

Today's Date: _____

Client ID: _____

BASIC INFORMATION

*First Name		*Last Name
*Date of Birth	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	Occupation
*Who may we thank for referring you? <input type="checkbox"/> Person <input type="checkbox"/> Doctor <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> LivingSocial <input type="checkbox"/> Other Please be as specific as possible:		

CONTACT INFORMATION

*Email Address		
*Primary Phone Number		*Primary Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Alternate Phone Number		Alternate Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
*Address		Emergency Contact Name, Phone, & Relationship
City	State	Zip

HEALTH INFORMATION

Specific health concerns you'd like to address	1. _____ since _____
	2. _____ since _____
	3. _____ since _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any pain or stiffness? If so, where? List years of any major injuries or surgeries.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have sleep issues? <input type="checkbox"/> difficult to fall asleep <input type="checkbox"/> wake easily in the night
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have digestive issues? <input type="checkbox"/> weight gain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> acid reflux
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have urinary issues? <input type="checkbox"/> frequent urination <input type="checkbox"/> difficulty urinating <input type="checkbox"/> urinary tract infection
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have circulation issues? <input type="checkbox"/> cold hands and feet <input type="checkbox"/> often short of breath <input type="checkbox"/> often tired
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have emotional issues? <input type="checkbox"/> stress <input type="checkbox"/> anxiety <input type="checkbox"/> depression
Health History	<input type="checkbox"/> Addiction <input type="checkbox"/> Bronchitis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Allergies <input type="checkbox"/> Cancer <input type="checkbox"/> Heart attack <input type="checkbox"/> Liver disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other _____
Contraindications	Please check if you are: <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Using a pacemaker Any food or drug allergies? _____ Current medications? _____

INSURANCE INFORMATION

Insurance Company: <input type="checkbox"/> Aetna <input type="checkbox"/> Carefirst BCBS <input type="checkbox"/> Cigna <input type="checkbox"/> Kaiser <input type="checkbox"/> UnitedHealthcare <input type="checkbox"/> Other	
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Member ID:
Name of Insured (if not self):	Date of Birth of Insured (if not self):
Primary Physician Name and Phone Number:	

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of massage and acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the client 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 clinic listed below or any other 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, Tui-Na (acupressure massage), herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the 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, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). These occur rarely if ever. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Eastern Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a staff member of the clinic 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, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff and administrative staff may review my patient 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, the above 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.

PRIVACY POLICY

Understanding your health record: A record is made each time you visit our clinic. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record" and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health providers who may contribute to your care.

Understanding your health information rights: Your medical record is the physical property of the health care practitioner that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities: This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

Your health information will be used for treatment, payment, and health care operations.

Treatment: Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you.

Payment: Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health care operations: The medical staff in this office will use your health information to access the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvements in our efforts to continually improve the quality and effectiveness of the care and services we provide.

- Yes, I agree to the Informed Consent to Treat and Privacy Policy as stated above.
- Yes, I authorize Nabacu to contact my primary physician regarding my health.
- Yes, I authorize Nabacu to release records to my insurance company if they so request.
- Yes, I would like to receive monthly emails with health tips, special offers, and other news.

Signature: _____

Date: _____