

Community Acupuncture of Mt. Airy Intake Form

(to be filled out on the first visit)

Name: _____ Date: _____

Address: _____

Phone No. _____

Email (not shared & used only to transmit info related to your health) _____

Physician's name & location of practice: _____

Permission to contact your physician to share info: Yes No

In Emergency contact (provide name & phone #): _____

Have you had acupuncture before? No If yes, was it helpful? _____

How did you hear about the Acupuncture Center? _____

Main health concern you'd like to address:

Have you seen a physician about your concern?

When did it first begin?

What treatments have you tried? Were they helpful?

What makes it better?

What makes it worse?

What do you think is the cause of the problem?

Clinician's Notes from first visit:

Clinician's Treatment from first visit:

Pulse:

Tongue:

Practitioner's Diagnosis/Assessment:

Initial Points on Body:

Ear Points:

Practitioner's Initials _____

**Community Acupuncture of Mt. Airy
Brief Health History Form
(to be filled out on your first visit)**

Patient Name:

Birth Date:

Age:

Western diagnosis, if known:

Is there any procedure or surgery scheduled for you? Yes No If yes, when? _____

Medical History:

Asthma Heart Disease Hypertension Diabetes Chronic Pulmonary Disease COVID-19

Vaccinated for Covid-19 Kidney Disease Liver Disease Bleeding disorder

Thyroid Disease Seizures Hepatitis Depression Anxiety High Stress Level Alcoholism

AIDS Cancer – what kind? _____ Other (specify) _____

Any other info you would like us to know about your health history:

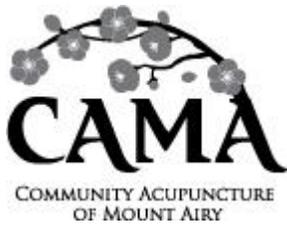
Allergies: None Yes If yes, please specify _____

Current Medications: None Yes If yes, please specify _____

Social History: Alcohol Tobacco

Significant Trauma (auto accidents, falls, etc.) _____

Significant Surgical History: None Yes If yes, please specify _____



Consent to Treatment

I hereby authorize licensed acupuncturists at CAMA to administer any style of Asian medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of acupuncture needles into my body at various depths and locations. Rarely, but on occasion, a small bruise can occur from needling which will resolve as bruises normally do.
2. Far Infrared Heat treatments known to expand capillaries to increase blood flow and detoxifies the body by enabling the elimination of toxins, lactic acid and heavy metals.
3. A technique call "gua sha" or "cupping" that eases the pain of aching muscles. This treatment leaves redness on the skin that can last for 1-5 days and is essential for the treatment to be effective. Slight tenderness may occur after the treatment and resolves shortly thereafter.

Furthermore:

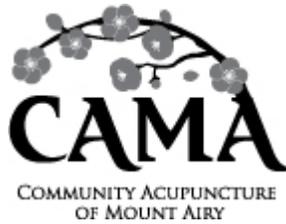
- I understand that I may feel extremely relaxed following treatment and therefore I am welcome to remain in the waiting room until I feel comfortable departing.
- I know I have the right to refuse any form of treatment, and that I can ask questions pertaining to the treatment at any time.
- I also understand that while acupuncture is considered extremely safe, there is always a small possibility of an unexpected complication and that no guarantees can be made concerning the results of treatment.

Please sign below to indicate that you understand both the cancellation policy and consent to treatment:

Signature

Date: _____

Name (please print)



HIPAA Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Community Acupuncture of Mt. Airy (CAMA) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for my diagnosis and diagnosis codes to any receipt I may request
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

If desired, I can request a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the CAMA is not required to agree to the restrictions requested if required by law.

I understand that I may revoke this consent in writing, except to the extent that the CAMA has already take action in reliance thereon, and am aware that upon request at reception, I can be provided with a HIPAA Compliance Assurance Notification to review.

At this time, I request the following restrictions to the use or disclosure of my health information: (write your request here)

Signature of Patient or Legal Representative:

Print Name: _____

Signature _____ Date: _____