgeries: _____

Significant Trauma: (auto accidents, falls etc)_____

Allergies: (drugs, chemicals, foods_____

Family Medical History (please specify family members)

Cancer	Diabetes	Seizures	Stoke
Heart Disease	High Blood Pressure	•Asthma	•Allergies

Occupational stress: (chemical, physical, psychological) _____

_____

Do you have a regular exercise program? If so, please describe_____

_____

Diet and Intake

Medicines taken within the last two months: (include vitamins, over-the-counter drugs, herbs, etc.)_____

_____

Are you, or have you ever been, on a restricted diet? If so, what kind?_____

_____

Please describe your average daily diet:

Morning Afternoon Evening

_____ _____ _____

Habits:

_____Cigarettes per day

_____Cups of coffee, tea or cola per day

_____Drinks of alcohol per week

Please describe any use of drugs for non-medical purposes:_____

Please make a check mark if you have experienced any of the following in the **last three months**.

Poor Appetite	Poor Sleeping	Fatigue	Fevers	Chills
Night Sweats	Sweat easily	Cravings	Change in appetite	
Localized weakness	Poor Balance	Tremors	Weight loss	
Weight gain	Tendency to feel warm		Tendency to feel cold	
Bleed or bruise easily	Peculiar tastes or smells			
Level of thirst: normal	•very thirsty	•rarely thirsty		

Sudden drop in energy: (please indicate at what time of day)_____

Skin and Hair

Rashes	Ulcerations	Hives	Itching	Eczema
Pimples	Dandruff	Loss of hair	Recent moles	

Any other skin or hair problems?_____

Head, Eyes, Ears, Nose and Throat

Dizziness	Concussions	Migraines	Facial pain	TMJ
Jaw clicks	Grinding teeth	Teeth problems	Eye Pain	
Glasses	Eye strain	Poor vision	blurry vision	

Night blindness	Color blindness	Cataracts	Spots in front of eyes
Earaches	Ringing in ears	Poor hearing	Recurring sore throat
Sinus problems	Nose bleeds	Sores on lips or tongue	

Headaches: (where and when)_____

Any other head or neck problems?_____

Cardiovascular

High Blood Pressure	Low Blood Pressure	Chest Pain
Irregular Heartbeat	Swelling of hands	Swelling of feet
Dizziness	Fainting	Cold hands or feet
Blood clots	Phlebitis	Stroke

Respiratory

Cough Coughing Blood 'Asthma Bronchitis Pneumonia
Pain with deep breath Difficulty in breathing when lying down
Production of phlegm: (please describe color) _____
Any other lung problems?_____

Gastrointestinal

Nausea Vomiting Diarrhea Constipation
Indigesüon Gas Belching Bad Breath
Black Stool Blood in stool Rectal pain Hemorrhoids
Heartburn Bloating Abdominal pain or cramping
Chronic laxative use

Any other stomach or intestinal problems? _____

Genito-urinary

Pain with urination Frequent urination Blood in urine

Urgency to urinate Incontinence Decrease in flow
Kidney stones Bladder infection Impotency
Sores on genitals

Do you wake from sleep to urinate? (indicate how often) _____
Please describe the color of your urine: _____
Any other genital or urinary problems? _____

Pregnancy and Gynecology

Number of pregnancies_____
Live Births_____ Premature_____ Miscarriages_____ Abortions _____
Menstruation:
Age of first menses_____ Duration between menses_____ Duration of menses_____
First date of last menses:_____
Amount of blood flow: heavy light normal_____Color of blood: •pale bright •red 'dark
Are there clots in the blood? Yes No
Are periods irregular? If so, please describe_____
Do you experience changes in your body / psyche prior to menstruation? (describe)_____
_____
Do you experience cramps or pain? (describe, including when and where)
_____
Vaginal Discharge Vaginal sores Breast lumps Fibroids
Do you practice birth control? Yes No
If yes, what type and for how long?

Musculoskeletal

Neck pain	Knee pain	Hip pain	Back pain
Shoulder pain	Foot/ ankle pain	Hand/wrist pain	Muscle pain

Muscle weakness

Any other joint or bone problems?

_____

Neuropsychological

Seizures	Dizziness	Loss of balance	Areas of numbness
Poor memory	Concussion	Lack of coordination	Depression
Anxiety	Bad Temper	Easily susceptible to stress	

Have you ever been treated for emotional issues? _____

Have you ever considered or attempted suicide? _____

Have you experienced any other neurological or psychological problems?

_____

How would you describe yourself emotionally?_____

_____

How would your friends describe you emotionally?_____

_____

Choose two emotions that seem predominant in your life: (frequently felt, difficult to express, influential)

_____

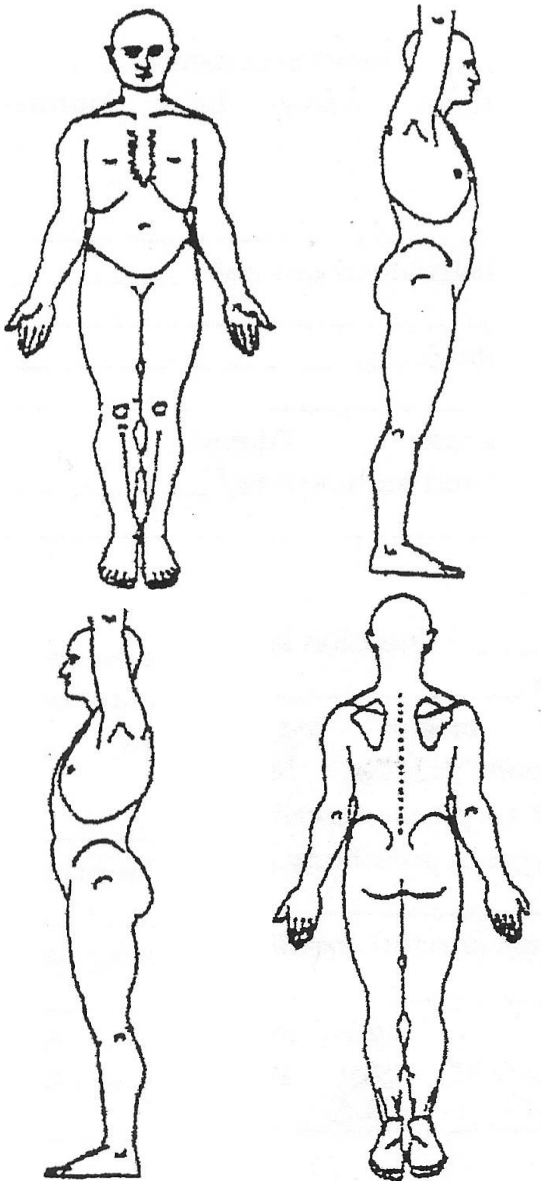
What is the quality of your sleep?_____

List any reoccurring themes in your dreams:_____

What is the quality of your breathing?_____

Are you having any relationship problems?_____

Please indicate on the diagram below any areas where you are currently experiencing pain



Place a mark <u>through</u> the line below to indicate how you are feeling <u>at this moment.</u>

No Discomfort |——————————————————————————| Extreme Discomfort

<u>Comments:</u> Please explain or list any other problems you would like to address: