Moon and Lotus, LLC

Acupuncture, Chinese Herbs, Bodymind Counseling

Kamala Quale, MSOM, LAc
966 Lorane Hwy, Eugene, OR 97405
541-345-2220

Appointments are scheduled during the following hours:

Tuesday – 2:00 pm – 4:30 pm
Wednesday – 10:15 am – 4:30 pm
Friday – 9 am – 3:15 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 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.

Every fifth or sixth visit we will have **re-evaluation assessment.** This is an important time to asses our progress and make further treatment goals. There is an extra fee for this visit as listed below. Again, if you need more specific information, please feel free to ask.

Health assessment & first acupuncture treatment: $125
Follow up visits: $85/hour
Re-evaluation assessment: $100
Herbs: separate charge

Insurance Policy

Please bring your insurance card with you to your first visit. We will bill insurance if we are a covered 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.

At present, Oregon Health Plan or Medicare/Medicaid do not cover my acupuncture services.

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. All 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 accident, falls, etc.)* _____

Your birth history: *(prolonged labor, forceps delivery, etc.)* _____

Allergies: *(drugs, chemicals, foods)* _____

Family Medical History *(please specify family members)*

□ Cancer □ Diabetes □ Seizures □ Stroke
□ Heart Disease □ High Blood Pressure □ Asthma □ Allergies

Occupation

Occupational stress: *(chemical, physical, psychological, etc.)* _____
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.

General

□ 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
□ Change in hair or skin texture
Any other skin or hair problems? _____
_____

Head, Eyes, Ears, Nose and Throat

□ Dizziness □ Concussions □ Migraines □ Facial pain □ TMJ
□ Jaw clicks □ Grinding teeth □ Teeth problems □ Sores on lips or tongue
□ Glasses □ Eye strain □ Poor vision □ Blurry vision □ Eye pain
□ Night blindness □ Color blindness □ Cataracts □ Spots in front of eyes
□ Earaches □ Ringing in ears □ Poor hearing □ Recurring sore throat
□ Sinus problems □ Nose bleeds
□ 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
□ Indigestion □ 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	□ Area 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)* _____

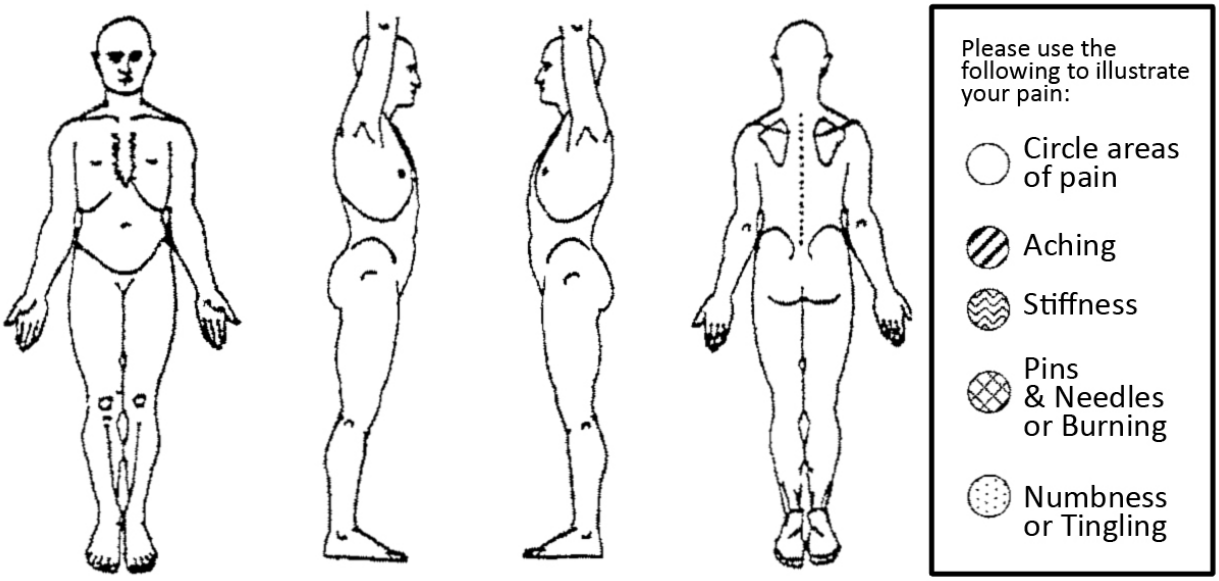
What is the quality of your sleep? _____

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 *through* the line below to indicate how you are feeling *at this moment*

No Discomfort ——————————————— *Extreme Discomfort*

Comments: Please explain or list any other problems you would like to address: _____

_____

ACUPUNCTURE CONSENT FORM

By signing below, I voluntarily consent to be treated with acupuncture and/or substances from the Oriental materia medica by Kamala Quale, who is an acupuncturist licensed by the state of Oregon. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that it is recommended that all patients have a primary care provider as part of a complementary care program.

Acupuncture is performed by the insertion of needles through the skin and/or the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions.

Adverse side effects may result. These could include, but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.

I understand that treatment with substances from the Oriental materia medica may be recommended. I understand that I am not required to take these substances but if I do take them I must follow the directions for administration and dosage. Adverse side effects may result from taking these substances. These include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. If I experience any problems, which I associate with these substances, I understand that I should stop taking them and call Kamala Quale.

I understand that acupressure massage may also be given as part of my treatment protocol. Possible side effects could occur and might include: muscle soreness or achiness and possible aggravation of symptoms existing prior to treatment.

I understand that Kamala Quale is a certified practitioner of bodymind counseling and has been trained in the Hakomi Method. I know she practices her own synthesis of verbal focusing methods that direct awareness to physical and emotional processes that occur during a session. I understand that this kind of self-exploration will be recommended if it could be beneficial to my overall well-being.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I know that I can ask questions about anything I am not sure about. I understand that there are no guarantees concerning the use and effects of the above methods and that I am free to refuse or stop treatment at any time.

_____ _____

Signature of Patient or legal Guardian Date

_____ _____

Printed name Phone

_____

Address

Consent to Treat a Minor:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive acupuncture and OMA treatment by Kamala Quale.