



Confidential Patient Information Form

Please let us know who referred you! _____

Name: _____ Home Phone: _____
LAST FIRST

E-Mail Address: _____ Cell Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Drivers License: _____

Physicians Name _____ Phone: _____

Date of Last Visit _____

Patient's Occupation: _____ Business Phone: _____

EMERGENCY Contact: _____ Relationship: _____

Phone: _____

How would you prefer my office to contact you? Home # ____ Business # ____ Cell # ____ E-mail ____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

Do you have a tendency to faint? Yes / No

Do you bleed for a long time? Yes / No

Do you have a pacemaker? Yes / No

Are you pregnant? Yes / No

I DO HEREBY CERTIFY THAT THE PROCEEDING QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to Patient

Whole Family Acupuncture Clinic

TREATMENT INFORMATION

NATURE OF TREATMENT: Your treatment may include acupuncture, acupressure and/or Tui Na, moxibustion, cupping, Gua Sha, electrical stimulation, infrared heat, Chinese herbal therapy, therapeutic exercises, and dietary counseling based on the fundamentals of Chinese medicine.

- **ACUPUNCTURE:** Acupuncture as practiced in the state of California involves the insertion of sterile, single-use disposable needles into the body at various points eliciting a therapeutic effect. It has been shown to be relatively safe with little to no side-effects for most people. There are some uncommon potential risks however. These risks may include but are not limited to: discomfort during and after needle insertion, localized minor bruising or swelling, dizziness, fainting or nausea, allergic reactions to metals used in acupuncture needles, organ puncture, and nerve damage.
- **ACUPRESSURE AND TUI NA:** These methods of massage and physical manipulation utilize the points and channels of Chinese medical theory to treat the body without the use of needles. They can be used as an adjunctive therapy to acupuncture, or as stand-alone treatments according to the patient's needs.
- **MOXIBUSTION:** This treatment method involves the combustion of the therapeutic herb *Artemisia argyi*, commonly known as mugwort, either directly on or over various points of the body. This therapy produces warmth and heat in the area of application, and exhibits other therapeutic effects attributed to the herb as described in the Chinese materia medica. Burns and/or scarring are potentials risks of moxibustion.
- **CUPPING:** Fire or a vacuum pump are used to create a vacuum inside of sterilized glass cups that are then placed on the patient's skin. This vacuum has a mild to strong suctioning effect, depending on the nature of the treatment as determined by the acupuncturist. The most common side effects are reddening of the skin that may last for a few days and/or bruising.
- **GUA SHA:** Gua Sha is a form of dermal friction whereby a sterilized tool is used to scrape along the surface of the skin. In Chinese medical theory, it has a wide range of therapeutic uses. The most common side effects are reddening of the skin that may last for a few days and bruising.
- **ELECTRICAL STIMULATION:** Pairs of acupuncture needles are attached to a device that generates continuous electric pulses using small clips. These devices are used to adjust the frequency and intensity of the impulse being delivered, depending on the condition being treated. Please inform your acupuncturist if you have any implanted medical devices.
- **INFRARED HEAT:** A far-infrared heat lamp may be utilized during treatment to either enhance the treatment or for the comfort of the patient. Please inform your acupuncturist if you have any conditions that are exacerbated by the direct application of heat.

- **CHINESE HERBS:** Patients may be prescribed Chinese herbs as part of their treatment plan. Prescriptions generally consist of a combination of several herbs into a customized formula according to the patient's signs, symptoms, and overall constitution. The herbs that are recommended are traditionally considered safe in the practice of Chinese medicine within their prescribed dosages and methods of administration. Some possible side effects of taking herbs are nausea, gas, stomach upset, diarrhea, and tingling of the tongue. Patients must be sure to inform the acupuncturist of all the medications and supplements they are currently taking, as well as any known allergies.
- **THERAPEUTIC EXERCISES:** These include stretches, light exercise, meditation, and breathing exercises that the patient may be asked to perform at home.

SPECIAL SITUATIONS: Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify the acupuncturist if you think you might be pregnant. Additionally, please inform us if you have severe bleeding disorders, if you are wearing a pacemaker or other electronic medical device, and if you have any known allergies to foods or medications.

USE OF DISPOSABLE NEEDLES: All needles are pre-sterilized, single-use needles made of surgical stainless steel. After treatment they are disposed of as medical waste; needles are never re-used. Very rarely, the acupuncturist may accidentally overlook a needle when removing them at the end of treatment. If you find that you have a needle with you after you leave the office, do not be alarmed. Simply remove the needle, place it in a hard container, and return it to the office on your next visit for proper disposal.

OUTCOME OF TREATMENT: The purpose of treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on the pre-scientific Chinese system of medical theory. Diagnosis and treatment based on this theory are used to promote health and treat organic or functional disorders. This medical system utilizes a holistic approach, thereby treating the entire person and not singular symptoms. You may experience changes in your physical, mental, or emotional health that may seem unrelated to your complaint. If you have any questions or concerns regarding any changes or new symptoms that arise during the course of treatment, please inform your acupuncturist.

The World Health Organization lists multiple diseases for which acupuncture and its adjunctive therapies have been proved through controlled trials to be an effective treatment, as well as listing many more diseases for which acupuncture has been shown to have a therapeutic effect. However, we cannot guarantee the outcome of any course of treatment.

Whole Family Acupuncture Clinic
PATIENT INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other Chinese medicine procedures by the licensed acupuncturist Teo Potts, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while working with Mr. Potts, or serves as a back-up for Mr. Potts in the event of a necessary cancellation, including those working in the same office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, tui na, cupping, gua sha, electrical stimulation, infrared heat, herbs, therapeutic exercises, and dietary counseling. I have been informed of the potential risks associated with these treatment modalities.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

Print Name of Patient

Teo Potts, L.Ac.

Print Name of Acupuncturist

X _____

Signature of Patient or Representative

X _____

Signature of Acupuncturist

Print Name of Patient Representative

Print Name of Witness or Translator

Date Consent Completed

X _____

Signature of Witness or Translator

Whole Family Acupuncture Clinic

PATIENT CARE FINANCIAL AGREEMENT

Dear Patient,

We want you to have a clear understanding of our policy concerning payment. Our office accepts cash, checks, Visa, MasterCard, American Express and Discover cards.

1. All fees for services are due at the time of the visit unless previous arrangements have been made in advance.
2. Most conditions require an average of 4-12 treatments, although some will respond well in fewer visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.
3. Your appointment time is reserved specifically for you. In the event of a missed appointment, an appointment cancelled with less than 24 hours notice, or arriving later than 20 minutes after your appointment time, please note you will be charged the full price of your visit.
4. There is a service charge of \$25 for every returned check.
5. At this time we are unable to accept insurance but we can provide you with a super bill that you may then present to your insurance for reimbursement, please verify with your insurance that you will be reimbursed.
6. We do have a sliding scale is available for all patients that demonstrate financial need. Please speak to me before our first appointment if you require consideration for a lower fee.

By signing below, you acknowledge that you have read and understand the financial agreement policy as well as appointment cancellation policy of this office.

Thank you very much for your understanding.

Patient Name

Patient Signature

Date

Whole Family Acupuncture Clinic

Privacy Policies

Dear Valued Patient,

This notice describes my office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from my office, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at my office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with me (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$10-20 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing. If you have questions, complaints or want more information, please contact this office.

I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

Patient Signature _____

Date _____

If I would like to review the Privacy Policies I may request a copy at the front desk of Whole Family Acupuncture Clinic, 1240 Powell St, Suite 2A, Emeryville, CA 94608.