CLIENT INFORMATION FOR ACUPUNCTURE TREATMENT

NAME: ____________________________________**DOB:** ____________________

ADDRESS: ____

____

DAYTIME PH: ___________________ **EVENING PH:** ___________________________

E-MAIL ADDRESS____

REFERRED BY: ____

IN CASE OF EMERGENCY CONTACT ____

PH:______________________________________

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN BELOW:

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine, and nutritional counseling. I understand that the herbs prescribed need to be prepared or taken according to the acupuncturists oral or written instructions and that I will notify a member of the clinical staff of any unanticipated effects associated with consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture including lung puncture. Burns and/or scaring are potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy, so I will notify a clinical staff member who is caring for me if I am or become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hive, tingling of tongue.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise reasonable judgment during the course of treatment based upon facts given. I understand results are not guaranteed.

I understand that clinical staff and administrative staff may review my patient records, lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature____**Date**____________________________
(patient or patient representative)

Office signature____________________________________**Date**_____________________________

MEDICAL HISTORY

BRIEFLY EXPLAIN THE REASON FOR YOUR APPOINTMENT TODAY.

PAST ILLNESSES, SURGERIES, HOSPITALIZATIONS (INCLUDE DATE/YEAR)

ARE YOU CURRENTLY BEING TREATED FOR ANY HEALTH CONCERN OTHER THAN THE REASON FOR YOUR VISIT TODAY? IF SO, PLEASE EXPLAIN.

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE CURRENTLY TAKING AND WHY. PLEASE INCLUDE DOSAGES.

DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE EXPLAIN

WHEN WAS YOUR LAST VISIT TO AN M.D. FOR A GENERAL PHYSICAL OR FOR ANY OTHER REASON?

DO YOU USE TOBACCO PRODUCTS? FREQUENCY/AMOUNT______________________

DO YOU DRINK ALCOHOLIC BEVERAGES? FREQUENCY/AMOUNT_______________

CAFFEINATED BEVERAGES? FREQUENCY/AMOUNT____________________________

HAVE YOU EVER TESTED POSITIVE FOR HEPATITS? ________IF SO, WHEN?_______

HAVE YOU EVER TESTED POSITIVE FOR HIV? _____________IF SO, WHEN?_______

PLEASE CHECK MARK YES OR NO TO THE FOLLOWING MEDICAL HISTORY QUESTIONS:

YES	NO	
____	____	DO YOU SUFFER FROM HEADACHES?
_____	____	DO YOU SUFFER FROM STRESS?
_____	_____	ARE YOU EPILEPTIC?
_____	____	DO YOU HAVE HIGH BLOOD PRESSURE? IF SO, ARE YOU TAKING MEDICATION FOR THIS?
____	____	ARE YOU A DIABETIC?
____	____	ARE YOU PREGNANT?
____	____	DO YOU HAVE ANY NUMBNESS OR STABBING PAINS?
____	____	THYROID DISORDERS?
____	____	HEART CONDITION OR ANY CIRUCULATORY PROBLEMS?
____	____	LUNG PROBLEMS?
____	____	BLEEDING DISORDERS?
____	____	REPRODUCTIVE DISORDERS?
____	____	STOMACH ULCERS?
____	_____	SKIN PROBLEMS, ACNE, DERMATITIS, ETC.
____	____	DIGESTIVE ISSUES?
____	____	DO YOU SUFFER FROM EXTREME FATIGUE OR LOW ENERGY?
____	____	FREQUENT COLDS OR INFECTIONS?
_____	_____	PSYCHIATRIC OR EMOTIONAL CHALLENGES?

HIPAA-FREE OFFICE

CERTIFICATE OF PRIVACY ASSURANCE TO PATIENTS

Welcome to our HIPAA-FREE office. The protection of your health information is a high priority in our office. The confidence and trust you have placed with us is appreciated and honored.

Under the new federal rules connected with the Health Insurance Portability and Accountability Act (HIPAA), your personal and health care information could be obtained by many third parties (including government agencies) without your consent. The new rules for HIPAA entity offices only require a notice or a log to be created when your records, in many situations, are used or disclosed.

Any health care provider (physician, doctor) who engages in any standard electronic transactions with others is considered under the law to be a HIPAA entity. The initial objective of the law was to stop and prevent the abuses that took place when patient health information entered the electronic world. However, under this HIPAA law–which has expanded, thousands of workers and many government agencies could have virtually unrestricted access to your health care records without your consent.

It would not be possible for us to give maximum protection to your patient information if we were a HIPAA entity. Therefore, our office has chosen to be a “HIPAA-Free” office. In our opinion, it is currently the best “protected health information” option available for our patients. We will not engage in any electronic transaction with others, as defined by HIPAA. Our office will not subject your information to the vulnerability and risks of the electronic world. Once your records enter into computer networks, your privacy is at risk–no matter how many rules are allegedly in force to protect you.

Additionally, we will be better able to serve your needs by concentrating on your health care problems and concerns instead of having to constantly respond to complex and ever changing HIPAA rules and regulations.

IN SUMMARY: our office will not be subject to HIPAA because we do not do electronic transactions. Your insurance claims and any associated information will be filed on paper. Processing and payments could be delayed, but your privacy is assured. Suggestion: when you file your own insurance claims there can be faster payment and better reimbursement (with the exceptions of some payers such as Medicare that require us to submit the claims).

Be assured that your records will NOT be disclosed nor released to anyone outside of our practice without your written consent unless specifically required to do so by law. We will continue to honor your trust in us and to protect your health information. As a HIPAA free office, we can and will maintain the highest standards of excellence in privacy matters.

Signature ____ Date __________________

HIPAA-Free OffIce Certificate (#E2703) courtesy of ChiroCode Institute, Inc., www.chirocode.com

CANCELLATION POLICY

IF YOU FIND IT NECESSARY TO CANCEL OR CHANGE YOUR APPOINTMENT, PLEASE ALLOW AT LEAST 24 HOURS NOTICE. YOU ARE OBLIGATED TO PAY FOR YOUR APPOINTMENT IN FULL IF ANY CHANGES, CANCELLATIONS OR MISSED APPOINTMENTS ARE RECEIVED WITH LESS THAN 24 HOURS NOTICE.

HOWEVER, IF YOUR MISSED APPOINTMENT TIME CAN BE FILLED WITH ANOTHER CLIENT, YOU WILL NOT BE CHARGED. WE BELIEVE THIS TO BE A FAIR PROFESSIONAL COURTESY AND APPRECIATE YOUR UTMOST RESPECT.

PLEASE AKNOWLEDGE WITH YOUR SIGNATURE THAT YOU'VE READ AND UNDERSTAND OUR POLICY. THANK YOU.

Signature__________________________**Date**_______________________