Consent to Treatment

I, (please print)_____, do hereby consent to treatments at Jade Mountain Wellness, involving acupuncture and/or herbal medicine. The general purpose of Chinese Medicine is to balance and strengthen the Qi (energy) to address symptoms and their deeper causes, as well as promote well-being. Although rare, adverse reactions to treatment can occur and include, for acupuncture, a short-term exacerbation of existing and past symptoms (usually 12-48 hours), localized swelling, minor bleeding, bruising, discomfort, and dizziness and fainting. With herbs, there can be looseness of stools, upset stomach and other digestive issues that usually subside quickly (within 6-24 hours) once the formula is discontinued.

I am aware I can stop treatments at any time and that all personal and medical information will be held confidential as per patient privacy requirements.

Patient Signature: _____

Date: _____

Guardian Signature (for patients under the age of 18):

_____

Date:_____

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Jade Mountain Wellness, inc.

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Contact information: By providing the below information, you are consenting to allow us to contact you via phone, mail and email about relevant treatment information. If you prefer that we not contact you via these methods, please leave blank.

Name:_____

Address:_____

_____

Phone Numbers:

home: _____

work: _____

cell: _____

Emergency contact:

name: _____

phone: _____

*relationship:*_____

Patient Email:_____

Can we send you information about classes and a newsletter via email? (We don't share email addresses.) Yes No

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A FAMILY PRACTICE

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes"

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

jade mountain wellness
A FAMILY PRACTICE

Financial Policies & Service Fees

Insurance Policy
Providers at Jade Mountain Wellness are in-network with Blue Cross & Blue Shield of Vermont, United, Empire United, MVP, the VA and most other companies that cover acupuncture in Vermont (with the exception of Cigna) and therefore accept their plans that include acupuncture benefits. We do not commonly bill other insurance plans including Medicare and Medicaid because, even though acupuncture coverage has been included in these programs, acupuncturists are not yet covered providers. If you have another insurance plan or if your referral needs are unique, please inquire with us as to whether we can accept your policy or facilitate in your reimbursement.

Payment Policy
Even if your insurance covers acupuncture, plans may not cover the services in full or benefits may have been exceeded. Ultimately, you are responsible for payment of your charges in full. Until your insurance benefits are verified by our office, you will be expected to pay for your care at the time of service. At each visit thereafter, you are expected to pay for the estimated charges not covered by your insurance this includes co-pays, co-insurance and any deductible charges. We will notify you of any amounts your insurance fails to pay and you will be expected to pay the balance.

Jade Mountain Wellness accepts cash, personal checks and credit cards (Visa, Mastercard and Discover). Please note that any returned checks are subject to a $25 service charge. Also, any insurance checks you might receive are to be paid to our office within 15 days of receipt.

Acupuncture and herbs are qualified expenses for most Flexible Savings Accounts (FSA's), Health Savings Accounts (HSAs), and Health Reimbursement Accounts (HRAs). Please ask for a receipt at each visit.

Cancellation Policy
Because each appointment is scheduled for a single patient, we require 48-hour notice if you need to cancel or reschedule. In the case of personal emergency, sickness or extreme weather, cancellation as soon as possible is acceptable. If 48-hour notice is not given, full payment for the unbillable service is expected for the missed appointment.

Treatment & Herbal Fees
The fees below are for payment at time of services. If your insurance policy covers acupuncture, your cost will be your copay, co-insurance or deductible for the treatment.

- *Initial Acupuncture Treatment* – $185 for about 90 minutes. This first appointment includes a thorough discussion of health concerns and history, a Chinese medical diagnosis including pulse and tongues evaluation, and an acupuncture treatment.
- *Each Subsequent Acupuncture Treatment* – $125 for about 60-75 minutes.
- *Herbal Medicine (with treatment)* – There is no additional cost for the time to formulate herbal prescriptions with acupuncture appointments.
- *Initial Herbal Consultation (without acupuncture)* – $135 for about 60 minutes.
- *Subsequent Herbal Follow-up (without acupuncture)* – $70 for about 30 minutes
- *Customized Herbal Formulas* – Usually $25-35 weekly (roughly $3.50-5.00 per day)

Jade Mountain Wellness reserves the right to change the terms of its financial policies and fees schedule and to make new provisions if necessary. By signing below, you authorize the release of any medical or other information necessary to process insurance claims, authorize the payment of benefits to the undersigned practitioner for the services described above, and acknowledge that any fees not billable or uncovered by the insurer will be the patient's responsibility.

I have read and understand the policies and fee schedule listed above.

Signature: _____ Date: _____

Relationship to patient (if signed by a patient's representative) _____

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Health History Questionnaire

Thank you for taking the time to fill out this questionnaire carefully. If you are printing this from the website, please bring this with you on your first visit. All information you provide will be held confidential. (There is extra space within parts of this questionnaire so the practitioners may add notes.)

Name
Date of Birth and Age
Others in your Home
Relationship Status
Children (names and ages)
Occupation and do you enjoy it

Main Concerns (When did this begin? To what extent does it interfere with your daily activities? Have you been given a diagnosis?)

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MEDICAL CONDITIONS (circle) and dates of onset.

Cancer	Heart disease	Seizures
Diabetes	Rheumatic fever	High/Low Blood Pressure

Infectious diseases (suspected or diagnosed HIV,TB, Hepatitis)

Other

SURGERIES (please include dates)

SIGNIFICANT TRAUMA (auto accidents, falls, etc. with dates)

ALLERGIES

MEDICINES (taken within last year: vitamins, drugs, herbs)

OCCUPATIONAL/ENVIRONMENTAL STRESS (chemical, physical, psychological, etc.)

EXERCISE

Describe an average daily intake of food

Breakfast	Lunch	Dinner

Do you snack between meals if hungry?
How many 12 oz. glasses of water do you drink a day?
How much coffee, tea, soda, or carbonated beverages do you drink per week?

How much alcohol do you drink per week?
How many packs of cigarettes do you smoke per day?
Please describe any recreational drugs?

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General (circle)

poor appetite
fevers
tremors/twitching
localized weakness
bruising or bleeding
poor sleeping
chills
cravings
poor balance
weight gain or loss
fatigue
night sweats
sweat easily
change in appetite
strong thirst
Other

Cardiovascular (circle)

high blood pressure
irregular heartbeat
difficulty breathing
palpitations
low blood pressure
fainting
blood clots
chest pain
cold hands or feet
swelling of hands or feet
Other

Skin and Hair (circle)

rashes
itching
dandruff
ulcerations
eczema
loss of hair
hives
pimples
moles
Other

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HEAD, EYES, EARS, NOSE, AND THROAT (CIRCLE)

dizziness
migraines
eye strain or pain
poor vision (glasses?)
night blindness
cataracts
earaches
ringing in ears
poor hearing
nose bleeds
sinus problems
jaw clicks/grinding/clenching
recurrent sore throats
teeth problems
sores on lip or tongue
headaches (where and when?)
Other

RESPIRATORY (CIRCLE)

cough
coughing blood
asthma
bronchitis
pneumonia
pain with deep breath
short of breath
Other

GASTROINTESTINAL (CIRCLE)

nausea
vomiting
indigestion
constipation
diarrhea
gas
belching
black stools
blood in stools
rectal pain
hemorrhoids
cramps
bad breath
laxative use
frequency of bowel movements
Other

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GENITO-URINARY (CIRCLE)

pain on urination	frequent urination	blood in urine
urgency to urinate	unable to hold urine	kidney stones
decrease in flow	impotency	sores on genitals
prostate concerns		

Do you wake at night to urinate? (how often)

Other

REPRODUCTIVE AND GYNECOLOGICAL

(Please provide the number, the date, or circle any that apply to you)

pregnancies____	births____	premature births____
miscarriages____	abortions____	age at first menses____
days between menses____	cramps or pain	last menses (date)_____
very heavy or light menses	clots	duration menses (#days)___
PMS	vaginal discharge	vaginal sores
infertility	breast lumps	hot flashes
age at menopause____	pharmaceutical contraceptives? _____ (what type and how long)	

REPRODUCTIVE AND GYNECOLOGICAL OTHER

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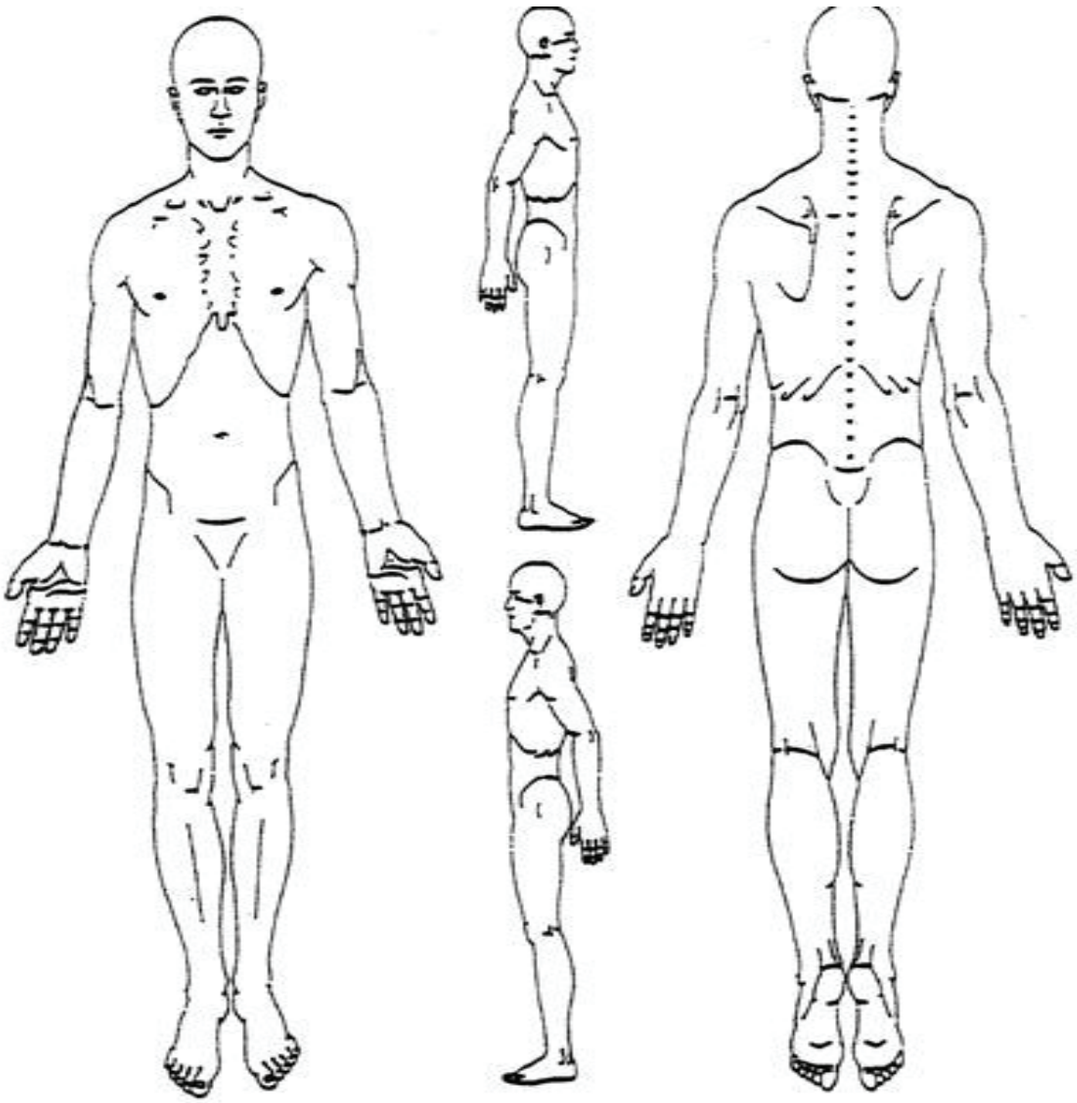
MUSCULOSKELETAL

Please mark where you experience pain in your body. Use the following **letters (you can use more then one) on the body parts** to let us know the type of pain you experience in each area of your body.

Stabbing Pain – S **Dull Ache – D** **Burning – B**
Radiating – R **Constant – C** **Intermittent - I**
Numbness-N
Circle what makes the pain feel better: Hot Cold Movement Rest Pressure



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NEUROLOGICAL/EMOTIONAL (CIRCLE)

seizures	loss of balance	areas of numbness
lack of coordination	poor memory	concussion
depression	anxiety	temper/frustration
easily susceptible to stress	emotional problems	suicidal thoughts
worry	racing thoughts	fears
sadness	grief	excess anger

Other

PLEASE FEEL FREE TO MENTION ANY OTHER CONCERNS OR COMMENTS (PLEASE USE THE BACK OF THIS PAGE IF NEEDED)

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TREATMENT SUGGESTIONS:

In order to maximize the effectiveness of your treatments, we suggest:

With acupucuture

• *Before and after treatments*:

• Eat only lightly 60-90 minutes beforehand. However, it is better to eat something close to the time of treatment than to come in very hungry. Eating too much before a treament will direct your Qi (energy) to your digestive system, possibly limiting the effectiveness of the session.

• Make every effort to not consume alcohol or non-prescription drugs for 24 hours before and after treatment. The body will be working to clear these substances, thereby potentially limiting the ability for healing.

• Avoid extremes in termperature, such as very hot or cold baths or saunas and hot tubs. Avoid vigorous physical and mental exertion. Ideally, the day of the treatment, both before and particularly after the session, will be relatively relaxed.

• *During treaments:*

• Most people experience various sensations during sessions, ranging form dull aches to tingling, feelings of lightness and heavienss, and cold and warmth. These are quite normal and part of the process. Many people also feel the flow of Qi (energy) in different parts of the body. Being as relaxed as possible with these sensations will facilitate the process.

With herbal medicine:

• Follow the directions on the sheet given with each herbal formula.

If you have any questions about acupuncture or herbal medicine, please don't hesitate to speak with us.

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