LIVE OAK
ACUPUNCTURE
& HERBAL MEDICINE

Patient Information

CONFIDENTIAL

305 Londonderry Drive, suite 3 ▪ Waco, Texas 76712 ▪ (254) 741-6030

Name _____ Date of birth ___/___/___

Street Address _____

City, State, Zip _____ E-mail address_____

Occupation _____ Marital status ____ Number of children _____

Home phone _____ Work phone _____ Cell phone _____

Emergency contact (name and phone) _____

How did you hear about us? _____

Referred by _____

Are you under the care of a physician at this time? *Yes* *No*

If yes, for what reason?_____

Physician (name and phone) _____

If you are currently taking any medications, nutritional supplements, or herbs, please list below or attach another sheet:

Medications (prescription & over the counter)	**Nutritional Supplements and/or Herbs**
_____	_____
_____	_____
_____	_____

Reason for today's visit? _____

Please describe your major symptoms:

_____

Describe what caused your primary complaint (if known) and how/when it started:

_____

Have you received treatment for this condition? _____

By whom? _____

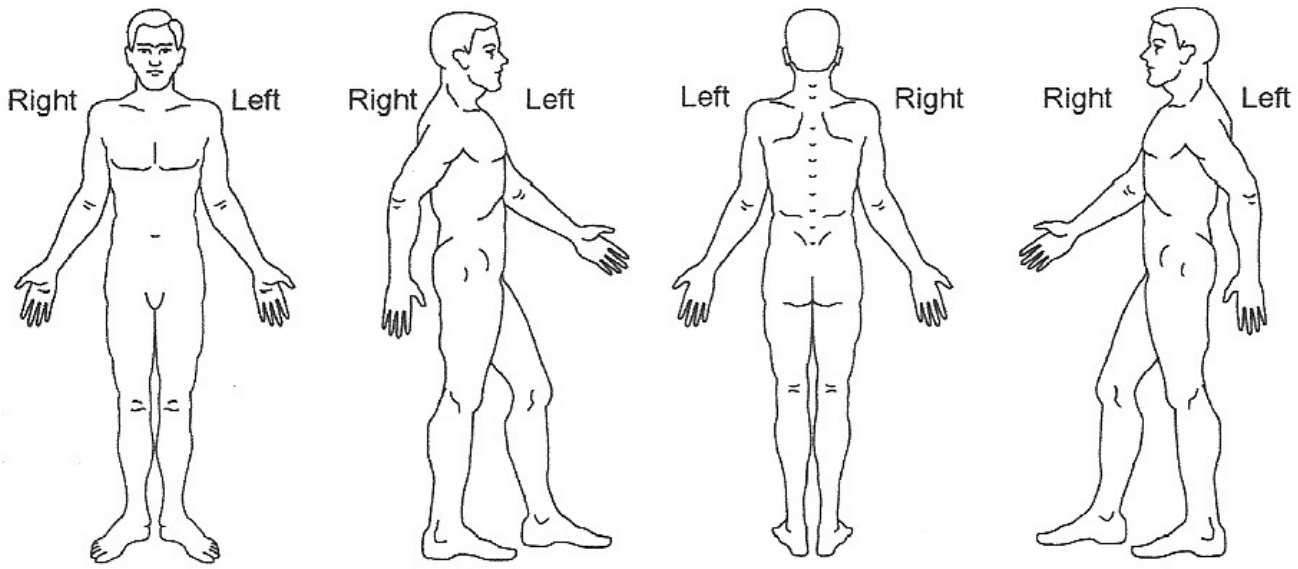
Diagnosis? _____

Results of treatment? _____

Pain Assessment

Name _____ **Date** _____/_____/_____

Please circle or shade the area(s) on the diagram where you feel pain <u>today</u>:



Next to each area marked above, please note the intensity of the pain using the following scale:

No pain	Minimal pain		Tolerable pain		Pain hinders some activities		Pain hinders most activities		Unbearable pain
0	1	2	3	4	5	6	7	8	9

Are you currently taking pain medication?

- ❑ Yes
- ❑ No

If yes, what medication(s) are you taking? _____

How often do you take pain medication(s)? _____

Does your pain disturb your sleep?

- ❑ Yes
- ❑ No

Has your condition changed since your last visit? If yes, how has it changed? _____

_____

_____

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Fee Schedule and Office Policies

The Westrock Center 1221 Hewitt Drive, suite C ▪ Waco, Texas 76712 ▪ (254) 741-6030

In the State of Texas, licensed acupuncturists are not considered primary health care providers. As a result, Live Oak Acupuncture & Herbal Medicine, PLLC (Kristen Horner Warren, L.Ac.) is 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 the statements below is "no".

Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to the Scope of Practice) and and Tex. Occ. Code Ann. §205.35 (governing the practice of acupuncture):

I _____ (patient name) am notifying Kristen Horner Warren, L.Ac. of the following:

Yes / No (please circle) I have been evaluated by a physician or dentist for the condition being treated within the past 12 months. If not, I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

Yes / No (please circle) 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

Yes / No (please circle) 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 am seeking treatment for symptoms related to one or more of the following conditions:

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

_____ _____

Patient or Guardian signature Date

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Fee Schedule and Office Policies

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Fee Schedule, effective January 1, 2014

Payments are due at the time of service.

Discounted rates for patients paying with **check or cash**:

Discounted Initial Consultation & Treatment	$95.00
Discounted Follow-up Treatment	$70.00

Rates for patients paying with **credit card, debit card, or HSA card**:

Initial Consultation & Treatment	$100.00
Follow-up Treatment	$75.00

For a comprehensive fee schedule, including other services such as cupping, consultation appointments, stop smoking packages, etc., please visit my website at http://www.liveoakacupuncture.com/cost. Fees are subject to change without notice.

Office Policies

I believe that your time is valuable and I make every effort to maintain an on-time schedule. Rarely will you have to wait in my reception room for more than a few minutes, all aspects of your care will be handled by me, and you will never be rushed through your appointment. In order to help me maintain this type of practice, please be aware of the following policies:

- Prior to your initial appointment, you were e-mailed several forms to fill out and sign. Please complete these forms prior to your Initial Consultation. If you are unable to complete the forms prior to your visit, you should arrive 30 minutes early to complete the forms in the office.
- Please notify me if you are unable to keep an appointment. Because I do not double book, your appointment time cannot be used by anyone else if you cancel on short notice or do not show up. **Cancellations with less than 24 hours notice given or no-shows will be subject to a $75.00 Missed Appointment Fee**. Valid emergencies are, of course, an exception to this policy.
- Patients who habitually arrive late, fail to show up, or cancel on short notice will be dismissed from the practice. If you are more than 15 minutes late for your appointment, you will have to reschedule.
- I do not participate in any insurance billing and full payment is due on the day of your visit. Monthly superbills are available upon request. You are responsible for all aspects of filing your own insurance claims and your responsibility for payment to this office is not contingent upon reimbursement from your insurance company. You are responsible for verifying that your insurance policy allows you to file your own claims with a superbill. I do not provide W-9s to insurance companies, nor do I make phone calls to insurance companies or provide documentation beyond superbills. Fees will not be negotiated or reduced, even if your insurance company's allowable amount for acupuncture services is less than you have paid. If you have questions about these policies, please ask.
- Returned checks are subject to a $25.00 fee.
- Please note that children must remain under the direct supervision of a parent or guardian at all times.

_____ _____

Patient or Guardian signature Date

Informed Consent for Cupping

Cupping is a wonderfully effective traditional therapy that has been used in various Asian, European, and Native American cultures for thousands of years. It involves the application of strong suction to the skin and underlying tissues and is often used to treat musculoskeletal pain, acute injuries, and respiratory conditions. When cupping is applied early in the course of treatment, progress will be faster and fewer treatments will be required.

Before you consent to this therapy, please be aware of the following:

- Cupping may leave dark circular marks on the area(s) that are treated. These marks, look similar to bruises and may be red, blue, or black and may take up to four weeks to completely disappear. If you plan to wear clothing in the next couple of weeks that will expose the treated areas, please let me know.
- It is important to avoid catching a chill or exposing yourself to wind or extreme heat in the 24 hours after cupping. Please plan on taking it easy for the remainder of the day after your cupping session. Please do not apply ice, heat, or analgesic balms or lotions for 24 hours after your treatment.
- Please be sure to keep yourself thoroughly hydrated following the cupping treatment. Cupping releases metabolic toxins that have accumulated in painful tissues, which may make you feel fatigued or mildly unwell for a day or so. Some people may experience headaches, particularly if cupping is applied to the upper back or neck. Drinking plenty of water will help to minimize this side effect.
- The day after cupping you may find that the treated area(s) feel sore or puffy, somewhat like a sunburn. If this side effect is severe or very bothersome, you can take ibuprofen (Advil or Motrin) or T-Relief (cream and/or tablets) when you get home from your treatment and the day afterward.

By voluntarily signing below, I show that I have read or have had read to me the above consent to treatment and have been told about the risks and benefits of cupping therapy and have had an opportunity to ask questions. 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.

Patient Signature _____ Date _____

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Notice of Privacy Practices

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Kristen Horner Warren, L.Ac., M.S., M.A., Dipl.OM.

Legal Responsibilities of Kristen Horner Warren: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints. If you have a complaint, please contact the regional office indicated below:

U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (214)767-4056
FAX (214)767-0432
TDD (214)767-8940

I have read and understood the HIPAA privacy policies of Live Oak Acupuncture & Herbal Medicine, PLLC and Kristen Horner Warren, L.Ac., M.S., M.A., Dipl.OM.

_____
Signature

_____ _____ _____
Printed name Date Relationship to patient (if applicable)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 understand that the herbs may need to be prepared and the teas 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 clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 uses sterile disposable needles and maintains a clean and safe environment.

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 will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient 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, the above 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)