Patient Information Form

Name: ______________________________________Date:_____________________

Social Security: ________________________ Sex: M/F Marital Status: S/M/D

Date of Birth: __________________ Age: ______ DL#_______________________

Home Ph: ______________Cell Ph: ______________Work Ph:________________

Email Address: ____

Home Address:____

City: _______________________________ State: _______Zip: ________________

Employer/Occupation: ____

Referred by: ____

Emergency Contact (Name & Number): ___________________________________

Chief Complaint: ____

Physician Name and Phone:____

Financial Agreement: The patient or patient's representative shall pay Essential Points Acupuncture for services rendered in accordance with the regular rates and terms of Essential Points Acupuncture. When the patient, or the patient's representative, or a financial guarantor executes this agreement, all shall be jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

As the patient, or legal guardian of a minor patient, I understand and agree to pay in full for all services at each visit. I understand the 24-hour cancellation policy, and I agree to pay the standard fee if cancellation occurs within 24 hours of the date and time of my scheduled appointment.

Date: ____________________Signature: _________________________________

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 the patient named below for whom I am legally responsible) by the licensed acupuncturist(s) 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, included those working at Essential Points Acupuncture, APC 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 (Oriental Massage), Chinese herbal medicine and nutritional counseling. 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 I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 only sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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 the clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

Patient Signature ____ **Date**_______________

Patient Representative____ **Date**_______________

Licensed Acupuncturist____ **Date**_______________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Essential Points Acupuncture, APC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to, Essential Points Acupuncture, APC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Essential Points Acupuncture, APC reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, Essential Points Acupuncture, APC may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Essential Points Acupuncture, APC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, Essential Points Acupuncture, APC may email to me appointment reminder cards and patient statements. I have the right to request that Essential Points Acupuncture, APC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Essential Points Acupuncture, APC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Essential Points Acupuncture, APC may decline to provide treatment to me.

______________________________ ________________________

Patient's Name **Date**

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Signature of Patient or Legal Guardian

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