MANDATORY DISCLOSURE STATEMENT

FEE SCHEDULE	Initial Exam, Consultation, and Treatment	$150
	Follow-up Treatments	$105

EDUCATION, DEGREES, EXPERIENCE, PROFESSIONAL MEMBERSHIPS, & CERTIFICATES

- **Northern Michigan University**, Marquette, MI - **Bachelor of Science in Nursing** - April 1995
- Certified in **Clean Needle Technique** - Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) - Jan 1999
- International Institute of Chinese Medicine, Santa Fe, NM - **Master of Oriental Medicine** - May 1999
- 4 year study including study tour to China (Chengdu University of Traditional Chinese Medicine)
- Total curriculum of 2400 hours and includes more than 900 practice hours spent in observation, hands-on experience, and actual treatments
- Certified **Diplomat in Acupuncture and Chinese Medicine (Herbology)** by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) - January 2000
- Board Certified **Doctor of Oriental Medicine (DOM)** by the State of New Mexico - February 2000
- Licensed and Insured to practice in the State of Colorado - **LAc** – 1999 to present

STATEMENT OF TRAINING AND EXPERIENCE IN ADJUNCTIVE TRADITIONAL ORIENTAL THERAPIES

This practitioner's training and experience in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts was encompassed in the Masters of Oriental Medicine degree. Such training and clinical experience included acupuncture, moxibustion, electrical stimulation, cupping, auriculotherapy, herbology, nutritional, diet, and supplementation therapy.

STATEMENT OF PRACTITIONER COMPLYING WITH PROPER RULES AND REGULATIONS

This practitioner is aware of and complies with the rules and regulations promulgated by the Department of Health with respect to proper cleaning and sterilization of needles - single use disposable needles are used in this practice of acupuncture and the sanitation of acupuncture offices.

This practice of Acupuncture and Oriental Medicine is regulated by the Colorado Department of Regulatory Agencies. Should you have any comments, complaints, or questions, you may contact them at the following address:

1550 Broadway, Suite 1545
Denver, Colorado 80202
(303) 894-2464

STATEMENT OF PATIENT RIGHTS

As a patient, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

As a patient, you are entitled to seek a second opinion from another health care professional and may terminate therapy at any time.

This is a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

CANCELLATION POLICY

An appointment has been reserved for you and someone else may have been denied the opportunity for service because of our agreed commitment. ***Thus, there will be a charge for missed appointments without a 24 hour notice.*** Keeping scheduled appointments helps me give you the quality of care and results that Traditional Chinese Medicine is known for.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

_____ _____

Patient or Guardian's Signature Date

NOTICE OF PRIVACY POLICIES

HIPAA, the Health Insurance Portability and Accountability Act of 1196, established rights and protections for healthcare consumers and created responsibilities for healthcare providers.
The HIPAA Privacy Rule of April 14, 2001, requires compliance in the year 2003 for healthcare providers to implement administrative, technical, and physical safeguards to ensure the security of your individually identifiable health information that we collect to conduct our business.

Information We Collect to Conduct Our Business:

On your initial visit, we ask you to sign an Acupuncture Consent Form and complete a written Acupuncture Intake/Health History Form concerning your health history and other relevant personal data. We ask that you read this notice, and sign the Patient Acknowledgment of Privacy Policies.
Each time your visit our clinic for your acupuncture treatment, a written record of your session is made on our Acupuncture Progress Notes. This contains results of your verbal and physical assessment, Acupuncture Diagnosis, Acupuncture Treatment (including acupuncture points or adjunctive tools used), and Recommendations or Referrals.
The above forms are placed in your own individual and completely confidential file, maintained in a locked cabinet in a secure room with access by Lakewood Acupuncture and Oriental Medicine staff only. If records are transferred to a computer, the computer will be secure and will be password protected. Computer records will be backed up on a continuous basis as required.
Other data that may be requested throughout your course of treatment such as laboratory or medical test results may also be kept in your file (or scanned to the computer).
We collect full payment for each acupuncture treatment upon each visit and will be given a paid invoice for our services. Any billing information sent by mail will be to the address listed on your intake form and sent to your attention. Any billing information sent to you via electronic mail will be sent to the e-mail address listed on your intake form.

Information Shared Outside our Clinic: It's YOUR Choice:

We do not share information outside our clinic without your written authorization.
We do request the right to call you at the phone numbers you have given us or through the e-mail addresses you have given us for the sole purpose of making appointments, notifying you of changes in clinic hours or cancellations due to inclement weather; or to inquire about your health status between treatments. We request the right to leave messages at these numbers. If you do not want us to provide these services, please indicate such in writing on the Authorization for Release of Health Information.
We do not share your health information with any family member without your express written consent on the Authorization for Release of Health Information. We do request the right to call a family member, at the number your have provided us with for emergencies, should one occur while you are in our care.
HIPPA explicitly allows disclosure of patient health information without consent for the following situations: emergency circumstances, identification of the body of a deceased person or the cause of death; public health needs; research; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

I HAVE READ AND UNDERSTOOD THE NOTICE OF PRIVACY POLICIES OF LAKEWOOD ACUPUNCTURE AND ORIENTAL MEDICINE.

_____ _____
Patient or Representative (relationship to patient) Date

_____ _____
Lakewood Acupuncture and Oriental Medicine Date

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Oriental medicine as administered by licensed acupuncturists at Lakewood Acupuncture and Oriental Medicine, LLC (LAOM). I have discussed the nature and purpose of my treatments with the acupuncturist and I insert my initials here_____.

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations), and adjunctive therapies (Tui Na, Shiatsu, breathing techniques and exercises, oriental dietary therapy, lifestyle and behavior, laser stimulation, cupping, thermal, magnets, gua sha and herbology).

I understand that acupuncture is a generally safe method of treatment with few but some potential risks including but not limited to: Slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic symptoms existing prior to acupuncture treatment. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage (I will notify the acupuncturist if I am, become or am trying to get pregnant), nerve damage and organ puncture, including lung puncture (pneumothorax). 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 and I insert my initials here_____.

I understand that herbs need to be applied, consumed and/or prepared according to oral or written instructions. I understand that herbs may have an unpleasant aroma or taste. I understand that if my condition were to change (that I suddenly catch a cold or have a fever) to something that was different from the issue for which I was prescribed the formulation, that I should stop taking the preparation and contact LAOM to schedule another appointment. I will immediately notify a LAOM of any unanticipated or unpleasant effects associated with the consumption of herbs and I insert my initials here_____.

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

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 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.

_____ _____

Printed Name Patient Signature

NEW PATIENT FORM

Date:	First Name:	Last Name:	
Date of Birth:	Age:	Occupation:	
Home Phone:	Work or Cell#:	Email:	
Street Address	City:	State:	Zip:
Emergency Contact (Name and phone)		Referred by:	

Reason for visit today:_____

Medical Diagnosis: _____

Describe Any Problems During Your Birth _____

Childhood Illnesses/Surgeries/Accidents: _____

Age:_____

Age:_____

Adolescent Illnesses/Surgeries/Accidents:

Age:_____

Age:_____

Adult Illnesses/Surgeries/Accidents:

Age:_____

Age:_____

Age:_____

Age:_____

Immediate Family History - Please note all major illnesses (diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.) for your immediate family (grandparents, parents, siblings, children, please include significant other):

_____

_____

Medications - Please note all medications, herbs, vitamins/minerals/supplements you take, even if only occasionally:

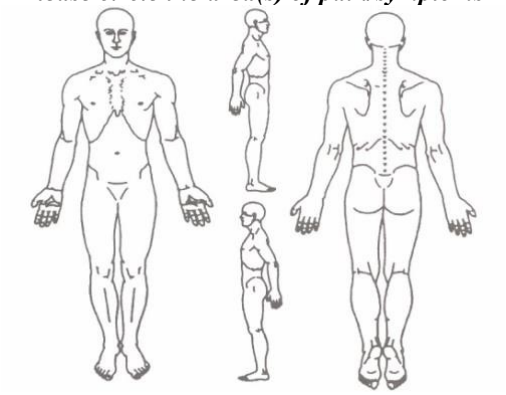
_____

Recreational Drugs - Cigarettes, Alcohol, Marijuana, Caffeine, Other (please include frequency of use and if used in the past):

_____

Note the location of any scars, even minor, from operations/injury:

Please circle the area(s) of pain/symptoms



How long have you had this condition?:

_____

Is it getting worse? ❍Yes ❍No

Does it bother your: ❍Sleep ❍Work ❍Other:

_____

Please circle the number indicating level of discomfort

Not Severe 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

What seemed to be the initial cause?: _____

What makes it better?: _____

What makes it worse?: _____

If there is pain, is it: ❍dull/achy ❍ sharp/stabbing ❍ burning ❍ tingling ❍ numb ❍ electrical ❍ other: _____

Are you under the care of a physician now?: ❍Yes ❍No

If yes, for what reason? : _____

Who is your physician?: _____

Physician phone#: _____

Have you had acupuncture before?: ❍Yes ❍No Chinese Herbal Medicine?: ❍Yes ❍No

Are there other therapies that you are currently undergoing?_____

WOMEN ONLY:

When was your last period? _____

How long does your cycle last? _____

Number of days for monthly cycle? _____

Describe menstrual flow: ❍ Heavy ❍ Moderate ❍ Light ❍ None

Color of menstrual flow: ❍ Dark ❍ Bright Red ❍ Slightly Reddish

Birth Control: ❍None ❍ IUD ❍ Pill ❍ Spermicidal ❍ Barriers

Do you suffer from:

❍ Cramping: ❍ Severe ❍ Mild ❍ During Period ❍ Moderate

❍ Before Period ❍ After Period

❍ Clotting ❍ Bleeding between periods

❍ Pelvic Inflammatory Disease ❍ Endometriosis

❍ Mastitis ❍ PMS

❍ Yeast or other Vaginal Infections: _____

❍ Infertility Cysts: ❍ Breast ❍ Ovarian

MEN ONLY:

❍ Do you suffer from:

❍ Impotence

❍ Weak Erection

❍ Discharge from Penis

❍ Testicular Pain or Lump

❍ Premature Ejaculation

❍ Prostate Problems: PSA: _____

❍ Infertility

❍ Low Sex Drive

Please check if symptom is in past or present and rate the symptom 1-10

Symptoms	Present	Past		Present	Past
Heart & Vascular:			***Gastrointestinal:***		
Rapid Pulse >100 bpm			Constipation		
Slow Pulse <60 bpm			Diarrhea		
Palpitations			Low appetite		
Irregular Pulse			Stomach pain		
Pressure in chest			Heartburn		
Shortness of breath			Gas		
Chest Pain			Belching		
Dizziness			Ulcer		
Migraines			Gastritis		
Cold hands/feet			Low Stomach Acid		
Raynaud's			***Respiratory:***		
Flushing			Asthma		
Anemia			Bronchitis		
High Blood Pressure			Emphysema		
Low Blood Pressure			Cough		
Cold sweats			Wheeze		
Red face			Pneumonia		
Dizzy/Faint on standing			Lung Abscess		
			COPD		
Skin:					
Eczema			***Hormonal Imbalance:***		
Acne			Hypothyroid		
Skin rashes			Hyperthyroid		
Dermatitis			Diabetes I		
Furuncles			Diabetes II		
Infections			Blood Sugar		
Warts			Other		
Psoriasis					
Effects of Focal Infect:			***Connective Tissue or Ligament Diseases:***		
Rheumatic disease			Myofacial pain syndrome		
Rheumatic fever			Fibromyalgia		
Arthritis			Tendonitis		
Skin disease					

Symptoms	Present	Past		Present	Past
Pericarditis					
Scarlet fever					
Glomerulonephritis					
Ear infections					
Staphylococci infections					
Easily catch cold					
Swollen glands					
Ear Nose & Throat:			***Oral Disease:***		
Deafness			Bleeding gums		
Tinnitus			Periodontitis		
Itchy ear			Dental abscess		
Ear pain			Mumps		
Frequent ear infections			Stomatitis		
Sinus head aches			TMJ		
Yellow mucus			Toothaches w/out cavities		
Stuffy nose			***Before Noon:***		
Post nasal drip			Low energy		
Dry throat			“Spacey” feeling		
Itchy throat			Scattered		
Sinus congestion			High Energy P.M./hate to wake		
Streptococci infections			Long shower leads to dizziness		
Sore throat					
Female Issues:			***Male Issues:***		
Menstrual problems			Impotence		
Cramping			Premature ejaculation		
Heavy period			Prostate problems		
Light period			Vasectomy		
Irregular period			Infertility		
PMS					
Menopause symptoms					
Tubal ligation					
Infertility					
Low Libido					
Other					
Insomnia					

Symptoms	Present	Past		Present	Past
Psychosomatic weakness			***Dental Procedures***		
Exhaustion			Please list:		
Anger easily			Wisdom Teeth ___		
Irritable			Crowns ___		
Depressed			Root Canals ___		
Anxious			Pulled Teeth ___		
Difficulty concentrating			Implants ___		
Motion sickness					
No appetite for breakfast					
Moodiness in morning					
Unusual sweating					
Lack of sweating					
Other:					