

## CLINIC GUIDELINES

### **Preparing for Treatment**

1. Always eat and drink a glass of water before you come. Energy moves better in a well-hydrated body, and you should not take treatments when you are hungry.
2. Do not stop any other treatment you are on: medication, therapy, chiropractic, massage, etc.
3. Limit the amount of jewelry you wear as most must be removed during treatment.
4. Some of our patients are very sensitive to scents and odors. Please do not wear any perfume, strong smelling deodorant, scented lotion, hair spray, etc. when you come to the clinic. If possible take a shower and wash your hair before you come, and always wash your hands before treatment. If you are a smoker please wear freshly laundered clothes.
5. For female patients, treatments are not advisable during the first three days of the menstrual cycle.

### **During Treatment**

1. Smoking is not allowed in or around the office.
2. Do not eat or chew gum.
3. Do not cross your hands or feet during treatment and the first 20 minutes after treatment.
4. Do not read or touch other objects during treatment.

### **After Treatment**

1. Wash your hands. If washing is not possible, vigorous rubbing of the hands for 30 seconds is sufficient.
2. Do not exercise for 6 hours.
3. Avoid exposure to extreme hot or cold temperature.
4. Do not bathe or shower for 6 hours.
5. Your doctor should recheck the item for which you were treated, preferably the next day, but no longer that a week after the initial treatment.
6. Drink lots of water (4-6 glasses) after NAET and acupuncture treatments to help flush out the toxins produced during the treatment.
7. You may need to take extra precautions when you get treated for environmental substances (minerals, metals, plants, chemicals, etc.). In addition to staying away from these items you may also need to wear a mask and gloves. We will furnish these for you.
8. If you are treated for a particular food that contains a vitamin, herb, or substance that you are taking, you may be asked to stop taking that supplement for 25 hours following the treatment.
9. It is recommended that you maintain a log of your treatments and a food diary. If you need help with recording, please ask your practitioner.

## Acupuncture & Allergy Center Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**Acupuncture & Allergy Center** is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### Disclosure of Your Health Care Information

**Treatment** - We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. (Example)

- On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with **Acupuncture & Allergy Center**.
- It is our policy to provide a substitute health care provider, authorized by **Acupuncture & Allergy Center** to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

**Payment** - We may disclose your health information to your insurance provider for the purpose of payment of health care operations. (Example)

- We will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

**Workers' Compensation** - We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies** - We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or your death.

**Public Health** - As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings** - We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement** - We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons** - We may disclose your health information to coroners or medical examiners.

**Research** - We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety** - We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies** - We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Change of Ownership** - In the event that **Acupuncture & Allergy Center** is sold or merged with another organization, your health information record will become the property of the new owner.

### Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Acupuncture & Allergy Center** is not required to agree to the restriction that you request.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request.
- You have the right to inspect and copy your health information,
- You have a right to request that **Acupuncture & Allergy Center** amend your protected health information. Please be advised, however, that **Acupuncture & Allergy Center** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **Acupuncture & Allergy Center**.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### Changes to this Notice of Privacy Practices

- **Acupuncture & Allergy Center** reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Acupuncture & Allergy Center is required by law to comply with this notice.
- **Acupuncture & Allergy Center** is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of the notice or if you want more information about your privacy rights please contact Joan Gregory by calling the **Acupuncture & Allergy Center** office at 817-276-0044. If Joan Gregory is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

### Complaints

- Complaints about your privacy rights or how **Acupuncture & Allergy Center** has handled your health information should be directed to Joan Gregory by calling this office at 817-276-0044. If Joan Gregory is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
- If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201
- This notice is effective as of March 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide **Acupuncture & Allergy Center** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized Facility Signature \_\_\_\_\_ Date \_\_\_\_\_

## Past Medical History

Circle any of the following conditions you currently have or have had in the past.

AIDS / HIV	Alcoholism	Allergies	Appendicitis
Arteriosclerosis	Asthma	Birth Trauma (your own)	Cancer
Chicken Pox	Diabetes	Emphysema	Epilepsy
Goiter	Gout	Heart Disease	Hepatitis
Herpes	High Blood Pressure	Measles	Multiple Sclerosis
Mumps	Pacemaker	Pleurisy	Pneumonia
Polio	Rheumatic Fever	Scarlet Fever	Seizures
Stroke	Thyroid Disorders	Tuberculosis	Typhoid Fever
Ulcers	Venereal Disease	Whooping Cough	Other: _____

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List medications you are currently taking. (Use reverse side if necessary)

<u>Medication</u>	<u>Strength</u>	<u>How many per day?</u>	<u>For how long?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List substances or medications you are allergic to: \_\_\_\_\_

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List any surgeries you have had:

<u>Date</u>	<u>Problem</u>
_____	_____
_____	_____
_____	_____

List significant trauma: (auto accident, falls, etc.)

<u>Date</u>	<u>Problem</u>
_____	_____
_____	_____
_____	_____

List significant family history:

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Your Diet (Circle all that apply.)

Appetite High	Sugar	Coffee	Salty Food
Appetite Low	Artificial Sweetener	Soft Drinks	Thirst for Water
Vitamins taken in the past two months: _____		Glasses of Water per Day: _____	

Your Lifestyle (Circle all that apply.)

Alcohol	Drugs	Regular Exercise (List type and frequency):	
Tobacco	Stress	_____	_____
Marijuana	Occupational Hazards	_____	_____

General Symptoms (Circle all that apply.)

Poor Appetite	Poor Sleep	Cold Hands or Feet	Sweat Easily
Heavy Appetite	Heavy Sleep	Poor Circulation	Muscle Cramps
Strongly like Cold Drinks	Dream-disturbed Sleep	Shortness of Breath	Fever
Strongly like Hot Drinks	Fatigue	Vertigo or Dizziness	Chills
Recent Weight Loss	Lack of Strength	Bleed or Bruise Easily	Night Sweats
Recent Weight Gain	Bodily Heaviness	Peculiar Taste (describe): _____	

Head, Eyes, Ears, Nose and Throat (Circle all that apply.)

Glasses	Glaucoma	Excessive Saliva	Nose Bleeds
Eye Strain	Cataracts	Sinus Problems	ringing in Ears
Eye Pain	Teeth Problems	Excessive Phlegm	Poor Hearing
Red Eyes	Grind Teeth	Color of Phlegm: _____	Earaches
Itchy Eyes	TMJ		Headaches
Spots in Eyes	Facial Pain	Recurrent Sore Throat	Migraines
Poor Vision	Gum Problems	Swollen Glands	Concussions
Blurred Vision	Sores on Lips or Tongue	Lumps in Throat	Dry Mouth
Night Blindness	Enlarged Thyroid	Other Head / Neck Problems: _____	

Respiratory (Circle all that apply.)

Pneumonia	Shortness of Breath	Cough	Color of Phlegm
Difficulty breathing when lying down	Tight Chest	Wet or Dry?	_____
	Asthma / Wheezing	Thick or Thin?	Coughing Blood

Cardiovascular (Circle all that apply.)

High Blood Pressure	Fainting	Tachycardia	Phlebitis
Low Blood Pressure	Chest Pain	Heart Palpitations	
Blood Clots	Difficulty Breathing	Irregular Heartbeat	

Gastrointestinal (Circle all that apply.)

Nausea	Bad Breath	Intestinal Pain or Cramping	Bowel Movements:
Vomiting	Diarrhea	Itchy Anus	Frequency: _____
Acid Regurgitation	Constipation	Burning Anus	Color: _____
Gas	Laxative Use	Rectal Pain	Odor: _____
Hiccups	Black Stools	Hemorrhoids	Texture / Form: _____
Bloating	Mucous in Stools	Anal Fissures	_____

Musculoskeletal (Circle all that apply.)

Neck / Shoulder Pain	Lower Back Pain	Limited Range of Motion	Other: (describe): _____
Muscle Pain	Joint Pain	Limited Use	_____
Upper Back Pain	Rib Pain		_____

Skin and Hair (Circle all that apply.)

Rashes	Psoriasis	Hair Loss	Other Hair /Skin Problems: _____
Hives	Acne	Change in Hair /Skin Texture	_____
Ulceration	Dandruff	Fungal Infection	_____
Eczema	Itching		_____

Neuropsychological (Circle all that apply.)

Seizures	Depression	Abuse survivor	Other (specify): _____
Numbness	Anxiety	Considered/Attempted Suicide	_____
Tics	Irritability	Seeing a Therapist	_____
Poor Memory	Easily Stressed		_____

Genitourinary (Circle all that apply.)

Pain on Urination	Incontinence	Wake to Urinate	Impotence
Frequent Urination	Incomplete Urination	Premature Ejaculation	Increased Libido
Urgent Urination	Venereal Disease	Nocturnal Emission	Decreased Libido
Blood in Urine	Bedwetting	Kidney Stones	Other: _____

Gynecological (Circle all that apply.)

Age Menses Began: _____	Irregular Periods	Date of Last PAP: _____	# Pregnancies:
Length of Cycle (Day 1 to Day 1) _____	Painful Period	Clots	# Live Births:
Duration of Flow: _____	Vaginal Odor	PMS	# Premature Births
Date Last Period Began _____	Vaginal Sores	Breast Lumps	Age at Menopause:
	Vaginal Discharge		
	Color: _____		

## Patient Registration

Patient Name:		Age:	
Address:		(Street)	(City)
		(State)	(Zip)
Email Address:			
Home Phone:		Cell Phone:	
Employer:		Work Phone:	
Date of Birth:		Social Security #:	
Please Circle:	Male    Female	Married    Single	Widowed    Divorced    Minor
Person to contact in case of emergency: _____			
Phone number for emergency contact person listed above: _____			
Reason for today's visit: _____			
How long have you had this condition?		Have you had this before?	Yes    No
Is this condition related to your job?	Yes    No	Motor vehicle accident?	Yes    No
Is it getting worse?	Yes    No		
Does this condition bother your:	Sleep    Work    Other (Describe)		
What seems to be the initial cause?			
What seems to make this condition better?			
What seems to make this condition worse?			
Have you had acupuncture before?	Yes    No	Have you used Chinese Herbal Medicine?	Yes    No
Are you under the care of a physician?	Yes    No	If yes, what for?	
Physician's Name:			
Concurrent Therapies:			
How did you hear about us? _____			
Patient Signature:		Date:	

Condition Treated: \_\_\_\_\_

### NOTICE TO THE PATIENT

(Pursuant to the requirements of section 183.7(e) of this title (relating to Denial of License; Discipline of Licensee) and section 6.11, subsections (b) through (d), V.A.C.S. article 4495b, governing the practice of acupuncture).

I (patient's name) \_\_\_\_\_ am notifying  
 the acupuncturist (practitioner's name), \_\_\_\_\_ of the  
 following:

Yes  No      I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognized that I should be evaluated by a physician for the condition being treated by the acupuncturist.

\_\_\_\_\_ (initials of patient)      \_\_\_\_\_ (date)

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 120 days of 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 to follow this advice.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the member of the Clinic Staff (Licensed Acupuncturist, Guest Acupuncturist, Student Intern, or Trainee) named below and/or other member of the Clinic Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Staff named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe methods of treatment, but that it may have side effects, including bruising, numbness of tingling near the needling sites that may last a few days, and dizziness of fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic used sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the Clinic Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Clinic Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely of the Clinic Medical Staff to exercise judgment during the course of treatment which the Clinic Staff thinks at the time, based upon the facts then known, is in my best interests.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intent 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.

\_\_\_\_\_  
(Print Patient Name)

\_\_\_\_\_  
(Print Name of Clinic Staff)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Signature of Clinic Staff)

\_\_\_\_\_  
(Minor Patient Representative)

\_\_\_\_\_  
(Print Name of Witness / Translator)

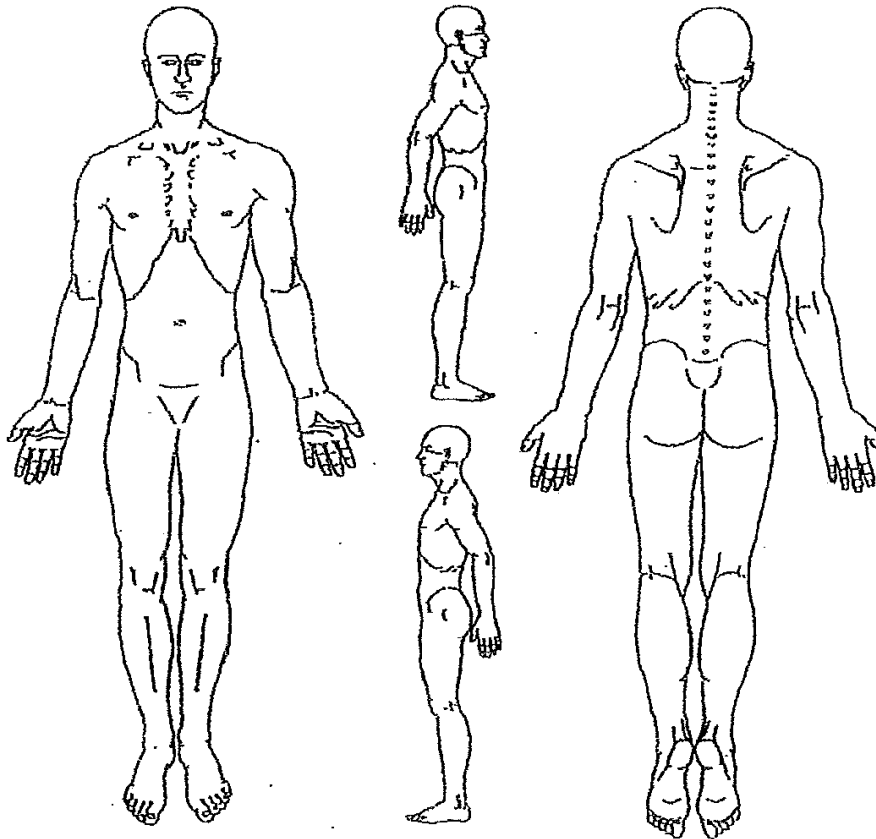
\_\_\_\_\_  
(Date Consent Completed)

\_\_\_\_\_  
(Signature of Witness / Translator)

## Patient Pain Drawing

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

Name (please print): _____		Date: _____	
Age: _____	Date of Birth: _____	Occupation: _____	
How long have you had this symptom? _____ Years _____ Months _____ Weeks			
Is this your first episode of this symptom? _____ Yes _____ No			
<b>USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.</b>			
KEY:	A= ache	B= burning	N= numbness
	P= pins & needles	S= stabbing	O= other



0    1    2    3    4    5    6    7    8    9    10

No pain

Highest pain

Please rate your current pain by circling the appropriate number above.