

Cardiovascular

- Chest pain or pressure
- Cold hands/feet
- Shortness of breath
- Low blood pressure
- Irregular heart beat
- Swelling of hands/feet
- Varicose/spider veins
- High blood pressure
- Palpitations at rest
- Blood clots
- Pressure in chest
- Spontaneous sweating
- Fainting
- Phlebitis
- Dizziness
- Raynaud's Disease

Respiratory

- Cough/Wheezing
- Pneumonia
- Difficulty breathing when lying down
- Coughing blood
- Pain with deep inhalation
- Asthma
- Tight sensation in chest
- Production of phlegm... what color? _____
- Bronchitis
- Difficult inhale/exhale

Gastrointestinal

- Nausea
- Gas
- Indigestion
- Bloating/Edema
- Changes in appetite
- Excessive appetite
- Vomiting
- Belching
- Bad breath
- Chronic laxative use
- Acid reflux/GERD
- Significant thirst (hot or cold drinks)
- Diarrhea
- Black stools
- Rectal pain
- Loose stools (>2 per day)
- Hernia
- IBS/Crohn's Disease
- Constipation
- Blood in stool
- Hemorrhoids
- Abdominal pain/cramps
- Poor appetite

Genito-Urinary

- Pain on urination
- Unable to hold urine
- Impotence
- Premature ejaculation
- Nocturnal emission
- Night urination... What time? _____ How often? _____
- Frequent urination
- Kidney stones
- Sores on genitals
- Decreased libido
- Pain in testicles
- Blood in urine
- Scanty flow
- Urinary tract infection
- Prostatitis
- Herpes
- Excessive libido
- Urgent urination
- Copious flow
- Burning urination
- Dribbling after urination
- Infections
- Low libido

Gynecological/Reproductive (Women Only)

- Difficult/Painful intercourse
- Vaginal dryness/itching
- Vaginal sores
- Vaginal discharge(color/amount/odor _____)
- Polycystic Ovarian Disease
- Infertility
- Number of pregnancies _____
- Number of miscarriages _____
- Ovarian cysts
- Endometriosis
- Uterine Fibroids
- Fibrocystic breast tissue
- Number of live births _____
- Age of first menses _____
- Date of last menses _____
- Date of last PAP/Pelvic _____
- Painful menstruation
- Irregular menstruation
- PMS
- Number of ectopic pregnancies _____

Do you practice birth control? _____ What type? _____ How long? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (describe size: large, small, black, purple, red, other)							
Vomiting/nausea (check if yes)							
PMS (what symptoms, duration of symptoms)							
Other							

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION

Turning Leaf Acupuncture

Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your personal information will not be used for other purposes unless we have asked for and have been given your permission.

Your health information will be used:

1. To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the practitioner and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.

2. To obtain payment: We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail.

3. Inspect and copy your health information: You have the right to read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.

4. Amend your health information: You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.

5. Documentation of your health information: You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you a copy of your health information upon request, as long as it is not 7 years or older.

6. Request a paper copy of this notice: You have the right to obtain a copy of this privacy notice policy for your records.

I acknowledge that I have read and agree to the above:

Signature of Patient: X _____ Date _____

Printed Name _____

Do we have your permission to thank the person who referred you to our practice? Y / N

Informed Consent for Treatment

Turning Leaf Acupuncture

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below named licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, intradermal needles, ear pressballs, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese herbal medicine, and nutritional counseling.

Heat therapy using moxa (Artemisia), a dried herb, that is lit and burned on the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment which will conduct the heat and prevent burns. On rare occasions, a blister may occur. The practitioner will explain the procedure as it is done and the patient is asked to let them know the status of the heat at all times.

Application of stainless steel pressballs onto various points in the ear. These are applied with adhesive tape and may be left in the ear for up to 7 days or as suggested by the practitioner.

Electrical stimulation of the needles using a battery operated machine to create a current through the needles may be used. This creates a constant vibration through the needles that would be adjusted according to patient comfort.

Bloodletting, when appropriate, is used to draw a few drops of blood from points on the body, or more commonly, on the fingertips or toes. A small needle is used to prick the skin and then cotton is applied to draw blood out until it stops.

Cupping is a technique used to resolve muscle tightness or help clear the lungs in respiratory conditions. A glass cup is applied to the skin and then a pump suctions the skin and muscle into the cup. The amount of suction is adjusted according to patient comfort. Depending on how tight the muscles are and the amount of restricted blood flow, the cups can leave a reddish or purplish mark on the skin that clears up in a few days, similar to a bruise.

Gua sha is a technique similar to cupping where a flat tool is used to scrape the skin to relieve muscle tension and congested blood flow. It leaves a similar bruise-like "rash" that lasts for a few days.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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.

Initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____

initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.

initials

Patient's Printed Name

Patient's Signature

Date Signed

Are you Pregnant?

OFFICE POLICIES

Turning Leaf Acupuncture

The following policies and procedures are in place to insure that your care is as efficient and effective as possible.

APPOINTMENTS: We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other’s time. If you are late, your remaining time may not be sufficient for a full treatment, so treatment will be tailored to fit within the time available or you have the option to reschedule. Occasionally, there are situations that arise that cause us to run over. If we are late, it will not effect the time of your treatment. If you have time constraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments for your comfort and to make acupuncture points accessible. You may bring a pair of shorts or loose undershirt to change into.

The courtesy of a 24-hour notice of cancellation for any appointment is expected and appreciated. The patient is responsible for payment of a non-emergency cancellation made without a 24-hour notice.

CONFIDENTIALITY: All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

FEES: Initial Visit (1.5 hrs): \$ 95
Follow-Up Acupuncture Treatment (1 hr): \$ 75 (plus cost herbs when prescribed)
Chinese Herbal Medicine Consult Only (1 hr): \$ 85 (plus the cost of herbs)
Follow-Up Herbal Consult (30 min): \$ 60 (plus the cost of herbs)
(Discounts are available for multiple treatments purchased in advance and for referrals)

PAYMENT: Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash and checks only at this time. Acupuncture is covered by worker’s compensation, auto insurance and a number of private insurance policies. Should you have coverage, we can discuss the procedure for billing and payment.

I have read and agree to the policies outlined above.

Signature of Patient: X _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Turning Leaf Acupuncture

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Healthcare 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.

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

We may contact you to provide appointment 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 written 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.

PATIENT RIGHTS

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

Access: You have the right to inspect and copy your protected health information.

Restriction: You have 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 other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Alternative Communication: You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive an accounting of disclosures of protected health information.

Electronic Notice: If you receive this Notice on our website or by electronic mail, you are entitled to obtain a paper copy of this Notice upon request.

Questions and Complaints

If you want more information about our privacy practices, please contact us.

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

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

Turning Leaf Acupuncture

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation and will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Date