How long is a treatment?

A treatment usually takes 1 hour.
A new patient intake takes a little longer, because it includes an initial consultation and a treatment

How long does acupuncture take to work?

Most patients feel beneficial results within 1 - 10 treatments. Response to acupuncture depends on the individual, the condition and its seriousness. The number and frequency of treatments needed will vary from once a day, to once every three months. For pain relief, typically 2 - 4 treatments per week is effective (usually 2 - 10 visits total).

In general, acute or short-term health conditions require fewer and more frequent treatments than chronic or long-term conditions. Each consecutive treatment acts to support the previous one to achieve optimal healing. NOTE: When multiple treatments are recommended it is important to return for the following treatment *before* symptoms return to their original intensity.

Treatment Guidelines

Pain medication

Do not take any pain medication before an acupuncture treatment (e.g., ibuprofen, prescription medication etc.).
Pain medication interferes with the effectiveness of acupuncture therapy.

How to prepare

Wear loose, comfortable clothing, such as a cotton t-shirt, sweatpants or shorts.

PLEASE: *Do not* wear any fragrances or makeup (it may need to be removed for treatment).
Also of concern, fragrances and makeup contain toxic synthetic chemicals which damage human health.
For more information: http://www.safecosmetics.org/

What to eat

Do not drink alcohol before or after the treatment. If possible, eat a small healthy meal one-hour before your appointment. Do not arrive with an empty, or very full, stomach.

Relax afterwards

Relax for 1 or 2 hours after your treatment.
Refrain from rigorous physical exercise for at least 1 hour after treatment.

What does acupuncture cost?

Private Acupuncture

A private acupuncture treatment cost is $150 (cash or check, payable at time of treatment).

Health Insurance

To help keep the cost of your treatment as low as possible, we do not bill insurance companies directly. If your health insurance plan includes acupuncture benefits, you can submit a copy of our invoice to your insurance company for reimbursement. Please speak with your benefits coordinator for the details of your policy's coverage. Some policies require a physician referral for you to qualify for reimbursement.

Health Savings Account (HSA) Plans

If you are enrolled in a Health Savings Account plan, you can use this account to pay for your acupuncture treatment.

Income Tax Deduction

Acupuncture is a qualified medical expense by the IRS and may be eligible for deduction when preparing your tax return. For more information, speak with your tax advisor.

Contact Information

First Name: MI:

Last Name:

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

Cell Phone:

eMail:

Work Phone:

Identification

Age: Birth Date:

Height: Weight:

Gender: ☐ F ☐ M

Ethnicity:

Status: ☐ Married/Partner ☐ Single

Occupation:

Employer:

Employer Phone:

Primary Physician

Name:

Clinic name:

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

Emergency Contact

Name:

Relationship:

Address:

City:

State/Prov: Zip/Postal Code:

Cell Phone:

eMail:

Phone/Daytime:

Phone/Evening:

Note / Comment

Visit Information

Primary reason for visit:

Have you seen other practitioners about this issue? ☐ No ☐ Yes

If yes, name and specialty of practitioner:

Diagnosis, test or lab results:

Medications or treatments received:

Secondary issue:

Have you ever had an acupuncture treatment? ☐ No ☐ Yes

How do you *feel* about receiving an acupuncture treatment?

Symptoms

Date symptoms started:

Describe:

Location:

Was there a triggering event?

My symptoms are: ☐ Improving ☐ Worsening ☐ Unchanged

How long do symptoms last?

Symptoms occur at certain times of day: ☐ No ☐ Yes:

Are you in a specific location or position when symptoms occur?

☐ No ☐ Yes:

How severe are symptoms? ☐ Severe ☐ Moderate ☐ Mild

What makes symptoms improve?

What makes symptoms worse?

Are symptoms affected by eating, sleeping, or other activities? ☐ No

☐ Yes, describe:

Do symptoms affect your daily activities? ☐ No ☐ Yes

Describe:

What do you think your symptoms mean?

☐ I have traveled outside USA/Canada recently (within the last 6 months).

Country traveled to:

Current Medications

List all current medications, supplements and herbs, and reason for taking each:

Allergy Checklist

☐ Medication, list:

☐ Food, list:

☐ Environmental (pollens, molds, etc.), list:

☐ Insect (bee stings, etc.), list:

☐ Contact dermatitis (hair dye, jewelry, etc.), list:

☐ Latex ☐ Cosmetics ☐ Lactose intolerance

☐ Other:

Electronic Implant / Blood Disorder

I have an electronic implant: ☐ No

☐ Yes, describe:

I have a bleeding disorder: ☐ No

☐ Yes, describe:

I am taking anticoagulant medication (blood thinner): ☐ No

☐ Yes, medication name:

Illness and Injury

List any serious illnesses, include dates:

List any serious injuries, include dates:

List any surgeries, include dates:

List any long-term or persistent condition, include date condition began:

Family Medical History

List any serious illnesses, persistent condition, and cause of death for your parents and your siblings:

Statement of Informed Consent

I hereby request and consent to the performance of acupuncture and other Traditional Chinese Medicine (TCM) treatments on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that acupuncturists are not allopathic care providers and that care by a licensed allopathic physician may be recommended by this clinic depending on medical needs.

Acupuncture/Moxibustion/Cupping

I understand that the scope of practice for acupuncture includes but is not limited to: insertion of sterile acupuncture needles through the skin, electrical stimulation or the application of heat, moxibustion, cupping, dermal friction, dietary counseling, exercise and breathing techniques based on traditional Chinese medical principles. I am aware that certain adverse side effects may result. These could include, but are not limited to: transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles and risks of infection or pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that if I receive moxibustion as part of therapy, there is a risk of mild burning from its use.

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Acupressure/Tui-Na Massage

I understand that I may be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Medicinal Herbal Therapy

I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I will stop taking them and call the clinic as soon as possible.

Patient Agreement

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. All of my questions have been answered to my satisfaction. I understand that results are not guaranteed. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the information on this form and am fully aware of what I am signing. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment at this clinic. I give my permission and consent to treatment.

To indicate that you have read, understand and agree with this document, please sign and date below. Patient Signature (or Guardian, if minor):

Signature:.....

Printed Name:.....

Date:.....

Address:.....

.....

City:.....

State/Prov:..... Zip/Postal Code:.....

Phone:.....

Cell Phone:.....

Following Your Acupuncture Treatment

You may feel light headed after an acupuncture treatment. If this happens, please sit down and rest. You should feel fine in just a few minutes.

Medicinal herbs are prescribed for individual patient use only. Herbs prescribed for medical purposes should **not** be used by anyone else.

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality-monitoring.
Your consent, or the opportunity to agree or object, is not required in these instances:

Treatment

Information obtained by your practitioner at this clinic will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.

Payment

Your record will be used to receive payment for services rendered by this clinic. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.

Quality Monitoring

The staff in this office will use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA)

This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Worker's Compensation

This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health

This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Law Enforcement

1. Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law.
2. In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

It is this clinic's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested.

You have the right to request restrictions on these uses. Otherwise, this clinic will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

Business Associates

Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these business associates to follow the same standards held by this office through terms detailed in a written agreement.

Communications with Family

Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Marketing and Fundraising

This clinic may send information to you about treatment alternatives and other health-related benefits that you may find useful. This clinic may also contact you to request your charitable support in order to keep patient fees reasonable and provide for continuing practitioner training and research. Persons contacting you are employees of this clinic and will know only that you have been a patient but have no access to your medical records.

Notice of Privacy Practices

This notice and the accompanying; ***'Practices Regarding Disclosure of Patient Health Information'*** *notice describes how the Health Insurance Portability and Accountability Act (HIPAA) impacts your health information. How your health information may be used or disclosed, and how to get access to your health information. Please review this information carefully.*

Understanding your health record

A record is made each time you visit this clinic. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights

Your health record is the physical property of this clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Discretion Request

In accordance with HIPAA, you may indicate if any discretion is necessary when being contacted to remind you of your scheduled appointment via your home telephone.

Please use discretion when contacting me by phone: ☐ No ☐ Yes

If yes, explain:.....

.....

.....

.....

.....

.....

.....

Clinic responsibilities

This clinic is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. This clinic reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, this clinic agrees not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact this clinic. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

I, (please print name)**:**

.....

have received a copy of this **Notice of Privacy Practices** and the accompanying **Practices Regarding Disclosure of Patient Health Information**. I understand my health information will be used and disclosed consistent with these Notices.

Client/Patient Signature:

.....

Date:.....

Signature of Witness:

.....

Date:.....