HIGHLAND LAKES ACUPUNCTURE

Patient Intake Form

Full name		Sex F M	Date
Date of birth	Age	Occupation	
Phone #		Allow email contact	Yes No
E-mail address			
Emergency contact name & phone		Marital status	# of children
Address: Street		City	State Zip
Family physician		Chiropractor	
How did you find out about our clinic? *Friends/Relatives(name)*_____ *Website* *Yelp* *Google*			

Main problem(s):

_____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____What are the causes of this problem? _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Medicines: taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Signature: Adult Patient Parent or Guardian Spouse

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Highland Lakes Acupuncture "Notice of Privacy Practices". I understand that I have the right to review Highland Lakes Acupuncture "Notice of Privacy Practices" prior to signing this document.

I understand that Highland Lakes Acupuncture staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

CANCELLATIONS – Please note that if you do not show up for your appointment, Highland Lakes Acupuncture reserves the right to charge you the full treatment fee. If you cancel your appointment less than 24 hours before your treatment time, Highland Lakes Acupuncture reserves the right to charge you a $25 cancellation fee.

_____ _____

Patient Name (print) Date

_____

Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Highland Lakes Acupuncture the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____

Patient's Signature Date

HIGHLAND LAKES  ACUPUNCTURE

SUMMARY OF PRIVACY PRACTICES

We don't do anything with your health data without your written consent.
We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if want to read the complete details.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. When we can disclose your health data without your permission:

a) As required by federal, state, or local law
b) If child abuse or neglect is suspected
c) Public health risks (for public health activities to prevent and control spread of disease)
d) Lawsuits and disputes (in response to a court or administrative order)
e) Law enforcement (to help law enforcement officials respond to criminal activities)
f) Coroners, medical examiners and funeral directors
g) Organ or tissue donation facilities if you are an organ donor
h) To avert a threat to an individual or to public health safety

III. When we must get your express consent to use your health data:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may only share your health data with a family member, a close friend or other person if you have named them as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Highland Lakes Acupuncture at any time.

Patient Signature or Representative Date

HIGHLAND LAKES ACUPUNCTURE

INFORMED CONSENT TO CHINESE MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at Highland Lakes Acupuncture: acupuncture and other Chinese Medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, etc.; modes of manual or physical therapy such as Asian body work, acupressure, insertion and manipulation of acupuncture needles, administration of thermal or electrical treatments, moxibustion; energy flow exercise; the prescription of herbal as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling. I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Chinese Medicine procedures. Although I am aware that acupuncture and the other procedures used in Chinese Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Chinese Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible, particularly when face rejuvenation acupuncture is given. I understand that these risks include, but are not limited to: bleeding, bruising, puncture of organs, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, blisters, aggravation of current symptoms, appearance of new symptoms, general aches, fatigue, dark red or purple marks from cupping, skin itching, redness, discomforts from taking herbs, sprains, strains, dislocation, miscarriage, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner, to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an 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 at Highland Lakes Acupuncture.

_____ _____

Patient name (please print) Patient signature

_____ _____

Date Witness

_____ _____

Print name of patient's representative (if applicable) Relationship or authority of patient's representative

_____ _____

Signature of patient's representative (if applicable) Date Signed

HIGHLAND LAKES  ACUPUNCTURE

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, HLA is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (patient's name) _____ am notifying Highland Lakes Acupuncture of the following:

____ Yes ____ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

____Yes____No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

____ Chronic Pain ____ Smoking addiction
____ Weight loss ____ Alcoholism ____ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____

Patient Signature Required Date