TRIANGLE ACUPUNCTURE
CLINIC

Community Clinic - Campus Health Services **Personal Information**

Name:			Date:
Address:			
City:		State:	Zip:
Best Phone:	Email:		
Occupation:			PID#:
Emergency Contact:			Phone:
How did you hear about us?			

Chief Complaint

Please describe the main concern you're coming in for today:

Tell us about your condition

How long have you had the problem? When did it begin?

How did it start? (ie: injury, stressful/traumatic situtaion, gradual onset, illness, etc)

What seems to make it worse?

What seems to make it better?

How severe is the condition? No severity 0 1 2 3 4 5 6 7 8 9 10 Most Severe (circle one)

Health History

Please indicate significant illnessnes your or a blood relative (grandparent, parent, or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	( )	( )	_____	Diabetes	( )	( )	_____
Hepatitis	( )	( )	_____	Heart Disease	( )	( )	_____
Hypertension	( )	( )	_____	Seizures	( )	( )	_____
Rheumatic Fever	( )	( )	_____	Mental/Emotional	( )	( )	_____

Other Infections:

Tuberculosis ( ) HIV( ) HPV ( ) Herpes ( ) Syphilis ( ) Chlamydia ( ) Gonorrhea ( )

Please indicate if any of the following statements are true:

I have known allergies ( ) I am taking Coumadin/Warfarin ( )

I have a pacemaker ( ) I am taking Lithium *(Eskalith, Lithoboid, Lithonate, Lithotabs)* ( )

Patient Name:_____

****For Practitioner Use Only*****

Practitioner: **Time needles inserted:**

Subj/Obj Notes:

Tongue: **Pulse:**

Treatment:

Tx Plan for next visit: **Herbs:**

UNC STUDENT AFFAIRS

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

CAMPUS HEALTH SERVICES

JAMES A. TAYLOR BUILDING
320 EMERGENCY ROOM DRIVE
CAMPUS BOX 7470
CHAPEL HILL, NC 27599-7470

T 919.966.2281
F 919.966.0361
campushealth.unc.edu

Acknowledgement and Agreement for Payment / Acupuncture Services

By signing this agreement, I acknowledge

1. Acupuncture services provided at UNC Campus Health Services carry a $50.00 charge per visit and
2. These services will not be billed to any insurance carrier and
3. I will be financially responsible for the entire cost of the service; it will be billed to a student's university account or invoiced to private patients.

I have read and understand the above and agree to pay all charges for treatment(s) or diagnostic procedure(s) to Campus Health Services.

_____ _____
Date Signature of Patient

_____ _____
PID # Printed Name of Patient

_____
Signature of Parent/Guarantor

**** PARENT/GUARANTOR INFORMATION AND SIGNATURE REQUIRED FOR PATIENTS UNDER AGE 18****

Name (Print): _____ Relationship to Patient: _____

Address: _____

Phone: _____ Date of Birth: _____

Revised 9-7-18

thrive Campus Health Services
Campus Health Services at the University of North Carolina at Chapel Hill
CB #7470 | (p) 919.966.2281 | (f) 919.966.0616 | campushealth.unc.edu

CAMPUS HEALTH SERVICES PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures: I authorize Campus Health Services (CHS), their employees and consultants, to provide medical treatment and perform diagnostic procedures and services, which in their judgement may be medically necessary for my care. These may include the use of clinical photography as well as requesting and accessing information available from third party payors and other healthcare providers about my prescription medications, including my prescription medication history and medications that are covered by my insurance plan. I agree that I will be involved and engaged in my care and treatment. If I require specialized and/or emergency care, I will be referred to appropriate outside medical facilities or professionals. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of CHS.

Confidentiality: Medical and mental health information contained CHS health record is strictly confidential and may only be released to outside sources with written permission from the patient, by a court order, or when permitted by law. Confidentiality and privacy is protected in all CHS business relationships to prevent the exchange of any patient specific information without permission. In the instance where an outside medical provider orders lab tests or allergy injections for patients at CHS, the results or follow-up from those tests or visits will be relayed back to the ordering provider. In addition, if a CHS provider refers you to an outside provider; your records pertaining to that referral may also be released.

Notification: I authorize CHS to contact me via University e-mail to include, but not limited to, appointment reminders, pre-matriculation immunization requirements, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling CHS at (919) 966-2283. Because conventional email is inherently unsecured and the confidentiality of sensitive medical information cannot be assured, it is advised for matters that are sensitive in nature to contact CHS directly by calling 919-966-2281 or by sending a secure message through the patient portal at https://healthyheels.unc.edu. To Opt Out of appointment reminder text messages from Campus Health Services, please call 919-966-2283.

Financial Information and Authorization to Process Insurance Claims: All UNC students are required to have health insurance either through an individual policy or through their family policy. CHS will file insurance claims on behalf of patients. The filing of claims does not guarantee either full or partial payment by the insurance company. For more information about using insurance at Campus Health Services, please visit: http://campushealth.unc.edu/charges-insurance/using-insurance-campus-health. Please remember that the CHS Pharmacy is In-Network with virtually all US health insurance plans.

I, the undersigned, have read and understood the above information and authorize the release of any medical or insurance information to my insurance company and/or their agents, including but not limited to any plan administrator, pharmacy benefits manager, underwriter, or sponsor, which is necessary to process claims for services rendered by CHS. I hereby authorize my insurance company to distribute the payment of my coverage directly to CHS. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize CHS to place any unpaid charges on my student account at the Office of Student Accounts and University Receivables (SAUR). I understand the office of SAUR may place a registration hold on my account for any unpaid CHS charges. I understand I cannot use Title IV federal financial aid to pay CHS charges unless I have signed permission with the Office of Scholarship and Student Aid. If I am a student at UNC-Chapel Hill, I understand that I am responsible for any charges incurred by my spouse or partner if treated at CHS. I authorize the use of this signature on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

I verify by my signature below that I have read and understood the above information and give my permission as stated above.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____ PID#: _____

Signature of Parent/Guardian (If patient is under age18:_____Date: _____