Wellbeing Acupuncture

New Patient Intake Form

Name_____Date_____Date of Birth_____

Age_____Gender_____Height_____Weight_____Occupation_____

Address_____

Phone_____Email_____

Emergency Contact (Name/Relation/Phone)_____

How did you find us? If referral, from whom? We offer referral discounts! _____

Have you had acupuncture before? ❑ Yes ❑ No If so, how recently? _____

Check any other treatment modalities you have tried or currently receive:

❑ Chiropractic ❑ Massage Therapy ❑ Herbal Medicine ❑ Physical Therapy ❑ Energy Work ❑ Other_____

Briefly describe your results/experience_____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?

_____

How long has it been an issue?_____ What seemed to be the cause?_____

What makes it better? _____What makes it worse? _____

If you have been diagnosed, what is the diagnosis? _____

Other areas of concern or pain_____

Any recent injury or illness?_____Any significant past traumas, accidents, or illness?

_____Surgeries?_____

Name of your physician or other healthcare provider_____

Are you allergic/dislike any scents or oils (such as lavender, eucalyptus)?_____

Anything I should know about you?_____

<u>For Women</u>:

Are you pregnant? ❑ Yes ❑ No Are you trying to conceive? ❑ Yes ❑ No Any issues with infertility? ❑ Yes ❑ No

Do you take hormonal contraceptives? ❑ Yes ❑ No # Of Pregnancies_____ # of Live Births_____

Any concerns with your menstrual cycle?_____

Any known hormonal issues or hormone replacement therapy? _____

Any concerns with menopausal symptoms?_____

<u>For Men</u>:

❑ Prostate Problems ❑ Urinary Difficulty ❑ Low Libido/ED ❑ Low Testosterone ❑ Other_____

Medical History (Please check all that apply in your recent health-in the past few years)

❑ Abdominal Discomfort ❑ Addictions_____ ❑ Aids/HIV ❑ Allergies ❑ Anxiety ❑ Arthritis_____ ❑ Asthma ❑ Autoimmune Disease ❑ Blood Pressure High ❑ Blood Pressure Low ❑ Cancer_____ ❑ Clotting Disorder or Bleeding ❑ Cholesterol High ❑ Constipation ❑ Covid-19	❑ Depression ❑ Diabetes ❑ Disc Problems ❑ Diverticulitis ❑ Diarrhea ❑ Dizziness ❑ Eating Disorder ❑ Emotional Trauma ❑ Epilepsy ❑ Fibromyalgia ❑ Headaches ❑ Heart Disease ❑ Heart Attack ❑ Hepatitis ❑ Herpes ❑ Numbness_____	❑ Pacemaker ❑ Pain_____ ❑ Scoliosis ❑ Sinus Problems ❑ Skin Condition ❑ Sleep Problem ❑ Stress ❑ Stroke ❑ Thyroid (Hyper/Hypo?) ❑ Urinary Problems ❑ Varicose Veins Male/Female: ❑ Prostate Problems ❑ Menstrual Problems ❑ Hormonal Imbalance ❑ Infertility ❑ Miscarriage

Please list current medications, supplements, and vitamins: _____

_____

_____

***Wellbeing Acupuncture* Professional Policies:**

- Arrival time: We make every effort to stay on schedule as we respect the value of your time. Please arrive early or on time for your appointment. If you are running late, we cannot guarantee that you will receive the full treatment time. Payment in full is still required if your session is shortened due to late arrival.
- Appointment Length: Your scheduled appointment includes your dress/undress time and any dialogue/consultation pertaining to you or your treatment.
- Financial Policy: Payment is due at time of service. There is a $30 returned check fee. This office does not bill insurance. Upon request we will provide receipts for you to submit to your insurance carrier.
- ***Cancellations***: Please give 24 hours notice for cancellation or rescheduling. Repeated instances will be charged a cancellation fee of 50% of the service price.
    - **No-Shows without notice given will be charged the full price of the service- ONE "free pass" is allowed per year to allow for an emergency situation.**
    - **Your Billing information is saved through your Square Account and will be used for late cancellations or no-shows according to this cancellation policy.**
- Right to Refuse Service: We reserve the right to refuse service or end a session due to inappropriate or threatening behavior, without refund.
- Your Comfort and Safety: Please agree that you will communicate with your practitioner if you feel physically or emotionally uncomfortable at any point in your treatment. It is our intention to provide a comfortable healing space for you and attend to your needs.

I, the undersigned, have honestly and comprehensively answered the questions above. I have read Wellbeing Acupuncture policies and agree to them. I understand and agree to the cancellation policy and understand that my card may be charged for cancellations or no-shows without 24 hour notice.

*Signature of Patient or Legal Guardian*_____

Acupuncture Informed Consent to Treat

Scope of Practice of Acupuncture.
Definitions: North Carolina Acupuncture Licensing Board § 90-451
(1) Acupuncture- A form of health care developed from traditional and modern Chinese medical concepts that employ acupuncture diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.
(2) Practice of acupuncture – The insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon acupuncture diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include massage, mechanical, thermal, electrical and electromagnetic treatment and the recommendation of herbs, dietary guidelines, and therapeutic exercise. (1993, c. 303, s. 1.)

Acupuncture Informed Consent:

I hereby request and consent to the performance of treatments and other procedures within the NC "scope of practice of acupuncture" on myself (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed practitioners 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, including those working at the clinic or office listed below or any other office or clinic, 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, massage, Chinese herbal medicine, and nutritional counseling.** I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. 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 it may have some side effects, including bruising, 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 t**he clinic uses 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 a 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 the 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 or Patient Representative (Indicate relationship if signing for patient):

_____Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

This notice outlines your protected health information, how it may be used, and what your rights are regarding your protected health information. **Please review carefully** and ask any questions prior to signing. Questions about this notice can be directed to Wellbeing Acupuncture.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Wellbeing Acupuncture is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from Wellbeing Acupuncture. This Notice details how your PHI may be used and disclosed by our clinic. This Notice also describes your rights regarding your PHI. The law requires us to:

- Make sure that Protected Health Information (PHI) that identifies you is kept private
- Notify you about how we PROTECT your PHI
- Notify you about how we USE and disclose your PHI
- Follow the terms of this notice. We reserve the right to change the terms of this notice and to make new provisions effective for all PHI by: Posting the revised notice in our office, Making copies of the revised notice available upon request, Posting the revised notice on our website.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU (No Consent Required):

The following categories describe different ways that we are legally permitted to use and disclose protected health information without your written authorization.

1. For Treatment: In order to provide you with health care services, we may provide your PHI to other professionals directly involved in your care within our clinic so that they may understand your health condition and your needs. We may use your PHI to communicate with you about your treatments and appointments. We may use your PHI in communication with providers outside our office such as your primary care provider or other individuals involved in your care.
2. For Payment: We may use and disclose your PHI for billing and payment within our office and with insurance providers or billing companies when applicable.
3. For Healthcare Operations: We may use and disclose PHI for practice operations such as case management, coordination of care, business planning, customer services, and quality assessment.

According to the HIPAA rules, the following additional instances do not require your permission to disclose your PHI**. However, some of the disclosures listed below may never occur at our facilities**.

- Personal representative: We may disclose PHI to an individual who, under applicable law, has the authority to represent you in making decisions related to your healthcare.
- Your family/Friend: We may disclose information about your healthcare or payment to an individual you choose, if the information is directly relevant to that person's involvement in your care. Your verbal agreement is enough to authorize us to communicate about your healthcare to a chosen family member or friend. We may also communicate with your family or representative in certain extenuating situations that may require our professional judgment that you would not object to a disclosure made in your best interests.
    - You may also request that we do NOT communicate about your healthcare to your family or other individuals.
- Emergency situations: for the purpose of rendering or coordinating emergency care for you, or in disaster relief circumstances.
- As required by law: We will disclose PHI when required to do so by federal, state, or local law.
- Business associate: PHI is sometimes shared with a business associate such as a billing company or health data management company. Legally binding written agreements must be in place for all business associates ensuring they will protect any PHI they have access to.
- Public health activities: when authorized by law, information may be collected by a public health authority to prevent or control disease. This information would not include your name and cannot be used to identify you individually.
- Health risks: We are authorized to disclose PHI to an authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is deemed necessary to prevent or lessen a serious and imminent threat to you or another person.
- Health oversight activities: When authorized by law, we may disclose PHI to authorities in the process of an investigation, inspection, or audit for the monitoring of the health care system and compliance with governmental programs.
- Law enforcement/Judicial and administrative proceedings: We may release PHI as required by law or in response to a court order, subpoena, or administrative request.
- Worker's compensation: we may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

- Coroner/Medical examiner/Tissue donation: In the event of death, any healthcare practice may be required to release PHI to funeral directors, medical examiners, and organizations that handle organ donation.
- Research: This practice is not involved in research activities, but PHI disclosures are permitted for research purposes and the information must not identify the individual by name.
- Avert a threat to health or safety: We may disclose your PHI if it is deemed necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES. Unless you object, or request that only a limited amount or type of information be shared, the above listed disclosures are permitted by law. If you wish to request limitation to these disclosures, you may notify our office in writing.

AUTHORIZATION: Uses or disclosures other than those described above, will only be made with your written authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

Right to revoke authorization: If you authorize us to share your PHI in a written agreement, you still have the right to revoke your authorization to us at any time. Your revocation must be in writing.

Right to inspect and copy: You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Wellbeing Acupuncture. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend: If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information. To request an amendment, your request must be made inwriting and submitted to Wellbeing Acupuncture. In addition, you must provide a reason that supports your request. We will act on your request for an amendment no later than 60 days after receiving the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment, Is not part of the protected health information kept by Wellbeing Acupuncture, Is not part of the information which you would be permitted to inspect and copy, or if we believe is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you. To request this list or accounting of disclosures, you must submit your request in writing to Wellbeing Acupuncture. You may ask for disclosures made up to six years before your request (not including disclosures made before June 25, 2014). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following: For your treatment, For billing and collection of payment for your treatment, For health care operations, Made to or requested by you, or that you authorized, Occurring as a byproduct of permitted use and disclosures, For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates, Or as part of a limited data set of information that does not contain information identifying you.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described in the permitted disclosures section. To request restrictions, you must make your request in writing to Wellbeing Acupuncture.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Wellbeing Acupuncture. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time by contacting Wellbeing Acupuncture.

OTHER USES AND DISCLOSURES: We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES: If you believe your privacy rights have been violated, you may file a complaint with Wellbeing Acupuncture, or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence of the complaint or violation. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

Acknowledgement Confirming Receipt of HIPAA Privacy Notice:

I acknowledge I have received a copy of the HIPAA Privacy Notice. I have read them and understood the content or declined the opportunity to read it. I understand that this form will be placed in my patient file and maintained for six years.

Please sign and date below.

I hereby agree to the document above_____Date_____

COVID-19 INFORMED CONSENT TO TREATMENT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted.
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in any healthcare office.
- **I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:**
    - **Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat, Loss of Taste or Smell**

I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered honestly and fully. I appreciate that it is not possible to consider every possible complication to care. By signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and any future condition for which I seek care from this office.

Patient Signature_____Date_____