Healthy Point Acupuncture Clinic, Cancellation, Financial, and Privacy Policies

Patient Name: ____ Date of Birth:____/____/_______

Clinic Policies:

- Acupuncture and other related treatments may not be advisable for some conditions, and the identification of current medical conditions, medications, supplements, and other ongoing treatments as completely and accurately as possible is required prior to acupuncture treatment.
- Informed consent, arbitration agreement, and physician care form must be signed before treatment can begin.
- Informed consent must be signed by the parent or guardian of any patients under the age of 18, and patients under the age of 16 or those under guardianship must be accompanied by their parent, legal guardian, or other caretaker for the duration of the treatment.
- Patients deemed under the influence of alcohol and/or drugs will not be treated.
- Practitioner reserves the right to refuse service to any patients in cases of lack of courteous behavior to the practitioner and/or other patients.
- Sexual misconduct (including, but not limited to sexual advances, inappropriate language or contact, and/or requests for sexual favors) from patients will not be tolerated and will result in termination of treatment. Patients will be responsible for full payment for the session and will be prohibited from future treatments.

Cancellation Policies:

- Please cancel or reschedule within 24 hours of the scheduled appointment. Last minute cancellations *may* result in a late cancellation fee not to exceed 50% of the scheduled service price, to be assessed at the practitioner's discretion. If no payment method is on file, appointments will not be rescheduled until this late cancellation fee has been paid.

Financial Policies:

- Payment must be rendered at the time of service unless prior arrangements have been agreed to by both parties.
- Service prices will be re-evaluated on a regular basis and may be updated periodically. The practitioner will give at least 30 days notice before implementing new pricing by updating pricing listings on any printed or online material and by giving verbal and/or written notice during patient visits. Previously paid prices are not a guarantee of cost for future services.
- Patient is solely responsible for payment of all assessed treatment costs.

Notice of Privacy Practices

The federal and state government both have laws and regulations about how your medical information can and can't be used. Generally, your medical information must be kept confidential, except in very certain circumstances, such as in cases where a court has issued a subpoena for the release of your medical records, or in cases where you've authorized a provider to release your information for a certain purpose. These laws also describe the rights that you have as a patient in regards to your medical information.

Healthy Point Acupuncture has a full brochure that details all of your rights, and would be happy to provide a copy of that brochure to you if you'd like one. By signing this form, you attest that you have been informed that you have rights regarding the use of your information, and that you can request a copy of our complete privacy practices whenever you wish and one will be provided to you.

Here are the basic high points of our privacy practices:

- Your information will be kept confidential unless it is absolutely necessary to release it, such as cases where it's necessary to release your information in order to treat you, in cases of court order or the safety of yourself or your family members, or if certain communicable illnesses are suspected.
- You have the option of allowing us to release your information to your primary care provider, or another medical provider of your choosing, so that we can work together to improve your condition more efficiently. All you have to do for that is sign a Release of Information form.
- There are certain cases of mandatory reporting that require practitioners to immediately report a situation to the Cabinet for Health and Family Services. These situations include child abuse, neglect, and dependency, and abuse, neglect, or financial exploitation of adults with disabilities who cannot protect themselves.
- You can tell us who we can and can't release information to for your own purposes. Just ask for a release of information form from us. This permission is good for one year, unless you specify a different period of time.
  We will never share your information for marketing purposes. We will never sell your information to any third party.

By signing below, I attest that I have read and agree to the clinic, cancellation, and financial policies listed above.

Signature: ____ Date: ____/____/20_____

Guardian Signature: ____ Date: ____/____/20_____

Healthy Point Acupuncture Intake Form

This ***confidential*** questionnaire will help your practitioner determine the optimal treatment plan for your condition(s). Please answer honestly and as thoroughly as possible, and ask any questions you may have.

Patient Information:

Patient Name: ____ Date of Birth:_______/_______/__________

Occupation: ____

My gender is: ______________________________ My pronoun(s) is/are:____

Emergency Contact Information:

Name: _____________________________________ Phone: (   ) _________________________

Relationship to patient: ____

Physician Contact Information: (check the appropriate box)

☐ I have a primary care provider: Name: _____________________________________ Phone: (   ) _________________________

OR

☐ I do not have a primary care provider.

☐ I understand that I may be referred to a primary care provider if my condition changes or worsens, or if there are other circumstances that require my acupuncturist to issue a referral for evaluation. If this situation arises, I agree to seek medical care from a licensed physician for such a condition, and to provide my acupuncturist with their contact information for follow up.

Have you received acupuncture treatment before? ☐ Yes ☐ No

If yes, when and where?____

Health Information:

Please be honest, and as thorough and accurate as possible. Remember, all of your answers are confidential and will be used *only* for the planning of your treatment. Feel free to write on the back of this form or in the margins if you need to.

Please check if any of the following statements is true:

☐ I have a bleeding or clotting disorder. ☐ I have a pacemaker. ☐ I have a history of seizures.

☐ I have cancer. ☐ I am pregnant. (Due : _________________)

☐ I am taking blood thinners (Warfarin, Coumadin, Heparin, Eliquis, Pradaxa, Xarelto, etc.).

I have been diagnosed with **AND** currently experience the following condition(s) (check all that apply):

☐ Hypertension (High Blood Pressure) **AND** Cardiac (Heart) Condition
☐ Acute, severe abdominal pain
☐ Undiagnosed neurological changes
☐ Unexplained weight loss or gain of more than 15% of body weight over the last 3 months
☐ Suspected bone fracture or dislocation
☐ Suspected systemic infection
☐ Serious hemorrhagic (bleeding) disorder
☐ Acute respiratory distress without previous history

Please list all of the medications you are taking, including dosages if known, and any supplements or herbal teas you use as a supplement.

____

____

____

____

What are the **two** main concerns that you'd like to be addressed with acupuncture treatment, in order of importance to you?

1. ____

When did this problem start? ____

What treatments have you tried? ____

2. ____

When did this problem start? ____

What treatments have you tried? ____

Have you traveled abroad in the last year? If so, where? ____

Please list any major or chronic illnesses suffered by family members: ____

____

____

Please list any major or chronic illnesses or injuries suffered by you (including car accidents): ______________________________

____

____

Please list any surgeries you've had, including the date if known: ____

____

____

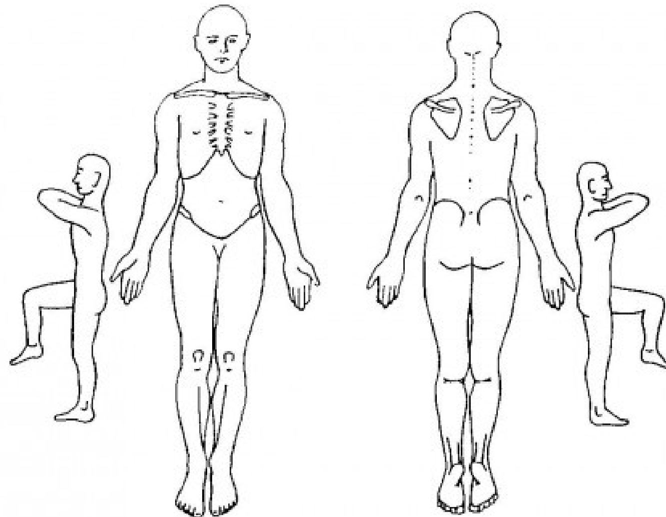
Please list any allergies or intolerances you experience, including medications or foods you are allergic or intolerant to, seasonal allergies you suffer from, and any contact allergies or sensitivities you've noticed:____

____

____

____

Please indicate on the following diagram the location of any pain you are currently experiencing:



What is the current severity of your pain? Please mark with an X on the following spectrum line:

None |--|--| Worst Ever

What is the frequency of your pain (circle all that apply, and explain if necessary):

Constant Comes and goes on its own Comes and goes with movement

Other: ____

If you had to describe what this pain feels like using only words, what words would you use? ______________________________

____

What, if anything makes the pain better? Worse? ____

____

If any answers to this questionnaire change, please let your practitioner know as soon as possible, so any changes to your treatment plan can be made, if necessary, to ensure continued improvement in your condition.

Signature: ____ Date: _______/_______/20________

Guardian Signature: ______________________________________ Date: _______/_______/20________

Patient Contact Preferences

Patient Name: ____ Date of Birth:____/____/_______

Patient Address: ____

Patient Phone: ( ) _______________________ ☐ Home ☐ Work ☐ Mobile

Alternate Phone: ( ) _______________________ ☐ Home ☐ Work ☐ Mobile

Patient email: ____

May we leave a voicemail? ☐ Yes ☐ No

For appointment reminders/confirmations, I prefer: ☐ Call ☐ Text ☐ Email

For general communication, I prefer: ☐ Call ☐ Text ☐ Email

Opt out of promotions and/or newsletters by checking here: ☐

Signature: ____ Date: ____/____/20_____

Guardian Signature: ____ Date: ____/____/20_____