HOOKED ON ACUPUNCTURE

Community Clinic • Galveston, TX

Welcome! Please read this brief introduction to the clinic…

When you get acupuncture at Hooked on Acupuncture you are not just a patient, you are a participant. We are one of many clinics around the country in recent years to address the issue of affordability and access to acupuncture by offering **treatment in a group setting with a sliding pay structure**. Treating in a group setting is actually a very traditional way of providing acupuncture, so we're kind of shining a new light on a very old way of doing things.

Community acupuncture is community *supported* acupuncture (we don't receive any grants or other funding to do what we do), and by supporting this clinic, you are participating in making the benefits of acupuncture accessible to more people than previously possible. You are also participating in receiving acupuncture in the context of a community of other people who, like yourself, have come to acupuncture because they need help with something. We are, after all, all in this together. Thank you for being here.

Here are some guidelines to follow to help the clinic run smoothly and make your experience a pleasant one:

- Cell phones must be turned off in the clinic.
- Plan to be at the clinic for about 90 minutes. Follow up treatments may not take as long. While typically a treatment lasts about an hour, we'll leave you as long as you look like you're resting soundly. So please give a sign if you're done and be sure to let us know if you need to be out by a certain time.
- Please do not wear cologne, perfume, or scented lotions. Many people are sensitive to smells. Also, please don't wear oils on your skin or hair when you come, as it ruins the sheets.
- Please eat a little something before. Acupuncture's not recommended on an empty stomach.
- Wear loose, comfortable clothing with sleeves that can be rolled up to the elbows and pants that can be rolled up to the knees.
- Please be considerate of others in the group treatment room. Quiet is appreciated. Most people fall asleep when they get acupuncture. There are earplugs and eye pillows provided, but if you'd like to bring your own please feel free to do so.

Select how much you pay:

Check One: ___$20 ___$25 ___$30 ___$35 ___$40 ___$45 ___$50

There is an additional $10 New Patient fee with your first appointment.

Cancellation policy agreement: If you have an appointment scheduled and you don't show up and don't call us prior to the appointment to let us know you won't be coming, you will be charged a missed appointment fee of $20.

I have read and agree to the above:

Signature of patient/guardian _____ Date _____

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered primary care. As a result, we are required to have you respond 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 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the practitioners at Hooked on Acupuncture of the following:

___ Yes ___ No I have been evaluated by a physician or dentist 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. After being referred by a chiropractor, if after two months or 20 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 (check all that apply):

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

Signature of Patient/Guardian _____ Date_____

Hooked on Acupuncture is not responsible for untrue statements made by patients.

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. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
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 share your health data with a family member, a close friend or other person that you have named 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 Hooked on Acupuncture at any time.

Signature of Patient/Guardian_____ **Date**_____

INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, bodywork, and nutritional counseling.

I am hereby informed that the aforementioned treatment methods are all generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although Hooked on Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment.
Potential risks of moxibustion include blistering, burns, and scarring.
Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days. Cupping can also cause blistering of the skin in some instances.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include: nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. My health information will be handled in accordance with the Summary of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment. I intend this consent form to cover the entire course of treatments for my present condition and for any future condition(s) for which I seek treatment at this clinic.

Signature of Patient/Guardian_____ **Date**_____

Patient Intake Form

All medical information is confidential. We appreciate your time, thoughtfulness and honesty in completing this overview.

Name: _____Date: _____

Address: _____

Phone: (home) _____(cell) _____

Email:_____

Age: _____ Date of Birth: _____ Height: _____Weight: _____

Occupation: _____ Hours per week: _____ Do you enjoy your work? _____

Gender: F M Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse: ___ Partner: ___ Parents: ___ Children: ___ Friends: ___ Alone: ____Other:____

How did you hear about us?_____

Have you ever had acupuncture before?_____

Your medical doctor's name & phone number: _____

Emergency contact name & Relationship: _____

Emergency Contact Phone Number: _____

What is your primary reason or chief complaint for this visit?

1)

2)

3)

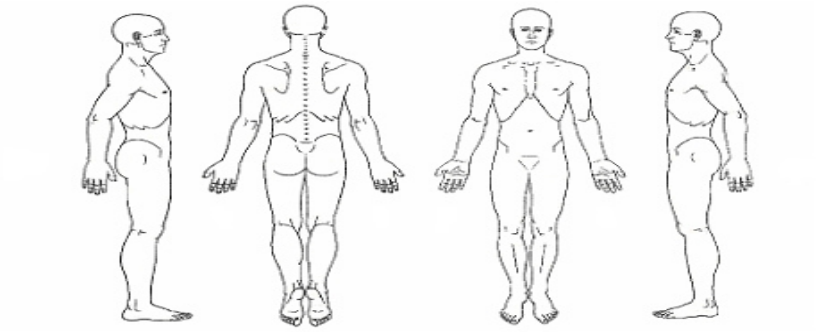
What initiates your symptoms? _____

What makes them better? _____

What makes them worse? _____

Pain

Please mark the location(s) of your pain on the diagram below



Pain Level (circle): 1 2 3 4 5 6 7 8 9 10

Location/Description of Pain: _____

Dull Pain? Y N Sharp Pain? Y N Radiating Pain? Y N Where to?_____

Circle any illnesses or conditions you currently have or have had in the past:

AIDS/HIV	Bleed Easily	Heart Disease	Multiple Sclerosis	Shingles
Alcoholism	Cancer	Hepatitis A B C	Vascular Disease	Stroke
Allergies	Chicken Pox	High Blood Pressure	Whooping Cough	Thyroid Disorder
Anemia	Diabetes	Jaundice	Pneumonia	Tuberculosis
Antibiotic Use	Epilepsy	Kidney Disease	Polio	Ulcers
Asthma	Glaucoma	Mental Disorder	Rheumatic Fever	Malaria

Other: _____

Have you received a diagnosis for any of the above? Yes No

Do you have a *PACEMAKER*? Yes No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: _____

_____

_____

Allergies: Are you allergic or hypersensitive to any:

Drugs? _____

Foods? _____

Alcohol? _____

Current Medications (list ALL you are taking and what you take them for):

_____
_____
_____
_____
_____
_____

Currents Herbs/Vitamins/Supplements (list ALL you are taking): _____

_____
_____
_____

Is there anything else you would like to share with us?

Female Only

Pregnant? Yes No Date of Last period: _____ Length of Cycle: _____

Days Bleeding: _____ Menstrual Pain? Yes No Clot PMS? Yes No

Birth Control? Y N Type of birth control: _____

Menopause*:* Age at Onset: _____ Hot Flashes? Yes No Night Sweats? Yes No

Other Information: _____

Patient Signature: _____ **Date:** _____