Acupuncture & Herbal
Healing Center

Ashley Will, LAc, DOM / Devon Linton, LAc, DOM

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Some advice to get the most benefit from your acupuncture treatments:

Before you come for your acupuncture visit:

Print & fill out new patient forms from our website or arrive 10 minutes early to fill them out. This prevents us from cutting into your treatment time. Allow 1-1.5 hours for your initial exam & treatment. Follow ups are usually 45-60 mins.

If extensive, bring a list of all medications and supplements you are taking.

Please do not wear any perfume or scented lotions or smoke before your visit for our environmentally sensitive patients/providers.

If possible, wear loose clothing that you could roll up sleeves or pant legs for accessibility. Otherwise, we may ask you to disrobe if the area to be treated is difficult to access. We have sheets and blankets in the treatment rooms for proper draping.

Have a light meal or snack sometime before the visit. Acupuncture while fasting could cause light headedness. Large meals right before a treatment are not optimal for qi flow. We advise against caffeine prior to your visit as it decreases the results of acupuncture for pain relief. We recommended skipping or decreasing your morning coffee/tea the day of your treatment. Also, no recreational drugs or alcohol use prior to care.

Drink plenty of water following the treatment.

Get ready to relax! Acupuncture is surprisingly relaxing and restorative.

New Patient Intake Form

Patient Name _____ Age _____ Male / Female

Date of Birth ____/____/_____ Height _____ Weight _____

Address _____

City _____ State _____ Zip _____

Cell Phone (_____) _____-_____ E-mail _____

Employer _____ Occupation _____

Social Security # (if a VA referral) _____

How did you hear about us? _____

Emergency Information

Please indicate who to notify in case of emergency.

Name _____ Phone (C) (_____) _____-_____

Relationship _____

List anyone you would like to allow to access your medical information if necessary (such as a spouse or child):

_____

Chief Complaint(s):

Other Complaint(s):

List any medications (prescription or over the counter) being taken (include condition taken for)

_____

_____

_____

Are you allergic to any of the following? If yes, please specify)

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Do you have or are you any of the following? (Please note all reports are kept confidential)

( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Other contagious disease
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C
( ) Tuberculosis

Financial Policy

1. All payments must be made at the time of service unless otherwise agreed upon. If using insurance, please note that verification of benefits is not guaranteed coverage. If your claim is denied you will be responsible for paying for the visit in full. Also, please note that if you have a deductible to meet you will be required to pay at time of service until your deductible is met and your copay or coinsurance comes into effect. We do our best to estimate coinsurances and it is our policy to collect copays/coinsurances at time of service. Note that your plan may have an annual visit limit or care may be limited to certain conditions (ie, Cigna typically only covers for neck pain, back pain, knee pain, migraines, dental pain and nausea).

2. **Cancellation policy:** We ask that you please provide 24-hour notice if you cannot make it to your appointment to avoid a $30 cancellation fee which may be charged to your card on file.

3. Please note we use a secure medical software system that stores your credit card information for future use, and we will charge your card on file after each visit unless you instruct us not to. This streamlines the checkout process so we can spend more time focusing on your care. If you need to update or change your card on file, simply notify your healthcare provider at the time of service. Our billing company will mail out statements for any overdue outstanding balances. If you do not respond, your card on file may be charged to settle your account. If your card on file does not work, you will be sent to collections. At any time, feel free to contact us or our billing company, CMC billing, with any questions about insurance charges. Thank you.

Fee Schedule if paying at time of service:
Initial Evaluation (appx 1 hour) $175.00 ($80 initial exam fee + $95 treatment fee)
Follow-up session (appx 1 hour) $95.00

Please sign that you have read and understand our financial policy (above) + consent to treat & HIPPA policy (see copies of the consent & HiPPA policy located at the bottom of the clipboard for your review)

Print Name: _____

Patient Signature: _____ Date: _____

Acupuncture Informed Consent to Treat

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for Devon Linton, Lac, DOM & Ashley Will, LAc, DOM

Please note that all of our services are generally recognized as safe and side effects or injuries are rare but we need to fully inform you of any potential risks involved with our services and obtain your consent before any services are performed. Thank you.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above 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 above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment within the scope of Chinese medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridian, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; Sono puncture; laser puncture; dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; Qi Gong; East Asian massage and Tui Na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies. I understand that the herbs are typically in pill form but on occasion may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application 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, fainting or needle sickness. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruise like marks are a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax), and broken needle. Infection is another possible risk, although the clinic uses sterile disposable needles and lancets 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. I will notify a clinical staff member who is caring for me if I am or become pregnant. Patients with severe bleeding disorders, pacemakers, diabetes, contagious diseases, lymphedema or if pregnant must inform practitioners prior to any treatment. 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 regarding cure or improvement of my condition.

I hereby release Acupuncture & Herbal Healing Center, LLC and its practitioners from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that the acupuncturist is not providing allopathic medical care, and that I should look to my allopathic primary care practitioner (i.e. MD) for those services and for routine check-ups. 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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

-- PLEASE REVIEW IT CAREFULLY & SIGN BELOW --

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how you health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health – related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.