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

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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 and Medicare.
   If you have HMO with HMSA you will need your primary care doctor referral note to HMSA.
   If you do not have HMSA coverage, Dr. Christenson will provide you Insurance coding for you to submit to your insurance company for reimbursement.
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

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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

Elizabeth Chen Christenson, MD - Medicare Patients
Advance Beneficiary Notice (CMS-R-131-G) For General Use

Patient's Name: _____ Medicare #:_____
NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

Right now, in your case. Medicare probably will not pay for -

Acupuncture and Oriental Medicine

Medicare will only pay for services that are determined to be "reasonable and necessary" under Section 1862 (a) (l) of the Medicare law. If Medicare determines that particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards. Medicare will deny payment for that service. I believe that, in your case. Medicare is likely to deny payment for acupuncture and Oriental Medicine, it is not a service for which Medicare provides coverage, neither the office visit in conjunction with the treatment.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

___Option 1. YES. I want to receive these services.
I understand that Medicare will not pay for these services.
I agree to be personally and fully responsible for payment.
I understand I can appeal Medicare's decision.

___ **Option 2. NO.** I have decided not to receive these items or services.
I understand that you will not be able to submit a claim to Medicare
and that I will not be able to appeal your opinion that Medicare won't pay.

Signature of patient _____
or person acting on patient's behalf
Date_____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare. 0MB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002).