Acupuncture

PATIENT INFORMATION (*Please print and complete in full*)

Name: ______________________________ Today's Date: ________________

Address: ____

______________________________ ZIP ________________

Home Telephone #: ____________________ Work Telephone #: ________________

Cell# ______________________

Would you like to be contacted by email with informational newsletters and special clinic offers?

If Yes ☐ Email Address: ______________________ No ☐

Patient Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ________________

Birth Date: ______________ Age: ________

Referred to our Clinic by: ______________________________________

Emergency Contact: ________________________ Relationship: ______________

Emergency Contact Telephone #: ______________________________________

Employment/School Status:

Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐

Occupation: ____

Employer's Name: ________________________ Telephone #: ________________

Employer's Address: ____

Primary Health Care Source

Physician's Name: __________________________ Telephone #: ______________

Physician's Address: __________________________ Date of last visit: __________

Date of Injury or Onset of Illness: ______________________________________

Medical Insurance status:

Self ☐ Private Insurance ☐ Medi -Cal ☐ Worker's Comp ☐ Other ______________

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for a medical condition? Please describe

Please briefly describe any chronic pain:

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue?

Do you have other health concerns?

Please describe the type of foods you eat regularly:

Breakfast ____

Morning Snack ____

Lunch ____

Afternoon Snack ____

Dinner ____

Evening Snack ____

Do you exercise regularly? Yes □ No □

What type of exercise do you do?

____

FAMILY HISTORY *Complete for each family member, placing an X in the appropriate box:*

	self	mother	father	sister	brother	spouse	child
allergies							
blood disorder							
diabetes							
cancers or tumors							
seizures							
high blood pressure							
kidney or bladder disorder							
stomach or intestinal disorder							
drug abuse							
tuberculosis							
heart disease							
stroke							
depression							
mental illness							

MAJOR HOSPITALIZATIONS - If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

Year	Operation or Illness	Name of Hospital	City & State

PREVIOUS PREGNANCIES:
Total Pregnancies____Living___Ectopic___Miscarriages___Induced Abortions____

MEDICINES - Mark an X in the box next to any of the following that you are now taking:
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Acetaminophen (Tylenol)
- ☐ Insulin, diabetic pills
- ☐ Antacids
- ☐ Laxatives
- ☐ Cold tablets
- ☐ Oral contraceptives
- ☐ Diet pills
- ☐ Tranquilizers
- ☐ Fiber supplements
- ☐ Sleeping pills
- ☐ Hay fever tablets
- ☐ Blood pressure pills
- ☐ Blood thinning pills
- ☐ OTHER: ________________

vitamins (please list)____
herbs (please list)____

DRUG ALLERGIES ____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Coffee	☐yes	☐no	cups per day/week____	age started____	age quit____
Tobacco	☐yes	☐no	# cigarettes per day___	age started____	age quit____
Marijuana	☐yes	☐no	use per day/week _____	age started____	age quit____
Alcohol	☐yes	☐no	use per day/week _____	age started____	age quit____

Other ____

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, ____ give consent to Integrated Health the use and disclosure of my individual identifiable health information or Protected Health Information for the specific purposes:

A. Providing treatment to me;

B. Relating to the payment of the services this office has rendered to me; and

C. The general administrative operation this practice provides to me

<u>The purpose of this consent</u>:

Protected Health Information is any information that includes:

A. Demographic information

B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition.

C. Information gathered by this office for past, present or future payments for providing the healthcare services.

D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my protected Health Information for the purposes of treatment; payment of healthcare operation of the Acupuncture practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.
I understand I have the right to read and discuss the Notice of Privacy Polices and Procedures from this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time except to the extent that Integrated Health has acted in reliance on this consent.

______________________________ Date____________________

Signature of Patient or Personal Representative

______________________________ Date____________________

Description of Personal Representative's Authority

Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*
We gather personal information and health information in several ways:
• Information we receive from you;
• Information we receive from other healthcare providers; and
• Information we receive from third party payers.
This information is used for treatment, payment and healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure
This office may use or disclose your Protected Health Information when required by law.
Patient Rights
1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________________, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.
This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature ___________________________ Date________________________

Informed Consent to Treatment-Acupuncture

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the Licensed Acupuncturist of Integrated Health. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Acupressure Massage, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. Infection is another possible risk, although Integrated Health uses sterile needles and maintains a clean and safe environment. *Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).* I understand that while this document describes the major risks of treatment other side effects and risks may occur.

Herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. *I understand that some herbs may be inappropriate during pregnancy.* ***Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy.***

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of Integrated Health of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the member of Integrated Health who is caring for me if I am or become pregnant.

I do not expect the Clinical Staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the Clinical Staff to exercise judgment during the course of treatment which the Clinical Staff thinks is best at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and 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 that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

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To be completed by patient (or by patient's representative if the patient is a minor or is physically or legally incapacitated) providing information and obtaining consent.

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Print Name of Patient

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Signature of Patient (or Representative)

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Date