Dr. Lorri Beauchamp, AP
6435 Central Ave
St. Petersburg, FL 33710
Phone: (727) 279-5388
Email: info@DrLorri.com
Website: DrLorri.com

Bio and Health History

Today's date: _____/_____/_____
Name:_____DOB:_____/_____/_____Age:_____Gender:_____
Address_____ City_____State_____Zip_____
Phone:_____E-mail address:_____
Marital Status:_____# of children _____ ages_____
Occupation:_____Hrs per week:_____
How did you hear about us: _____
Emergency Contact: _____Phone:_____Relationship_____

Under 18 ---Responsible Party Information

Name_____ Relationship_____
Healthcare Providers ---please list those you work with: _____
_____
Physicians: GP/Primary Care: _____
OB-GYN: _____
Other:_____
Previous experience with acupuncture?_____

Health History
*******Please list your current health concerns in order of importance to you:**
_____
_____
_____
_____

List any diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:
_____
_____
_____
Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had in your past:_____
Any chronic issues you can think of?_____
Current Medications, Herbs, Supplements:
_____
_____

Family History:
Mother_____
Father_____
Grandparents_____
Siblings_____
Children_____
Lifestyle Habits
How is your
Diet?_____**Sleep?**_____
Digestion?_____**Stress?**_____
Do you
Smoke?
Drink coffee?
Drink alcohol?
Use recreational substances?_____

Signature:_____**Date:**_____

Informed Consent & Disclosure of Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling. I understand that these therapies are safe methods of treatment. As with all medical procedures, they involve potential but unlikely risks. Such uncommon risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very, very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible but highly unlikely (we've never witnessed this), as the clinic uses alcohol, sterile disposable needles, and a safe and clean environment. A burn is a possible but extremely rare side effects of moxibustion. Temporary bruising (not painful) or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, antidepressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Regular treatment and completing the prescribed treatment plan is what gives acupuncture and herbs the best results. I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendations may be toxic, and some herbs are inappropriate during pregnancy. Some possible but rare side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and hives. I understand that I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known. In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

_____

Patient Name

_____ _____

Patient Signature Date

Financial Policy

Acupuncture Clinic Fee Schedule

Welcome to our office! The information below is provided to make you aware that our billed amount are the same paying patient versus if you have insurance, a personal injury (auto accident) or worker's compensation case.

Insurance Patients: You will be responsible for payment of any deductibles or copays not covered by your insurance provider. Please note that we usually charge insurance companies between a national pre-set average per visit, depending on the therapies performed in conjunction with the acupuncture, such as: manual therapy (massage), infrared, e-stim, moxibustion, therapeutic exercises, etc. We do not receive what we bill since all charges are reviewed and reduced by insurance companies. When you receive your explanation of billing (EOB) it may tell you that you owe Dr. Lorri Beauchamp,AP. the difference between what we charged for your visit and what your insurance actually paid. This is not necessarily the case. There may be times when our billing service is mis-quoted information and payment is not made as initially described by your insurance. You are legally responsible for ant payment and will receive the best customer care by contacting your insurance company directly. **All patients, whether covered by insurance or self pay, are billed the same amount, however monies collected may differ.**

Self Pay Patients: Currently our self pay collections for a new patient visit (thorough exam, treatment, and plan) is $175 and follow-up acupuncture visits are $120. For Fertility Patients, the initial visit is $170 since we incur more training for reproductive medicine. These fees are called "point of service fees" as they are paid at the time services are delivered. Understand that this is also a discounted fee because it does not involve the administration, processing, and delay in payment. of insurance, and because we know most people are unable to pay our regular fees that we bill insurance companies. **We have an allotted amount of sliding-scale spots available in our practice and are reserved for those with financial hardship.**

Worker's Compensation (injury on the job) and Personal Injury (car accident) Cases: Patients are not usually responsible for any costs associated with a worker's comp or personal injury claim except for herbs/supplements. Please speak directly with our billing service about your case and provide your adjuster's information. The fees charged are our standard rates set by a third party.

All fees collected by Dr. Beauchamp, AP are reasonable and in keeping with industry standards.

Other Services:

• Herbal and Dietary consultations (includes a prescription for an herbal formula or specific dietary program); 30 minutes for $65.

• Labor Induction Treatment-Series of 3 $300.

• House-calls for hospice, labor, postpartum or surgical recovery, or for those who are unable to travel to us; $50 for up to 30-minutes of travel (to and from location) or $100 for up to 60 minutes of travel plus our regular hourly rate. Herbal and Nutritional Supplements are NOT covered by insurance or third-party payers and must be paid at the time these items are received.

I have read and understood the fees charged at Dr. Lorri Beauchamp, DOM and LL Beauchamp, Inc.

_____

Patient Name

_____ _____

Patient Signature Date

Practice Policies

The following are specific policies that will govern our work together:

Cancellation Policy

In the event that you must cancel an appointment, please give us 24 hours notice (you can change and cancel appointments through our online scheduling system). You will be charged the late fee for your session if you do not show up for or cancel your appointment with less than 24 hours notice. **Late Policy**

If you are going to be late, please call and let us know and we will wait until the time we agree upon.

Phone Calls and Emails

You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. All contacts that require beyond 20 minutes of our time are considered session work and will be billed a flat rate of $50.

Confidentiality and Privacy Practices

As a healthcare provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff..

Our office has a right to deny or discontinue treatment with a patient if there is an endangerment, health concerns out the legal scope of practice, or ethical concerns.

We are partners in your healthcare.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Now let's get started!

Agreement

I have read and understood the clinic's policies. I agree to all of the above treatment terms and conditions.

_____

Patient Name

_____ _____

Patient Signature Date