**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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**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

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.

Acupuncture and herbs are qualified expenses for most Flexible Savings Accounts (FSAs), 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.

- *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 tongue 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.

**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

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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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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.

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**Radiating – R** **Constant – C** **Intermittent - I**
**Numbness-N**
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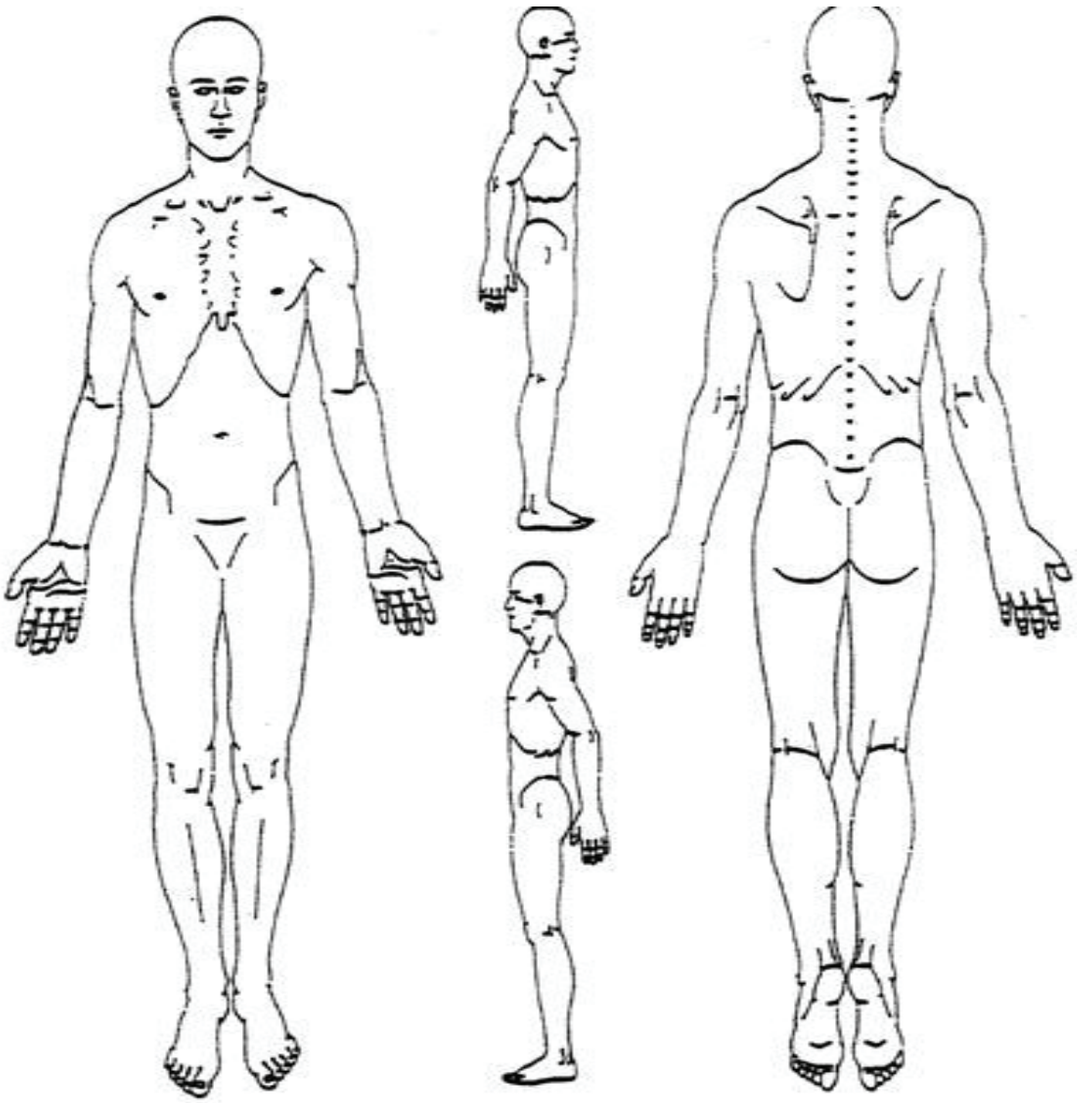

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**NEUROLOGICAL/EMOTIONAL (CIRCLE)**

| | | |
|---|---|---|
| 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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hemorrhoids
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bad breath
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frequency of bowel movements
**Other**

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| decrease in flow | impotency | sores on genitals |
| prostate concerns | | |

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

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| 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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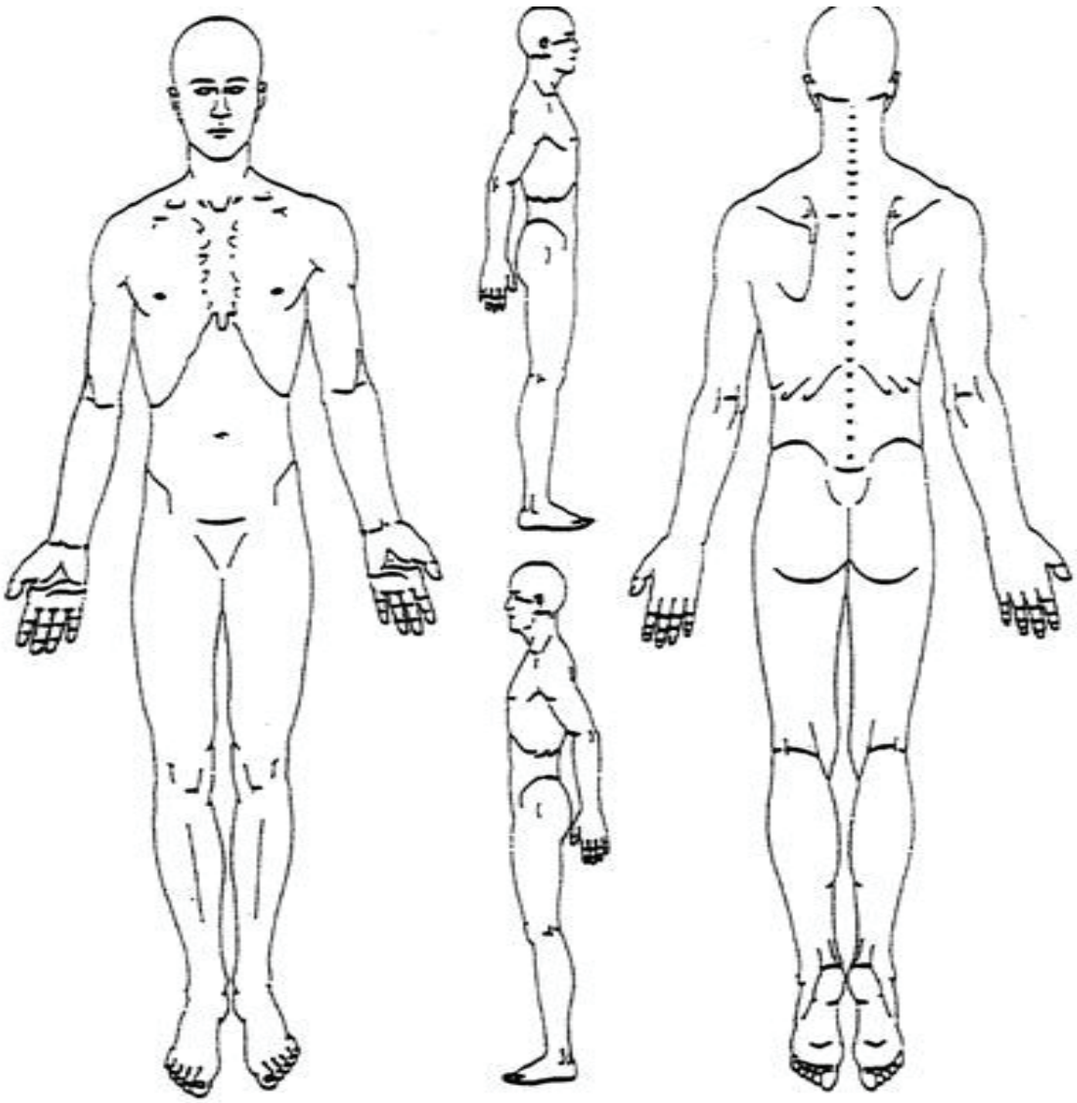

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| lack of coordination | poor memory | concussion |
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