

**INFORMED CONSENT TO ACUPUNCTURE AND
ORIENTAL MEDICINE CARE**

Clinic name and address:

San Francisco Acupuncture
Emily Mooney, L. Ac. #7787
311 California Street #300
San Francisco, CA 94104

Patient's name: _____

Date: _____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxabustion, cupping, electro-stimulation, herbology, various modes of physiotherapy, on me (or on the above named patient for whom I am legally responsible) by the acupuncturist (s) named above or in any other office or clinic, whether signatories to this form or not.

I have had the opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxabustion, cupping, electro-acupuncture, herbology, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including but not limited to slight bruising, tingling near the needling sites that last a few days, nausea, infection, and blisters. There have been instances reported of fainting, infections and scarring. There have been instances of reported pneumothorax and spontaneous miscarriage. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above-named procedures. 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.

Signature of Patient or Patient's Representative

Print name of Patient's Representative

Witness to Patient's Signature

Date

Relationship or Authority of Representative

**SAN FRANCISCO ACUPUNCTURE
FEES, INSURANCE, PAYMENT, AND COMMUNICATION AGREEMENT
FOR ACUPUNCTURE CARE**

TO ALL NEW PATIENTS:

Welcome to our office and thank you for choosing San Francisco Acupuncture. If your health insurance policy covers acupuncture treatment, we will bill them at your request. We urge you to carefully review your policy in advance to find out exactly what is covered, or you may submit your insurance information to us at www.sf-acu.com and we will check for you. Please bring your insurance card to the first appointment. If you have a deductible that has not yet been met, you will be responsible for payment until it is met. You will be expected to assign payments to the acupuncturist. Please understand that we have no payment agreements with the insurance companies. Should there be a dispute between you and your insurance company, you will become directly liable for payment of the bill.

CANCELLING AND CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of treatments in a set amount of time is required to get the desired result. If you need to change or cancel an appointment be sure to make up the missed appointment within a week. If you need to cancel your appointment, please call ahead and let us know so that we may accommodate another patient at that time. We make every effort to accommodate your busy schedule. **We require 24 hours notice for a cancellation, and failure to provide us with this will result in a \$50 fee.**

FEES:

Our non-insurance fees are as follows and are (along with any co-payments or deductibles) due at the time of treatment:

Initial evaluation and treatment	\$95-\$110
Acupuncture	\$80
Group acupuncture (inquire for days and times)	\$25-\$50

I agree to the above terms and hereby instruct my health insurance carrier to forward all payments, inquiries and explanation of benefits to the acupuncturist.

(Signature)

COMMUNICATION/ EMAIL:

Being located downtown, most of our patients schedule appointments during short breaks in their day. This may describe your situation as well. We respect your time and make every effort to see you at your scheduled time with minimal, if any, wait time. In order to maintain this high level of punctuality, we frequently have to make appointment confirmations. We have found that email communication is the best way to accomplish this as it seems to be convenient for most people.

You may schedule appointments by email and communicate directly with the acupuncturist, ask questions about your treatment, and request things ahead of time, such as a statement.

Please check one:

Yes, I want to be able to communicate via email. My email address is:

I do not wish to provide my email address and prefer to be contacted by phone.

NOTE: We guarantee that your email will not be disclosed to anyone outside this office and will not be used beyond what is mentioned on this form.

PATIENT INTAKE FORM

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____

Date Injured (if applicable): _____

Social Security No.: _____

Marital Status: M / S / D / W / PAR

Occupation: _____

Employer: _____

Employer Street Address: _____

Employer City: _____ Employer State: _____ Zip: _____

Work Phone: _____

How did you hear about us? _____

Describe your main pain / symptoms for which you are seeking help: _____

Describe secondary health concerns: _____

INSURANCE INFO

Insurance Company: _____

Type of Insurance: Group coverage Workers Comp Claim Auto Med Pay

Insurance Street Address: _____

Insurance City: _____ Insurance State: _____ Zip: _____

Insurance Phone: _____

Insurance Policy#: _____ Claim#: _____ Group#: _____

Insured's Name (if not same): _____

Insured's Street Address: _____

Insured's City: _____ State: _____ Zip: _____

Insured's ID: _____ Insured's Birth Date: _____

Insured's Relationship to Patient: spouse dependent guardian**CASE HISTORY:**

How long have you had the condition for which you are seeking treatment? _____

List doctors you have seen for this condition: _____

Did your condition arise from a car accident? Y N. Date/Time of Accident: _____

Did your condition arise from your occupation? Y N. If Yes, did you report it? _____

What activities make your symptoms worse? _____

Your symptoms are: getting worse constant come and go

Do you feel deep, unrelenting pain in your body at night which makes sleep difficult? Y N

List and date all prior significant injuries (fractures, dislocations, hospitalizations): _____

List any orthopedic implants you have (artificial joints, surgical rods/pins, etc.): _____

List any surgically fused vertebrae: _____

List medications that you are taking: _____

Please sign here and complete back page: _____

REVIEW OF SYSTEMS: Please check (x) all present symptoms.

HEAD:

- Headache
 - sinus (allergy)
 - entire head
 - back of head
 - forehead
 - temples
 - migraine
- Head feels heavy
- Loss of memory
- Light headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck
 - Neck pain with movement:
 - Forward
 - Backward
 - Turn to left
 - Turn to right
 - Bend to left
 - Bend to right
 - Pinch nerve in neck
 - Neck feels out of place
 - Muscle spasms in neck
 - Grinding sounds in neck
 - Popping sounds in neck
 - Arthritis
- you

SHOULDERS:

- Pain in shoulder joint (R – L)
 - Pain across shoulders
 - Bursitis (R – L)
 - Arthritis (R – L)
 - Can't raise arm:
 - above shoulder level
 - above head
 - Tension in shoulders
 - Pinched nerve in shoulder (R – L)
 - Muscle spasms in shoulders
- (type: _____)

ARMS & HANDS:

- Pain in upper arm
 - Pain in elbow
 - Movement aggravated
 - Tennis elbow
 - Pain in forearm
 - Pain in hands
 - Pain in fingers
 - "Pins & needles" feeling in arms
 - Pins & needles feeling in fingers
 - Numbness in arms: R – L
- Other: _____
- Numbness in fingers: R – L
 - Hand/fingers go to sleep
 - Cold hands
 - Swollen joints in fingers
 - Sore joints in fingers
 - Arthritis in fingers
 - Loss of grip strength
 - Finger joints "lock" when opening hand

MID-BACK:

- Mid-back pain
- Location: _____
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange-peel texture of breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Low back pain
 - upper lumbar
 - lower lumbar
 - sacroiliac
 - Low back pain is worse when:
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
 - lying down/sleeping
 - walking
- Pain relieves when _____
- Slipped disc
 - Low back feels out of place
 - Muscle spasms
 - Arthritis

HIPS, LEGS & FEET

- Pain in buttocks (R – L)
- Pain in hip joint (R – L)
- Pain down leg (R – L)
- Pain down both legs
- Knee pain
 - inner knee
 - outer knee
- Leg cramps
- Cramps in feet (R – L)
- Pins & Needles in legs (R – L)
- Numbness of leg (R – L)
- Numbness of feet (R – L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R – L)
- Swollen feet (R – L)

WOMEN ONLY:

- Menstrual pain
- Cramping
- Irregular periods
- Cycle: _____ days
- Birth control _____ (type)
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY:

- Frequent Urination
- Difficulty starting
- Night urination
- Prostate pain / swelling

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep _____ hrs/ day
- Loss of sleep _____ hrs/night
- Recent loss of weight: _____ lbs.
- Recent weight gain: _____ lbs.
- Coffee _____ cups/day
- Cigarettes _____ /day
- Other: _____
- Diabetes
- Hypoglycemia

DISEASES:

- Check diseases you have had. Circle those which currently have:
- Cancer (type: _____)
 - Diabetes Type: _____
 - Hypothyroidism
 - Heart disease
 - High blood pressure
 - Stroke
 - Epilepsy (Last seizure: _____)
 - Hepatitis (type: _____)
 - Tuberculosis
 - Venereal Disease
 - HIV+ (How long? _____)
 - AIDS (How long? _____)
 - Rheumatoid arthritis
 - Chicken pox
 - Measles
 - SARS
 - Multiple sclerosis
 - Parkinson's disease
 - Brain tumor
 - Glaucoma
 - Vertigo / Tinnitus
 -

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy.

At San Francisco Acupuncture, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice.

You have the right to see or receive a copy of any of your health information.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Emily Mooney.

Acknowledgement

I have received a copy of San Francisco Acupuncture's Notice of Privacy Practices

Print Name _____

Date _____

Signature _____

If signing as a parent or guardian, please print the name of the patient.