# LIVING ALIGNED CLINIC FORM FOR NEW PATIENTS

Welcome to our practice!

# PATIENT INFORMATION

Full Name ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Gender Identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Full Time\_\_\_\_ Part Time\_\_\_\_ Retired\_\_\_\_ Unemployed \_\_\_\_ Student \_\_\_\_ Other \_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name, Phone #, Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Primary Health Care Physician’s Name, Contact, Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of any other practitioner(s)?

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently being treated for a medical condition(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, date of last visit and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the date of injury or onset of illness or condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan for future tests, follow up or treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## REFLECTION QUESTIONS

What brings you in for acupuncture, herbal medicine, massage or medical qigong treatment? (Please describe)

What other treatments or modalities have you tried for this health condition(s) and what were the outcomes?

Please list 3 or more goals you may have for your health and personal wellness.

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### SPECIFIC HEALTH QUESTIONS

Please list any other secondary health conditions you may experience – chronic pain, mental health, physical or mind-body health issues, etc.

Please list any significant personal health history (medical conditions, mental health events, hospitalizations, accidents, etc.)

Please list any pertinent family or genetic medical conditions or health history.

Do you have a pacemaker? Y / N Any recent or planned upcoming surgeries?

If applicable, are you currently pregnant Y / N Do you plan or intend to get pregnant in the future?

Current Medications (please list) Current Supplements/Vitamins (please list) Other

How would you describe your current lifestyle, diet, and exercise level?

Lifestyle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Level

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your first time getting acupuncture, massage or medical qigong therapy, which have you had and when was your last treatment?

How did you hear of Suzannah M. Stason, L.Ac. (Referral, Web Search, Classes, Other)?

Do you have any questions or concerns?

**INFORMED CONSENT TO TREAT**

I consent to acupuncture, herbal, massage or medical qigong therapy treatments and other procedures associated with Traditional Chinese Medicine by Suzannah M. Stason, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, guasha, massage, medical qigong therapy, Chinese herbal medicine, and nutritional & lifestyle counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Dark marks (like bruising) that last for weeks 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 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. Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy. I will notify Suzannah M. Stason, L.Ac. if I am, could possibly be or become pregnant.

I understand that massage and medical qigong therapy intended for the purpose of stress management, relief of muscle tension, and promoting wellness in the body. I understand that any sexual overtures will be sufficient grounds to end the massage and that payment for the session will be collected in full. Since a massage only session does not include diagnosis and a full health evaluation or treatment for disease, I understand that it is my responsibility to state any pertinent health or existing physical conditions and will keep Suzannah M. Stason, L.Ac. up to date prior to any session.

I do not expect Suzannah M. Stason, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinic medical staff to exercise judgment during the course of treatment which the clinic medical staff thinks at the lime, based upon the facts then known, is in my best interests.

I understand that 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 modalities, 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.

**Financial Agreement:** I acknowledge that I am responsible for the payment of services at time of appointment. I acknowledge that if I do not give 48 hour of notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Consent is to be completed by patient or by patient’s representative if the patient is a minor or is physically or legally unable to do so.

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Print Name of Patient Signature of Patient (or Representative) Date Signed

Representative Name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO USE AND PUBLICATION OF CLINICAL DATA AND CONTENTS OF PATIENT RECORDS FOR STATISTICAL PURPOSES, RESEARCH AND PUBLICATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print patient's name) authorize Suzannah M. Stason to review my records for the purpose of collecting statistical data or pertinent clinical information for the purposes of research, publication, education and case review. I give my permission and consent to the publication of statistical and/or clinical data obtained from by records. I understand that all patient records are protected by clinic protocols and confidentiality agreements. I also understand that I will never be identified as the source of this information and that if any particulars of my case are used for the purposes of publication all possible clues to my identity will be disguised or altered. I understand that there is the remote possibility of being accidentally identified as the source of the clinical data but that the way this information is handled makes the risk very small.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Signed

**NOTICE OF PRIVACY PRACTICES**

Our Pledge Regarding Medical Information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information

We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

For treatment; For payment; For healthcare operations (including for insurance reimbursement); When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls or mail.

Patient Rights

Upon written request, you have the right to access, review or receive copies of your health care records. There is a copy fee of $15 and with 10 working days to process it. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information. You have the right to request that this office place additional restrictions on disclosure of your protected health information. You have the right to request that we amend your protected health information; the request must be in writing. You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact Suzannah M. Stason, L.Ac.

Send written complaints to the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services in this office. This practice has attempted to provide each patient with a statement of Privacy Practices.

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Patient Signature Date Signed