ACUPUNCTURE VERMONT

ORIENTAL MEDICAL CLINIC

Restoring health and balance, naturally.

Patient Intake Forms

Full Name_____ Today's Date_____

Address_____ Evening Phone _____

_____ Daytime Phone_____

_____ E-mail_____

How did you hear about our clinic? Check all that apply: Yellow Pgs.___Dr. Referral___ Internet___ Other - please specify: _____

Date of Birth_____ Age____ Occupation_____

Married____ Single____ Divorced____ Co-habiting____ Widow(er)____

Primary Care Physician_____

Other Health Care Providers_____

_____

Do you take any: Medication (prescription or over-the-counter). Please list.

_____

_____

_____

Vitamins, supplements?_____

Caffeine?_____ Alcohol?_____ Tobacco?_____

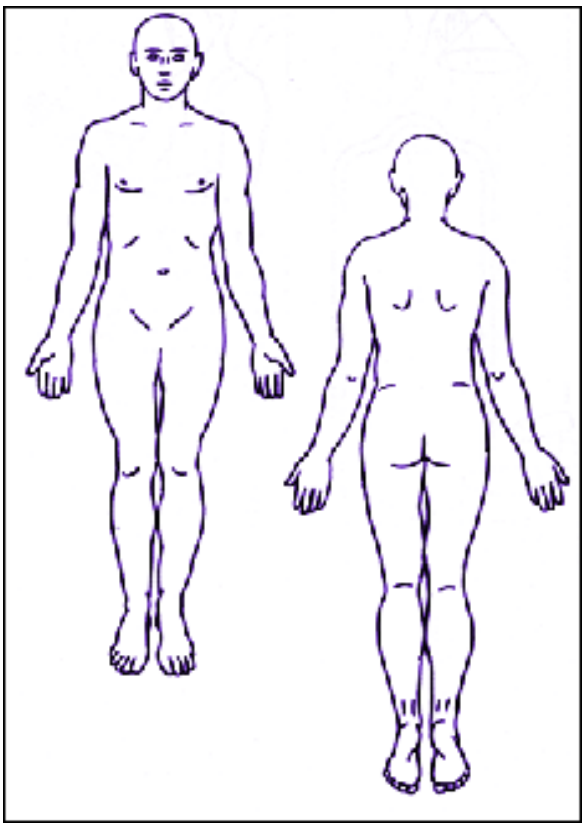
Rate your energy level over all: Low 1 2 3 4 5 6 7 8 9 10 High

Rate your overall body temperature: Cold 1 2 3 4 5 6 7 8 9 10 Hot

Major complaint(s):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please mark any areas of pain, numbness, tingling, rashes, etc.



Past medical history: (Please list any major illnesses, surgeries or hospitalizations and the dates they occurred.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Any significant past or present emotional states? (i.e. depression, anxiety, grief, anger, fear, etc.)

_____
_____
_____

Have you been diagnosed with one of the following?

__Heart Disease	__High Blood Pressure	__Chronic Pain	__Cancer
__Diabetes	__Arthritis	__Depression	__Hepatitis
__Epilepsy	__Stroke	__Anemia	__Other
__HIV/AIDS	__Migraines	__Asthma	

put a check mark by the symptoms that pertain to you

___cold hands
__ cold feet
__ fatigue
__ feverish in the afternoon or flushes
__Heat sensation in hands, feet, chest
__night sweats
__ catch colds easily
__shortness of breath
__sweat easily
__ general weakness
__ feel worse after exercise
__dizziness
__ see floating black spots

__palpitations
__restlessness
__anxiety
__ insomnia
__mental confusion

__cough
__nasal discharge
__nose bleeds
__sinus congestion
__dry mouth, throat, nose, or skin
__allergies
__chills alternating with fever
__sneezing
__headache
__feel achy
__stiff neck/shoulders
__sore throat

__low appetite
__loose stools
__constipation
__abdominal bloating or gas after eating
__fatigue after eating
__prolapsed organs (previously diagnosed)
__bruise easily
__general feeling of heaviness in body
__mental heaviness, sluggishness or fogginess
__swollen hands
__swollen feet
__nausea
__diarrhea

__burning sensation after eating
__large appetite
__bad breath
__mouth (canker) sores
__bleeding, swollen or painful gums
__heartburn
__belching
__vomiting

__diarrhea alternating with constipation
__feel better after exercise
__pain in ribs or side
__ tight feeling in chest
__bitter taste in mouth
__blood shot eyes
__anger easily
__skin rashes
__headache at top of head
__hot flashes
__dry eyes
__numbness of hands and feet
__muscle spasms, twitching, cramping
__seizures

__sore, cold or weak knees
__low back pain
__frequent urination
__do you get up at night to urinate?
__lack of bladder control
__memory problems
__hair loss
__ringing in ears

Urine is:

__clear __light yellow __dark yellow
__reddish yellow __ cloudy__scanty
__ has odor __ burning __painful
__ difficult __urgent

Women only

Please answer each question or check the appropriate response.

1. Are you currently pregnant?
__yes __ no
2. The date of your last menstrual period?

3. Number of children _____

4. Number of pregnancies_____

5. Age of first period _____
6. Age of Menopause
(if applicable)_____

7. Is your menstrual cycle regular?_____

a. Number of days from the start of one period to the start of the next_____

b. Average number of days of flow _____

c. the flow is: light 1 2 3 4 5 6 7 8 9 10 heavy

d. The color is: __ red __dark red __ pale red __bright red __ brown

e. are there blood clots ? __ yes __ no

f. Do you have pain/cramps? __ yes __ no
__ before period __ during period __ after period

g. Do you have nausea or vomiting before or during period? __ yes __ no __before __during

h. Do you experience any of the following before your period each month?
__ water retention __ breast tenderness or swelling
__ depression __ irritability __food cravings
__ migraines

i. Do you have bleeding between periods?

j. Do you have any vaginal discharge between periods?

_____
Robert Davis, MS, LAc.

Men only

Please put a check mark by the symptoms that pertain to you.

__ coldness or numbness in the external genitalia

__pain or swelling of the testicles

__premature ejaculation

__erectile dysfunction

___number of children

Office use only:

Treatment Goals:

Tongue:

Pulse:

Diagnosis:

Treatment:

needles in out
time in out

Herbs:

ACUPUNCTURE VERMONT

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date:_____

Patient: _____

I, _____by my signature below,
(Print Patient Name)
give Acupuncture Vermont Oriental Medical Clinic, LLC permission to consult with any or all of the agencies or person's listed below. I further agree to allow any conversation or documentation, in reference to my treatment, to be exchanged between the two agencies.

Primary Care Physician: _____
Office Phone: _____
Office Address: _____
_____
_____

Specialist: _____
Office Phone: _____
Office Address: _____
_____
_____

Other Health Care Provider: _____
Office Phone: _____
Office Address: _____
_____
_____

_____ _____
(Patient or Guardian Signature) (Date)

Disclosure Statement
In accordance with the State of Vermont Office of Professional Regulation rules, each new patient must read and sign the following disclosure:
A) The licensed acupuncturists' professional qualifications and experience:

Robert Davis, MS, L.Ac.
Professional Credentials:
* Licensed Acupuncturist in the state of Vermont.
* Hospital privileges – University of Vermont Medical Center
* Nationally Board Certified in Acupuncture (National Certification Commission for Acupuncture & Oriental Medicine).
* Nationally Board Certified in Chinese Herbal Medicine (National Certification Commission for Acupuncture & Oriental Medicine).
* Master of Science degree in Acupuncture and Oriental Medicine from Southwest Acupuncture College.
* National Clean Needle Technique certification (Council of Colleges of Acupuncture & Oriental Medicine).
* Thaddeus Bukowski Memorial Scholarship in recognition for showing promise as an outstanding practitioner.

Miscellaneous professional experiences:
* Co-President - Society for Acupuncture Research.
* Co-founder – Stromatec, Inc., a medical device company that develops tools for clinicians to address problems related to connective tissue, such as chronic pain, restricted mobility, and scarring.
* Principle Investigator on 6 National Institutes of Health SBIR grants totaling over $3M.
* Past President – Vermont Acupuncture Association (2001-2006)
* Steering Committee – UVM Integrative Health

Personal:
* Robert enjoys traveling and spending time outdoors with his wife, Teresa, and his two children, Jonathan and Veronica. His travels have included most of the US, Europe, the Middle East, Australia, and the Caribbean. He also loves reading great books, watching good movies, hiking and sculpting. He grew up in Pennsylvania, and has lived in California, Minnesota, and New Mexico before settling in Vermont.

B) A copy of the statutory definition of unprofessional conduct.
3410. UNPROFESSIONAL CONDUCT

(a) A licensed acupuncturist, or applicant shall not engage in unprofessional conduct.

(b) Unprofessional conduct means any of the conduct listed in this section and section 129a of Title 3, whether committed by a licensed acupuncturist or an applicant:

(1) Using dishonest or misleading advertising.

(2) Addiction to narcotics, habitual drunkenness or rendering professional services to a patient if the acupuncturist is intoxicated or under the influence of drugs.

(3) Sexual harassment of a patient.

(4) Engaging in sexual intercourse or other sexual conduct with a patient with whom the licensed acupuncturist has had a professional relationship within the previous two years.

(c) After a hearing and upon a finding of unprofessional conduct, an administrative law officer appointed under 3 V.S.A. 129(j) may take disciplinary action against a licensed acupuncturist or applicant.

129a. UNPROFESSIONAL CONDUCT

(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action.

(1) Fraudulent or deceptive procurement or use of a license.

(2) Advertising that is intended or has a tendency to deceive .

(3) Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession.

(4) Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.

(5) Practicing the profession when medically or psychologically unfit to do so.

(6) Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials to perform them.

(7) Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records.

(8) Failing to make available promptly to a person using professional health care services, that person's representative, succeeding health care professionals or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner.

(9) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

(10) In the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a client, patient or customer has occurred.

(11)Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party.

Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct. Failure to practice competently includes:

performance of unsafe or unacceptable patient or client care: or

(2) failure to conform to the essential standards of acceptable and prevailing practice.

The burden of proof in a disciplinary action shall be on the state to show by preponderance of the evidence that the person has engaged in unprofessional conduct.

After hearing, and upon a finding of unprofessional conduct, a board or an administrative law office may take disciplinary action against a licensee or applicant, including imposing an administrative penalty not to exceed $1,000.00 for each unprofessional conduct violation. Any

money received from the imposition of an administrative penalty imposed under this section shall be deposited in the general fund.
In a case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern. (added 1997, No. 40, 5.)
C. Information on the process for filing a complaint with, or making a consumer inquiry to, the Director.

Each profession or occupation is governed by laws defining professional conduct. Consumers who have inquiries of wish to obtain a form to register a complaint may do so by calling: (802) 828-2372, or by writing to the Director of the Office, Secretary of State, 109 State Street, Montpelier, Vermont 05609-1106.

Upon receipt of a complaint, an administrative review determines if the issues raised are covered by the applicable professional conduct statute. If so, a committee is assigned to investigate, collect information, and recommend action or closure to the appropriate governing body.

All complaint investigations are confidential. Should the investigation conclude with a decision for disciplinary action against a professional's license and ability to practice, the name of the license holder will then be made public.

Complaint investigations focus on licensure and fitness of the licensee to practice. Disciplinary action, when warranted, ranges from waning to revocation of license, based on the circumstances. As a result of the process, you should not expect a return of fees paid or additional unpaid services as part of the results of this process. If you seek restitution of this nature, consider consulting with the Consumer Protection Division of the Office of the Attorney General, seeing an attorney, or filing a case in Small Claims Court.

By signing below, I acknowledge reading the above disclosure in accordance with the rules outlined by the State of Vermont Office of Professional Regulation.

_____ _____
(Patient Signature) (date)

_____
(Printed Name)

_____ _____
(Acupuncturist Signature) (date)

ACUPUNTURE VERMONT
ORIENTAL MEDICAL CLINIC, PLC ("AVOMC")

Acknowledgment of Receipt of Privacy Notice

Federal law requires that all patients be given a copy of the AVOMC Notice of Privacy Practices. The Notice of Privacy Practices describes in detail how patient health information is used and shared with others.

AVOMC has reserved the right to change the Notice of Privacy Practices at any time. You may obtain a current copy of the Privacy Practices Notice by contacting AVOMC.

All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by e-mail or facsimile mail.

I have been given a copy of the Acupuncture Vermont Oriental Medical Clinic Notice of Privacy Practices.

Name (print): _____ Date: _____

Signature: _____ Date of Birth: _____

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Representative: _____ Date: _____

Print Name: _____ Relationship to patient: _____

Office Use Only

Patient given Privacy Notice, however:

Patient states they have signed Acknowledgement form previously ☐

Patient refused or did not sign Acknowledgment form ☐

Patient unable to sign Acknowledgment form ☐

ACUPUNCTURE VERMONT

ORIENTAL MEDICAL CLINIC

Restoring health and balance, naturally.

ACUPUNCTURE VERMONT FINANCIAL POLICIES

We accept **cash, checks, Visa, Mastercard, American Express & Discover**

If you are uninsured or your insurance does not cover acupuncture, you will be expected to pay your charges in full at each visit. You may also choose to participate in our **Prepayment Discount Program** (described on next page).

If your insurance covers acupuncture, you are still ultimately responsible for payment of your charges in full. **At each visit you will be expected to pay for the estimated charges not covered by your insurance.** We will notify you of any amounts your insurance fails to pay and you will be expected to pay the balance. Any insurance checks you might receive are to be paid to our office within 15 days.

For off-site visits, including UVM Medical Center, additional fees may be charged depending on time and travel requirements.

A $35 fee may be assessed for cancellations without 24-hour advance notice. Missed appointment fees are not billable to your insurance.

Acupuncture is a qualified expense for Flexible Savings Accounts (FSA's) and Health Savings Accounts (HSA's).

Signature:_____
Date:_____

Prepayment Discount Policy

Our prepayment discount plan is designed to help defray the cost of our services for those who do not have insurance coverage for acupuncture.

Patients may prepay for a block of care and receive a discount at the following levels:

$960 of care (12 regular $80 visits) is available for $825 (a discount of $11.25 per visit for a net fee of $68.75 per visit)

$480 of care (6 regular $80 visits) is available for $425 (a discount of $9.16 per visit for a net fee of $70.84 per visit)

Prepayment credits:- are transferable to friends and/or relatives- can not be used for new patient visits- can not be used in combination with insurance coverage

Unused credit is refundable with no expiration period.When refunding credits, the unused portion of the credit will be calculated based upon the regular (non-discounted) cost of treatments received. For example, if a patient requests a refund after 1 (regular $80) visit, the refund would be issued for $745 ($825 less $80).

Signature:_____
Date:_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated 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 or 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, Tui-Na (Chinese massage), Chinese 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. The herbs may have an unpleasant smell or taste. 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. Bums 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). 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 Chinese 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 clinical staff member who is caring for me if I am or become pregnant.

While 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 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 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.

ACUPUNCTURIST NAME:
Robert Davis, MS, L.Ac.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative - Indicate relationship if signing for patient)