**Lakewood Acupuncture and Oriental Medicine M. Jennifer Lara Wright, LAc, DOM**

# 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** | **Rate 1-10 Date:** | **Rate 1-10 Date:** | **Rate 1-10 Date:** | **Rate 1-10 Date:** |
| ***Heart & Vascular:*** |  |  |  | | | |
| Rapid Pulse >100 bpm |  |  |  |  |  |  |
| Slow Pulse <60 bpm |  |  |  |  |  |  |
| Palpitations |  |  |  |  |  |  |
| Irregular Pulse |  |  |  |  |  |  |
| Pressure in chest |  |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |  |
| Chest Pain |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |
| Cold hands/feet |  |  |  |  |  |  |
| Raynaud’s |  |  |  |  |  |  |
| Flushing |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Low Blood Pressure |  |  |  |  |  |  |
| Cold sweats |  |  |  |  |  |  |
| Red face |  |  |  |  |  |  |
| Dizzy/Faint on standing |  |  |  |  |  |  |
| ***Skin:*** |  |  |  | | | |
| Eczema |  |  |  |  |  |  |
| Acne |  |  |  |  |  |  |
| Skin rashes |  |  |  |  |  |  |
| Dermatitis |  |  |  |  |  |  |
| Furuncles |  |  |  |  |  |  |
| Infections |  |  |  |  |  |  |
| Warts |  |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |  |
| ***Gastrointestinal:*** |  |  |  | | | |
| Constipation |  |  |  |  |  |  |
| Diarrhea |  |  |  |  |  |  |
| Low appetite |  |  |  |  |  |  |
| Stomach pain |  |  |  |  |  |  |
| Heartburn |  |  |  |  |  |  |
| Gas |  |  |  |  |  |  |
| Belching |  |  |  |  |  |  |
| Ulcer |  |  |  |  |  |  |
| Gastritis |  |  |  |  |  |  |
| Low Stomach Acid |  |  |  |  |  |  |
| ***Respiratory:*** |  |  |  | | | |
| Asthma |  |  |  |  |  |  |
| Bronchitis |  |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  |
| Cough |  |  |  |  |  |  |
| Wheeze |  |  |  |  |  |  |
| Pneumonia |  |  |  |  |  |  |
| Lung Abscess |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |
| ***Hormonal Imbalance:*** |  |  |  | | | |
| Hypothyroid |  |  |  |  |  |  |
| Hyperthyroid |  |  |  |  |  |  |
| Diabetes I |  |  |  |  |  |  |
| Diabetes II |  |  |  |  |  |  |
| Blood Sugar |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| ***Autoimmune &***  ***Inflammatory***  ***Conditions*** |  |  |  | | | |
| Thyroiditis |  |  |  |  |  |  |
| Rheumatism |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |
| Colitis |  |  |  |  |  |  |
| Chron’s |  |  |  |  |  |  |
| Alopecia |  |  |  |  |  |  |
| Allergy |  |  |  |  |  |  |
| Food allergy |  |  |  |  |  |  |
| Atopic dermatitis |  |  |  |  |  |  |
| Neurodermatitis |  |  |  |  |  |  |
| Cellulitis |  |  |  |  |  |  |
| Vulvitis |  |  |  |  |  |  |
| Low immunity |  |  |  |  |  |  |
| ***Effects of Focal Infect:*** |  |  |  | | | |
| Rheumatic disease |  |  |  |  |  |  |
| Rheumatic fever |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |
| Skin disease |  |  |  |  |  |  |
| Pericarditis |  |  |  |  |  |  |
| Scarlet fever |  |  |  |  |  |  |
| Glomerulonephritis |  |  |  |  |  |  |
| Ear infections |  |  |  |  |  |  |
| Staphylococci infections |  |  |  |  |  |  |
| Easily catch cold |  |  |  |  |  |  |
| Swollen glands |  |  |  |  |  |  |
| ***Connective Tissue or Ligament Diseases:*** |  |  |  | | | |
| Myofacial pain syndrome |  |  |  |  |  |  |
| Fibromyalgia |  |  |  |  |  |  |
| Tendonitis |  |  |  |  |  |  |
| ***Ear Nose & Throat:*** |  |  |  | | | |
| Deafness |  |  |  |  |  |  |
| Tinnitus |  |  |  |  |  |  |
| Itchy ear |  |  |  |  |  |  |
| Ear pain |  |  |  |  |  |  |
| Frequent ear infections |  |  |  |  |  |  |
| Sinus head aches |  |  |  |  |  |  |
| Yellow mucus |  |  |  |  |  |  |
| Stuffy nose |  |  |  |  |  |  |
| Post nasal drip |  |  |  |  |  |  |
| Dry throat |  |  |  |  |  |  |
| Itchy throat |  |  |  |  |  |  |
| Sinus congestion |  |  |  |  |  |  |
| Streptococci infections |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |
| ***Oral Disease:*** |  |  |  | | | |
| Bleeding gums |  |  |  |  |  |  |
| Periodontitis |  |  |  |  |  |  |
| Dental abscess |  |  |  |  |  |  |
| Mumps |  |  |  |  |  |  |
| Stomatitis |  |  |  |  |  |  |
| TMJ |  |  |  |  |  |  |
| Toothaches w/out cavities |  |  |  |  |  |  |
| ***DENTAL PROCEDURES:*** |  |  | \_\_\_ ROOT CANALS \_\_\_\_ EXTRACTIONS  \_\_\_ WISDOM TEETH \_\_\_ CROWNS  \_\_\_ MERCURY FILLINGS | | | |
| ***Before Noon:*** |  |  |  | | | |
| Low energy |  |  |  |  |  |  |
| “Spacey” feeling |  |  |  |  |  |  |
| Scattered |  |  |  |  |  |  |
| High Energy P.M./hate to wake |  |  |  |  |  |  |
| Long shower leads to dizziness |  |  |  |  |  |  |
| ***Male Issues:*** |  |  |  | | | |
| Impotence |  |  |  |  |  |  |
| Premature ejaculation |  |  |  |  |  |  |
| Prostate problems |  |  |  |  |  |  |
| Vasectomy |  |  |  |  |  |  |
| Infertility |  |  |  |  |  |  |
| ***Female Issues:*** |  |  |  | | | |
| Menstrual problems |  |  |  |  |  |  |
| Cramping |  |  |  |  |  |  |
| Heavy period |  |  |  |  |  |  |
| Light period |  |  |  |  |  |  |
| Irregular period |  |  |  |  |  |  |
| PMS |  |  |  |  |  |  |
| Menopause symptoms |  |  |  |  |  |  |
| Tubal ligation |  |  |  |  |  |  |
| Infertility |  |  |  |  |  |  |
| Low Libido |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| ***General:*** | | | | | | |
| Insomnia |  |  |  |  |  |  |
| Psychosomatic weakness |  |  |  |  |  |  |
| Exhaustion |  |  |  |  |  |  |
| Anger easily |  |  |  |  |  |  |
| Irritable |  |  |  |  |  |  |
| Depressed |  |  |  |  |  |  |
| Anxious |  |  |  |  |  |  |
| Difficulty concentrating |  |  |  |  |  |  |
| Motion sickness |  |  |  |  |  |  |
| No appetite for breakfast |  |  |  |  |  |  |
| Moodiness in morning |  |  |  |  |  |  |
| Unusual sweating |  |  |  |  |  |  |
| Lack of sweating |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |