Thank you for taking the time to complete this form. The information you provide is ***confidential.***

Contact Information:

Patient:
First:_____Last:_____

Address:_____

City:_____State:_____Zip:_____

DoB:_____/_____/_____ Sex: Male:_____ Female_____

Martial Status:_____

Home Phone: _____ Work: _____ Mobile: _____

Best Number to contact you during the day:
Home_____ Work_____ Cell___

E-Mail:_____

Is it permissible to send follow-up (e.g. how are you doing since your last treatment?) emails? Yes:_____ No:_____

Occupation_____

Employer:_____

Emergency Contact Person:_____

Relationship_____Tel:_____

Responsible Party (if you are not patient)

Relationship to patient:_____

Name of Responsible Party:_____

Phone: _____

Address: _____

City:_____ State:_____ Zip:_____

Current Health Practitioners- Please list your physicians or other healthcare practitioners.

1.

2.

3.

Patient Medical Condition

When and where did you last receive health care?

For what reason?

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Do you have any reason to believe you may be pregnant?
If so, how far along are you?

Do you have any infectious diseases? Yes:_____ No: _____

If yes, please identify:

Please list all medications you are currently taking:

Medication	**Dose**	**Condition Treated**

Please list over-the-counter medications, vitamins, and supplements you are currently taking:

Do you smoke or use tobacco? Yes: ___ No: _____

What kind?_____

How much, how often? _____

Do you consume alcohol? Yes: _____No:___

How much, how often? _____

Do you use any recreational drugs? Yes: _____ No:_____

What kind?_____

How much, how often?_____

Do you consume caffeine? Yes:____ No:_____

In what? _____

How much, how often?_____

Do you currently have, or have you ever had:

____ fainting easily ____ bruising easily ____ slow blood clotting

____ heart problems ____ breathing difficulties

____ hepatitis (note type: _____) ____ HIV/AIDS

____ high blood pressure (most recent blood pressure reading:___ /___)

____ collapsed lung ____ diabetes ____ fear of needles

Please list any surgeries (major or minor) that you have had:

Please identify the health concerns that have brought you to Silver Current Acupuncture in order of importance below:

Condition: **Past Treatment:**

1)

How does this condition affect you?

2)

How does this condition affect you?

3)

How does this condition affect you?

4)

How does this condition affect you?

Silver Current Acupuncture Financial Policies

- Payment in full is expected at the time of treatment.

- If you have a special financial situation or need, please let us know so that we can create a
  payment plan designed for unique circumstances. Your health is important to us, so we work with you to ensure that you are able to complete a full course of treatments and achieve the best results. Your initial patient visit must be paid in full at the time of treatment, however.

- We do not accept health insurance or file health insurance claims. However, we will do our best to provide you with the documentation required for you to submit claims to your insurance provider.

- We have a 24 hour cancellation policy. Appointments canceled within 24 hours of the appointment time will be assessed a $30 missed appointment fee. We strive to provide the highest level of service. Failure to cancel with sufficient notice denies an opportunity for another patient to be seen at the time reserved for you.

- Please arrive on time to get the full value out of your treatment. Your appointment time has been reserved for your treatment and I work hard to not keep patients waiting long. To respect the time of patients with appointments after yours, I will not allow your appointment to run late because you arrived late. Please be punctual so I can be punctual.

- We accept payment by cash, check, Visa, MasterCard, and Discover.

- Returned checks are subject to a $20 service charge.

Patient Full Name: _____

Patient Signature: _____ Date: ___

Notice of Privacy Practices and Patient Rights – Silver Current Acupuncture

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.

Understanding your health record information

Each time you visit Silver Current Acupuncture a record is made of your visit. Typically this record contains your health history, current symptoms, examination results, Oriental medical diagnosis and treatment plans. This information serves as:

- a basis for planning your care and treatment

- a legal document describing the care you have received, written in a format appropriate for acupuncture

- a tool to assess the appropriateness and quality of care you have received

Your rights under the Federal Privacy Standard

Although your health record is the physical property of Silver Current Acupuncture, you have certain rights with regard to the information contained therein. You have the right to:

- request restrictions on the use and disclosure of your health information for treatment, payment, and education. This right does not include those required by law, for example mandatory reporting of communicable diseases like tuberculosis.

- ask us to communicate with you by alternative means and, if the method is reasonable, we must grant the request.

- receive and keep a copy of this notice of information practices. If you do request a copy, the law requires us to ask you to acknowledge receipt of your copy.

- inspect and copy your health information upon request. We reserve the right to charge a reasonable, cost-based fee for making copies.

- request a correction of our health information unless we did not create the record or if the record is accurate and complete.

- obtain an accounting of non-routine uses or disclosures.

- revoke authorization to use or disclose your health information at any time.

We may use and disclose your health information for treatment or payment
Silver Current Acupuncture will use your personal health information to diagnose, plan and implement the best course of treatment for you. Silver Current Acupuncture may also use your health information to receive payment from a third party payer, for example Workers Compensation, if applicable and appropriate. If Christina Fish L.Ac. uses your personal health information for other purposes, you will be informed and asked your permission in writing. You may revoke your authorization for consent at any time. **Our responsibility under the Federal Privacy Standard**
In addition to providing you your rights, the federal privacy standard requires Silver Current Acupuncture to:

- maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

- provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.

- abide by the terms of this notice

- train our personnel concerning privacy and confidentiality

- lessen the harm of any breach of privacy or confidentiality.

How to get more information or to report a problem
If you have any questions, problems, complaints or need additional information, you may contact Christina Fish, L.Ac. at 919-730-7886 or Christina@silvercurrentacupuncture.com.

Silver Current Acupuncture Consent to Treatment and Privacy Practices Form

Treatment Consent

I, _____, voluntarily consent to be treated with acupuncture and adjunct therapies.

Acupuncture: I understand that the acupuncture will be performed by the insertion of sterile, disposable single-use needles through the skin at certain points on my body; and that such treatment is intended to improve the body's physiologic function or modify the perception of pain. I have been informed that although rare, side effects may result from my acupuncture treatment. These could include, but are not limited to: minor pain or discomfort, localized bruising, fainting, nausea, and the temporary aggravation of pre-existing conditions.

Moxibustion: I have been informed that moxibustion (heat therapy) may be used in my course of treatment. Indirect moxibustion is the moxibustion technique of choice at Silver Current Acupuncture. The intent is that the burning herb is brought near, but does not does touch the skin. However in the unlikely event of contact with the burning herb a small burn may result.

Acupressure / Tui-Na Massage: I understand that I may be given acupressure or Tui-Na massage (Chinese therapeutic massage) as part of my treatment to modify pain perceptions and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible temporary aggravation of pre-existing conditions.

Cupping / Gua Sha: I understand that I may be given cupping (the application of glass cups that apply a vacuum to the skin) and gua sha (rubbing of the skin with a smooth, hard tool) as part of my treatment to modify pain perceptions and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment including, but not limited to: bruising, sore muscles or aches, and the temporary aggravation of pre-existing conditions.

I understand that I may refuse any of the above treatment methods and may stop my treatment at any time and for any reason. I accept that No Guarantee is made concerning the results of my acupuncture treatment, and I have been informed that I may stop treatment at any time. I do not expect Silver Current Acupuncture to be able to explain all possible risks and complications of treatment. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment.

Release of Information
I consent to the use and disclosure of my protected health information for treatment, payment and/or office operations. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in advance of my prior consent. I also understand that I have the right to request in writing that additional restrictions be placed on the use and disclosure of my private health information.

Notice of Privacy Practices and Patient Rights
I acknowledge that I have received a copy of the Notice of Privacy practices and Patient Rights and have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

Signature of Patient (or guardian): _____Date:

Printed Name: _____

Date of Birth:_____