

Elizabeth Chen Christenson, MD

Enclosed is your New Patient Information Packet.

Please read everything carefully and sign where indicated.

Your packet includes the following:

1. General Patient Questionnaires (11 pages)
(Additional 7 pages of pain questionnaires for pain patients)
2. Consent to Treatment Form
3. Financial Policy Form
4. Patient Financial Account Registration form
5. Cancellation Policy Form
6. Medicare Medical Necessity Form (if applicable)
(Advance Beneficiary Notice - CMS-R-131-G)
7. Notice of Privacy Practices (2 pages).
8. Consent for use and disclosure of health information
9. Acknowledgement of receipt of notice of privacy practices

For more information about Elizabeth Chen Christenson, MD, L.Ac.
please visit www.chimedicalcenter.com

Note: Please make copy of all the above documents for your own record.

If you have any questions, please feel free to contact Elizabeth Chen
Christenson, MD at 808-261-7801.

Consent to Treatment

I, _____, acknowledge that Elizabeth Chen Christenson, MD has informed me concerning the nature and consequences of the contemplated procedures known as: ***Acupuncture and Oriental medicine and /or Energy Medicine*** which is recommended for the purpose(s) of: ***Alleviating symptoms and to promote well being.***

I recognize that acupuncture is an art of healing involving the stimulation of specific points of the body aimed at alleviating or limiting diseases or relieving pain. The stimulation may be produced by needles (acupuncture), digital pressure (acupressure), heat (moxibustion, lamp, etc.), electrical currents (electrical stimulation), trigger point injections, but most frequently, in the form of needling. Although uncommon, I recognize that in rare instances certain side-effects or adverse reactions may result from these procedures which may include fainting, bleeding, infection, pneumothorax (puncture of the lung), puncturing of the viscera (internal organ), broken needles, failure of the treatment to render the desired results, and other possible hazards associated with the treatment procedures.

Although acupuncture has been used in the Orient as an authentic therapeutic modality for thousands of years and is medically documented, however in the United States, it is understood that there may be unknown risk factors involved.

I hereby acknowledge and understand the above language and believe that the treatment outlined above is in my best interest or the best of the patient for whom I am providing consent. I further acknowledge that no guarantee of results has been made.

I give my consent to the outlined treatment and to such treatment as may be necessary to diagnose, treat, and/or care for my needs.

I acknowledge that: (1) alternative therapies which are currently available at CHI Medical Center LLC, have been discussed with me as well as my right to refuse the recommended procedure, (2) the options available to me should I refuse consent for the recommended procedures, and (3) the expected consequences of my refusal to consent to the recommended treatment. It is with full recognition of the risks as they have been outlined that I hereby give my consent, voluntarily and freely, to the above-named procedures and authorize Dr. Elizabeth Chen Christenson to perform this procedure and understand that she may be assisted by other health professionals of Wellness Center at Complementary & Alternative Medicine Department, John A. Burns School of Medicine, as she may consider necessary.

I also acknowledge that in recommending treatment, Dr. Elizabeth Chen Christenson relies, in part, upon the history I have provided, in particular, any history concerning allergic or adverse reactions to unspecified, undisclosed, of unknown substances, whether they be medicine, foods, and/or environmental substances. Further, I acknowledge that continued treatment with Dr. Elizabeth Chen Christenson may depend on my willingness and ability to follow the precise treatment recommended and failure to do so may have detrimental effects and/or impede treatment.

I acknowledge that my treatment may be dependent upon reporting adverse or allergic reactions and agree to advise Dr. Elizabeth Chen Christenson of any such allergic or adverse reaction.

Patient

Date

Witness

Date

Guardian, Parent, Other Legal Representative, etc.

Date

Rev. 11/09

Financial Policy

Thank you for choosing Elizabeth Chen Christenson, MD as your health care provider. Dr. Christenson is committed to the success of your treatment. The following is a statement of our financial policy which we request you read and sign prior to any treatment.

Please be advised that all services rendered by Elizabeth Chen Christenson, MD, are non-refundable and payable upon receipt. Make check payable to Elizabeth Chen Christenson, MD

REGARDING INSURANCE

1. The policy of this office is FEE FOR SERVICE.
2. Elizabeth Chen Christenson, MD is a provider for HMSA, UHA, HMAA, Federal Employee Program, Medicare, Aloha Care, HMSA Quest and many other insurances. If you have HMO with HMSA you will need your primary care doctor referral note to HMSA.
3. Your insurance company may require additional information to process your claims, if the request is extensive, there may be a charge for resubmission of claims, copies of your records, letters of medical necessity, and narrative reports by the doctor. Dr. Christenson's office will confirm this charge with you before processing any documents. We are doing everything we can to keep our fees down, however, the increase in insurance correspondence and requests has caused an added expense to our office.
5. Please be aware that some medical services, including medical acupuncture and other alternative treatments, may not be covered by all insurance companies.
It is patient's responsibility to check with your insurance policy.
It is patient's responsibility to pay the uncovered services.

TELEPHONE CALLS

All patients are encouraged to call with any questions they have concerning medical problems. However, it would be most unfair to other patients if the doctor left to answer every telephone call. It is highly advised that extensive consultation be made in person with a scheduled appointment. However, in the event of specific situations, extensive phone consultations will be charged at the regular office visit consultation rate.

Patient's / Guarantor's Signature: _____

Date: _____

rev. 11/09

PATIENT FINANCIAL ACCOUNT REGISTRATION

Patient Information Date _____
Name _____ Soc. Sec.# _____
 Last Name First Name Initial
Address _____ City _____ State ___ Zip _____
Sex: _Male_ _Female_ Age ___ Birthdate _____ Home Phone # _____
Marital Status: Single ___ ; Married ___ ; Divorced ___ ; Widowed ___ ; Separated ___
Patient Employed By _____ Business Phone _____
Whom may we thank for referring you to this office ? _____
In case of emergency, whom should we contact ? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____ Soc. Sec # _____
Address _____ City _____ State _____ Zip _____ Phone _____
Person Responsible Employed by _____ Phone # _____
Insurance Company _____
Contract# _____ Group# _____ Subscriber# _____
Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? _____ Yes _____ No
Subscriber Name _____ Relation _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Subscriber Employed By _____ Phone # _____
Insurance Company _____
Contract# _____ Group# _____ Subscriber# _____

CANCELLATION POLICY

There is a policy of charging a fee for missing an appointment or canceling with less than 48 hours notice.

The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for them, and if the schedule is not adhered to, then other patients who need "same day" urgent visits, or earlier appointments than the schedule permits, are being obliged to wait longer than necessary.

Cancellations of convenience or last minute schedule conflict will be your responsibility. The fee is \$75.00 and the patient will be billed accordingly.

Patient's signature

Date

rev. 4/08