Heritage
ACUPUNCTURE & WELLNESS

Would you like to receive a copy of our newsletter containing helpful information about natural medicine and exclusive discounts?

Y ◯ N ◯

Patient Information

Name: _____
(first) (middle) (last)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell: _____ Email: _____

Date of Birth: _____ Age: _____ Marital status: _____ Occupation: _____

Employer: _____ Work Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Successful health care and preventative medicine are most effective when the practitioner has a complete understanding of the patient. Please complete this questionnaire as thoroughly as possible. Thank you.

Please list your current health concerns:

List all other present and past diagnoses:

Indicate dates and types of surgeries and injuries

List allergies or sensitivities (past and present):

List any medications (prescribed and over-the-counter), vitamins and supplements you are currently taking:

Does Heritage Acupuncture have your permission to communicate with your primary and/or referring physician(s)? Y ◯ N ◯
If so, please list the physician's name(s) and contact number(s)

Family History of (please check):

Heart disease	Food Allergies	Arthritis	Hypothyroidism
Hypertension	Infectious diseases	Asthma	Hyperthyroidism
Hypercholesterolemia	Seizures	Anemia	Adrenal disorders
Hypotension	Cancer	Kidney disease	Diabetes
Stroke	Infertility	Depression	Alcoholism
IBS	Premature menopause	Emotional problems	Autoimmune diseases

Other disorders not listed above:

Have you had any of the above illnesses? Please list

Have you been diagnosed with: Hepatitis B Y N Hepatitis C Y N HIV Y N

Current Height: Weight:

Blood Pressure: What is your most recent blood pressure reading? / When was this reading taken?

Lifestyle

a. Do you typically eat at least three meals per day? Y N If no, how many?

b. Please describe:

- A typical breakfast:
- A typical lunch:
- A typical dinner:
- Daily snacks:
- Beverages:
- Exercise routine:

c. How many hours per night of sleep:

Please indicate use and frequency of the following:

Tobacco		Coffee	
Alcohol		Carbonated drinks	
Sweets and desserts		Water	
Recreational substances			

Five Element Questionnaire

Please check if you experience any of the below on a frequent basis (3-5x/week or more):

Wood	Fire	Earth	Metal	Water
☐ Irritability	☐ Palpitations	☐ Body feels heavy	☐ Cough	☐ Urinary pressure or pain
☐ Anger	☐ Dizziness	☐ Fatigue	☐ Nasal discharge	☐ Frequent urination
☐ Depression	☐ Insomnia	☐ Swelling	☐ Sinus pressure	☐ Incontinence
☐ Headaches	☐ Easily startled	☐ Muscle aches	☐ Nose bleeds	☐ Knee pain
☐ Migraines	☐ Anxiety	☐ Craving sweets	☐ Dry mouth	☐ Aching bones
☐ Visual issues	☐ Breathlessness	☐ Excessive hunger	☐ Skin rashes	☐ Feeling cold easily
☐ Red eyes	☐ Vivid dreams	☐ Low appetite	☐ Dry skin	☐ Low sexual energy
☐ Dry eyes	☐ Difficulty concentrating	☐ Frequent worrying	☐ Oily skin	☐ Excess sexual desire
☐ Chest tightness	☐ Lack of joy	☐ Hypoglycemia	☐ Itchy skin	☐ Fear
☐ Lump in throat		☐ Nausea	☐ Shortness of breath	☐ Poor memory
☐ Jaw clenching		☐ Gas	☐ Allergies	☐ Hearing problems
☐ Muscle cramps		☐ Bloating after meals	☐ Frequent colds	☐ Ringing in ears
☐ Stiff joints		☐ Loose stool	☐ Low physical stamina	☐ Night sweats
☐ Acid reflux		☐ Hemorrhoids	☐ Asthma	
☐ Belching				
☐ PMS				

For Women:

Age at onset of menses: _____ First day of last period: _____ Are you pregnant? Y ◯ N ◯

Number of: A) Children born _____ B) Miscarriages _____ C) C-sections _____ D) Abortions _____

Painful periods? Y ◯ N ◯ Irregular periods? Y ◯ N ◯

For Men:

Decrease in urinary flow/pressure: Y ◯ N ◯
Premature ejaculation: Y ◯ N ◯
Infertility: Y ◯ N ◯
Nocturnal emission: Y ◯ N ◯
Low libido: Y ◯ N ◯

Informed Consent and Disclosure

I hereby request and consent to acupuncture, acupuncture-related modalities, herbal recommendations, skin care services and/or other forms of treatment for myself (or my legal charge) provided by Janet Lee, L.Ac., of Heritage Acupuncture LLC, hereby known as the Acupuncturist. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure and the treatment plan which the Acupuncturist determines in my best interest.

I understand that Acupuncture is one part of Oriental Medicine, which also may include the procedures listed below. I agree to the Acupuncturist's use of these treatments if indicated.

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the affected area. It also is normal for the patient to have a temporary warm sensation or feeling of pressure at the acupuncture site. Dizziness or temporary fatigue are possible outcomes. I understand that some patients feel a temporary increase in symptoms before they feel relief. Hematoma or bruising also is a possible result of acupuncture treatment. Rare outcomes include skin rash or tingling. Extremely rare possibilities include pneumothorax or other organ puncture.

Acupressure/TuiNa involves rubbing, kneading, pressing and other massage manipulations which may result in muscle soreness at the massage site that can last for several days. This technique and others described here may involve disrobing. I understand that all attempts will be made to assure my privacy.

Indirect moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burn exists.

Cupping involves a localized suction produced by creating an oxygen vacuum in a small glass cup. A normal outcome is temporary marks called "sha" which resemble bruises. Slight burning or blistering are also possibilities.

Gua sha involves scraping over a cutaneous area with a smooth instrument. This technique also may result in temporary "sha" marks.

Tapping, plum blossom, bleeding and pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

Electrical stimulation/TENS uses microcurrent electricity to stimulate acupuncture points. During this technique it is normal to feel a mild tingling sensation.

Treatment using points Ren 1 and Du 1 may be applied in rare cases. This involves using acupuncture points in the perineum area. If this treatment is necessary, the Acupuncturist will notify me and will provide alternative treatments if I am uncomfortable. I understand all attempts will be made to assure my privacy.

Chinese herbalism involves the use of a number of plant and mineral derived medicinals commonly used in Chinese medicine. I understand that the Acupuncturist is trained and licensed for the use of these materials. The use of Chinese herbalism will be determined by the Acupuncturist's expertise. Chinese herbal treatment may occasionally result in digestive upset. I understand that following the Acupuncturist's dosage and usage recommendations for herbal and other supplements is an important part of the treatment outcome.

I understand that Acupuncture and Chinese Medicine are commonly prescribed in a course of treatment, which may include herbalism, dietary recommendations, lab testing and analysis, exercises or other lifestyle changes. I acknowledge that my compliance to these recommendations will affect the treatment plan. I recognize that one treatment is not a course of treatment.

I understand that the Acupuncturist cannot guarantee results and cannot anticipate all possible risks involved in treatment.

I have read or have had read to me the above consent and understand the risks involved. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindictions and/or suboptimal results. I am aware that it is my responsibility to inform the provider of my current medical or health conditions and to update this history. I understand that the information herein is to aid the provider in giving better service and is completely confidential. The services I receive here are voluntary, and I release Heritage Acupuncture & Wellness LLC and this provider from any liability resulting from this or any services received at Heritage or from any products or tools used during treatments or purchased from Heritage Acupuncture LLC and assume full responsibility thereof.

Authorization for Release of Medical Information: I further understand that the Acupuncturist may need to contact my medical physician when it is determined that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: the diagnosis of diseases or request for lab and/or radiology results, withdrawal from prescription drugs, severe depression or other conditions. This coordination of care intends to manage my health condition in my best interest and to assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to the Acupuncturist to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that the treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to the Acupuncturist to contact my child's medical doctor if/when necessary.

Patient Name _____ Date _____

Cash Payment Policy Information

Payment at time of service is required unless you have purchased a series of treatments, available with certain facial services. A $35charge applies to all returned checks. Herbal and/or nutritional supplements may be invoiced separately from treatments; payment isrequested before delivery of such herbs and/or supplements. Please note that we do not accept commercial insurance plans. If your plan covers acupuncture for out-of-network providers, please inform us that you need a Superbill to submit to your insurance company. You may pay for services with Health Savings plans.

I plan to settle my bill today by paying by cash, MasterCard, Visa, Discover or personal check: Initial

Medical Records

Please note that medical records requests may take up to one month to process. In most cases, records can be provided within three business
days. Standard fees mandated by the North Carolina Industrial Commission apply. Fees must be paid before records are supplied. Medical records are supplied only in person or via fax or email. Records will be faxed if under 20 pages and emailed if above 20 pages.

Initial

Heritage

ACUPUNCTURE & WELLNESS

No Show and Cancellation Policy

Patient Name: _____ Date of Birth: _____

At Heritage Acupuncture, we view appointments as a progression toward reaching your optimal state of physical and mental health. Each visit is a chance to not only reduce uncomfortable symptoms, but learn how to improve your immediate and long-term well-being. As this busy practice sees one client per hour, it is vitally important to communicate clearly about scheduling. This allows us to reserve time for people who need care. Here's how we can work together so everyone benefits:

• Please make a note and/or alert of your appointment in whatever daily calendar you use. The scheduling system automatically sends email appointment confirmations and reminders. However, knowing the date and time of your appointment is ultimately your responsibility.

• We kindly request the courtesy of 24 hours minimum notice to cancel or reschedule. For Monday appointments, please notify Heritage by 5 p.m. Friday. Clients who are scheduled for any service combination totaling more than one hour must provide 48 hours notice to cancel or reschedule.

• One-hour appointments canceled or rescheduled with less than 24 hours notice are considered a no-show. For no-shows:

-The first instance is noted in our system, and fees may be waived as a courtesy;

-The second no-show is charged half the fee for the scheduled service;

-Third and subsequent no-shows are charged the full fee for the scheduled service. This fee must be paid before further appointments are scheduled. At this point, the practitioner may elect to forego reserving future appointments. In this case, clients may call the clinic the day they wish to be seen to inquire about openings. If an opening exists, it may be reserved with pre-payment.

- For appointments longer than one hour, the first no-show is charged 50 percent of the scheduled service. Subsequent no-shows are also charged at 100 percent.

-Skin care clients who have purchased packages follow the same policy, with no-show fees reflecting the undiscounted charge for the service.

Other scheduling policies: All new clients are charged a $60 nonrefundable deposit. For skin care clients, we will reach out once before the appointment to discuss new client forms and product and/or other sensitivities. If we cannot reach you we will charge the credit card on file. New clients may cancel and reschedule one time with that deposit. For acupuncture new patients, we will reach out before the first appointment to schedule a phone intake. This allows us to take your health history prior to the first appointment and devote that appointment solely to treatment. If you miss the phone intake, your intake will occur with the first appointment. New acupuncture clients may cancel and reschedule once per deposit. Also, new clients who do not verbally confirm their appointment time may be removed from the schedule.

If any client cancels and/or reschedules the same service three times consecutively, they can no longer book appointments online. To schedule in this case, clients may call the office the day they want to come in to inquire if there are openings, for which they must pre-pay. At this point, to reserve the service in advance, clients must pay a non-refundable deposit of 50% of the scheduled service.

Please note our goal is to utilize available time to treat patients in need rather than collecting fees. We thank you in advance for your cooperation and understanding. Your signature below acknowledges receipt and comprehension of this policy.

_____ _____

Patient Signature Date

_____

Patient Name Printed

HIPAA Authorization for Use or Disclosure of Health Information

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

The Health Insurance Portability and Accountability Act of 1996 **(HIPPA)**: HIPAA is a federal program that requires medical records and other individually identifiable health information (IHI) used or disclosed by us in any form to be handled and disclosed according to specific guidelines. A detailed description of IHI guidelines has been posted to our Web site, www.heritageacupuncture.com. The detailed notice also is available in our office to view upon request. Please note that Janet Lee, L.Ac., reserves the right to change the terms of the Notice of Privacy Practices at any time.

Our Responsibility:
We respect our legal obligation to keep your IHI confidential and treat it according to HIPAA mandates. Safeguards in place in our office include:
▪ Limited access to facilities where information is stored;
▪ Policies and procedures for handling information;
▪ Requirements for third parties to comply with privacy laws.

We ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment and health care operations in this office. This consent is necessary for treatment to be delivered.
Under HIPAA guidelines, we are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages via text or email.
In some limited situations, the law requires us to use and disclose your health information without your permission. Examples of these circumstances include:
▪ When state or federal law mandate certain health information be reported for specific purposes;
▪ For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
▪ Disclosure to government authorities about victims or suspected abuse, neglect or domestic violence.
▪ Disclosures for law enforcement purposes, such as to provide information about someone who may be a crime victim.
▪ Disclosure related to worker's compensation programs.

Your Rights:
You have the right to request restrictions on certain uses and disclosures of your IHI, including those related to the disclosure of family members or any other person identified by you. We are, however, not required to agree to the requested restriction. If we do agree, we must abide by it unless you agree in writing to remove the restriction.
You also have the right to request we communicate with you in a confidential way, such as contacting you at work rather than home. Please provide a written request.
You have a right to see or get copies of your health information. After a written request for your records, you may have to pay for copies in advance and allow up to 30 days for processing.
You have the right to obtain a paper copy of this notice at your request.

You have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the Clinic at the following address:

14 Consultant Place, Suite 250
Durham NC 27713

I hereby consent to the use and disclosure of my Identifiable Health Information by Janet Lee, L.Ac., of Heritage Acupuncture and Wellness LLC, for the purposes of treatment, payment and healthcare operations or as otherwise required by law.

Patient (18 years or older) Date

Parent, Guardian, Responsible Party Date