Foothills Acupuncture
11290 West Alameda Ave. Ste 240
Lakewood, CO 80226-2511

First Patient Prior to Treatment Forms

Hello and welcome to Foothills Acupuncture!

****Please read the following forms carefully. Sign and date each form prior to treatment. Forms are two sided.**

Patient Name: _____Date of Birth: _____Age:_____

Address: _____City/Zip_____

Home Phone: _____Work_____ Cell_____

Email: _____

Gender_____ Height _____ Weight_____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship to You: _____

Primary Care Physician: _____ Phone Number: _____

Number of Children: _____

Occupation: _____

Full Time/Part Time/Other: _____

OFFICE and FINANCIAL POLICIES

Welcome to Foothills Acupuncture. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies. Please initial below to confirm your understanding of each section.

Insurance Coverage:
Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and the percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

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ASSIGNMENT OF INSURANCE BENEFITS

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all "non covered" services and /or coinsurance/co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Isaac White, L.Ac. By printing my name and signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions

Fees: The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. The fee schedule is available upon request.

- We accept cash, credit cards, HSA and personal checks
- Please note there is a $25.00 charge for checks returned due to insufficient funds
- Cash payments are due in full at the time of services are rendered
- Co-Pays are due in full at the time the services are rendered

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your signature below authorize the release of medical information necessary to process your claim.

Marketing Expressed Consent:

Your privacy is important to us. Under HIPAA, we are required to obtain expressed consent to share new products or services provided by our practice that may be outside of your treatment plan but may benefit your wellbeing and health goals. Would you like to receive communications from us that may include, but are not limited to, new products and services?

Yes_____ No:_____

Cancellations & Missed Appointments:

Please provide 24-hour notice of cancellation prior to your scheduled appointment.
If you miss an appointment or cancel less than 24 hours in advance, you may be subject to a $35 fee.

Minors are required to have a parent/legal guardian in the treatment room at all times.

Reasons for being dismissed/denied treatment:

Patients who show inappropriate conduct
Non-or-late payment of fees
Patients who exhibit unsafe behavior toward themselves or anyone else.

I have carefully read and understood all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

Patient or Parent/Legal Guardian name. _____

Patient Signature: _____Date:_____

Phone: (720)683-0557
Email: info@foothillsacupuncture.com
Web: www.foothillsacupuncture.com

COLORADO MANDATORY DISCLOSURE STATEMENT

Foothills Acupuncture LLC
Isaac White, L.Ac.
11290 W. Alameda Ave, STE 240
Lakewood, CO 80226-2511
Phone: (720)683-0577
Email: info@foothillsacupunctre.com

Fee Schedule for time of service payment

- Initial treatment: $130
- Follow up treatment: $ 90
- Express treatment: $ 50

Patient's Rights:

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In 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.
- The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies.
- If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, and Denver, Colorado 80202. Telephone: (303) 894-2440.

Education and Experience:

- Isaac White received his Masters of Acupuncture and Oriental Medicine degree from the Colorado School of Traditional Chinese Medicine in August 2017. He was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2017 which also includes certification in Clean Needle Technique. Isaac's therapeutic techniques include acupuncture, Chinese herbal therapy, Tui Na, Cupping, Electro-Stimulation Acupuncture, Auriculotherapy, dietary recommendations, moxibustion and lifestyle recommendations. Isaac is a member of the American Association of Acupuncture and Oriental Medicine (AAAOM). He is a registered and licensed acupuncturist in the state of Colorado None of these licenses, certificates, or registrations has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

I have carefully read and understood all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

Patient or Parent/Legal Guardian name: _____ Date:_____

Signature: _____

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NOTICE OF PRIVACY/HIPAA PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
PLEASE REVIEW IT CAREFULLY. The privacy of your health information is important to Foothills Acupuncture and all the employees working for Foothills Acupuncture.

USES AND DISCLOSURES OF HEALTH INFORMATION

- **Treatment:** Your health information may be disclosed for treatment or to a physician or other health care provider providing treatment to you.
- **Payment:** Disclosure of your health information may be used to obtain payment for the services we provide to you. It may also be disclosed to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.
- **Health Care Operations:** Disclosure your health information may be used for our health care operations including quality assessment and improvement activities, reviewing the competence of healthcare professionals, evaluating practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. Disclosure of your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you may be to support some of their health care operations.
- **Protected Health Information:** You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
- **On Your Authorization:** You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
- **Family and Friends:** We may disclose your health information to a family member, friend or another person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.
- **Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:• As required by law• For public health activities: reporting disease/statistic, child abuse, work-related illness/injury• To report abuse, neglect, or domestic violence in response to court/administrative orders and other lawful processes

YOUR RIGHTS

<u>You Have The Right To:</u>

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information

- Revoke any authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practice
- Abide by the terms of this notice

For a full, easy to understand version of the privacy acts, please ask your practitioner

I have carefully read and understood all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

Patient or Parent/Legal Guardian name: _____ Date:_____

Signature: _____

INFORMED CONSENT

I hereby voluntarily request and consent to be treated, or give permission for my child/minor to be treated, with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/lifestyle recommendations and/or nutritional or herbal supplements and that it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

- Possible Side Effects/Healing Reactions: I understand that these treatments may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved. By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/or any modality under this scope of practice.

- Acupuncture: I understand that acupuncture is performed by the insertion of sterile needles through the skin with or without electrical stimulation which produces a vibration/tapping sensation on the needles or by the application of heat to the skin (or body) at certain point on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may occur. These could include, but are not limited to; local bruising, mild bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop treatment at any time.

- Herbs: I understand that herbs, minerals, and vitamin supplements may be recommended to me to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances, but must follow the directions for administration and dosages if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to; changes in bowel movements, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will stop taking them and contact Foothills Acupuncture Clinic as soon as possible.

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- Tui-na, Massage and Cupping: I understand that I may also be offered Tui-na, massage and/or cupping therapy to modify or prevent pain perception and to normalize the body's physiological functions. I am aware the certain adverse side effects may occur. These side effects include, but are not limited to, bruising, sore or achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable or painful. I understand that there may be other treatment alternatives, including treatment by a licensed physician.

- Medical Referral:
  I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed Foothills Acupuncture of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify Foothills Acupuncture of any changes.

- ☐ Infectious Disease/Clean Needle Procedures: I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully, and I have felt free to ask any questions.

I have carefully read and understood all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation.

Patient or Parent/Legal Guardian name: _____ Date:_____

Signature: _____

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First Patient Intake Form

GENERAL INFORMATION

What is the primary reason for coming in for treatment?

_____

How long has this been occurring? _____

Have you been given a diagnosis by a western physician? If so, please describe.

_____

_____

What other therapies have you tried? _____

HEALTH HISTORY

Please check all current/past conditions or diagnoses that apply.

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Accidents_____
- ☐ Surgeries_____
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Other _____

Please list all prescription medications (current or within last 2 months).

_____

_____

Please list any vitamins, supplements or herbs you are currently taking.

_____

_____

CURRENT CONDITIONS AND SYMPTOMS

General Health: – check all that apply.

- ☐ Insomnia
- ☐ Disturbed Sleep
- ☐ Night Sweats
- ☐ Sweating Easily
- ☐ Generalized Weakness
- ☐ Noticeable Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Edema
- ☐ Numbness or Tingling
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Generally Cold
- ☐ Generally Hot
- ☐ Strong Thirst
- ☐ Lack of Appetite
- ☐ Excessive Hunger
- ☐ Tremors/Trembling
- ☐ Dizziness/Vertigo

Do you exercise?

- ☐ Rarely
- ☐ Sometimes (2 days/week or less)
- ☐ Often (3 days/week or more)

What kind of exercise do you do?_____

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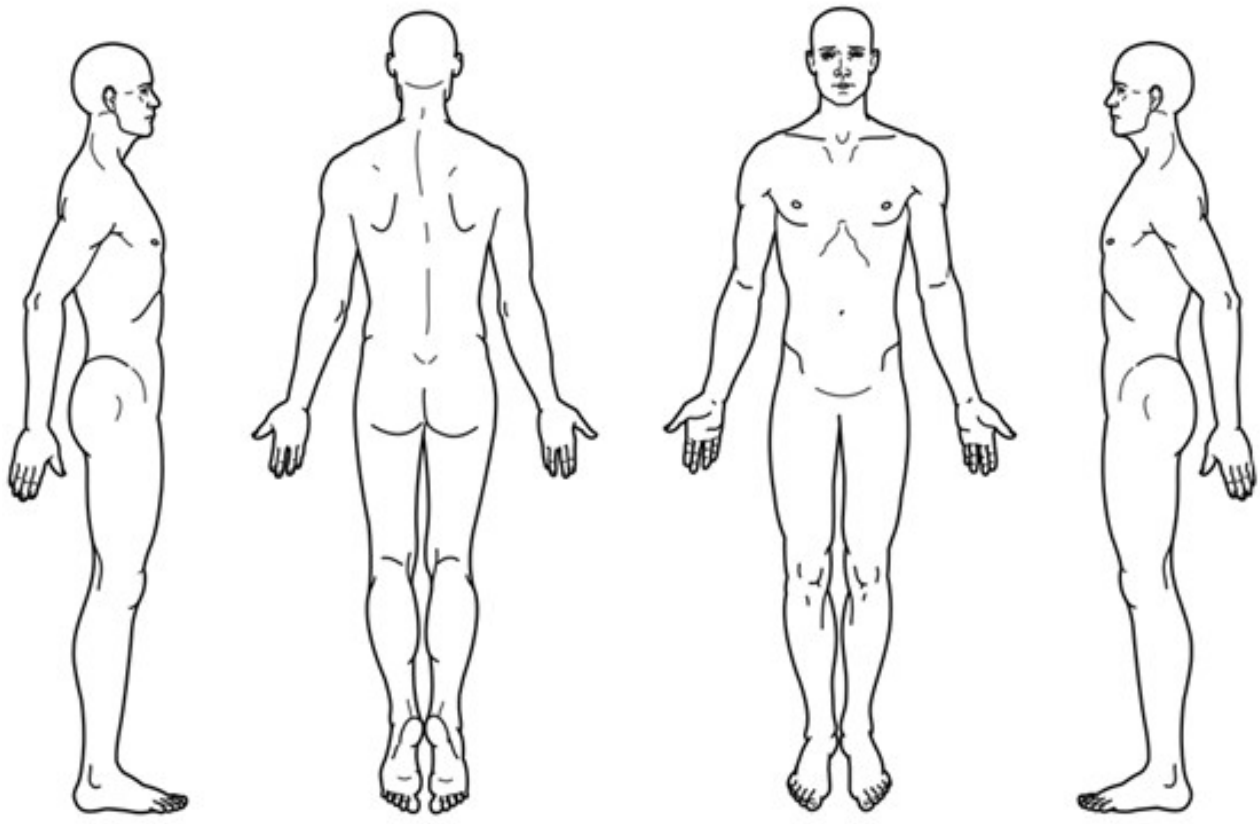
Musculoskeletal – check all that apply.

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Arthritis
- ☐ Hand/Wrist Pain
- ☐ Foot/Ankle Pain
- ☐ Muscle Weakness
- ☐ Overall Pain
- ☐ Chest/abdominal pain
- ☐ Other_____

Mark affected area(s) below



Psychological and Mental– check all that apply.

- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ Irritability/Frustration
- ☐ Poor Memory
- ☐ Lack of Concentration
- ☐ Lack of Motivation
- ☐ Addiction
- ☐ Worry
- ☐ Other_____
  _____

Skin and Hair– check all that apply.

- ☐ Rash
- ☐ Eczema or Psoriasis
- ☐ Ulcerations
- ☐ Acne
- ☐ Hives
- ☐ Dry Skin/Scalp
- ☐ Itching
- ☐ Hair Loss
- ☐ Other_____
  _____

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Face and Head– check all that apply.

- ☐ Migraines/ Headaches
- ☐ Eye Pain/Strain
- ☐ Eye Floaters/Spots
- ☐ Poor Vision
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Recurrent Sore Throats
- ☐ Sinus Congestion
- ☐ Nose Bleeds
- ☐ Sinus/Facial Pain
- ☐ Jaw Clicks/Pain
- ☐ Lip/Mouth Sores
- ☐ Dry Mouth
- ☐ Other_____

Respiratory– check all that apply.

- ☐ Difficulty Breathing
- ☐ Frequent Colds
- ☐ Cough
- ☐ Asthma
- ☐ Current or Previous TB Diagnosis
- ☐ Sinus Infections
- ☐ Excessive Phlegm
- ☐ History of smoking
- ☐ Other_____ _____

Heart/Cardiovascular– check all that apply.

- ☐ Palpitations
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Previous History of Heart Attack
- ☐ Previous History of Stroke
- ☐ Congestive Heart Failure
- ☐ Bleeding Disorder
- ☐ Clotting Disorder
- ☐ Other_____ _____

Digestion/Elimination– check all that apply.

- ☐ Food Allergies
- ☐ Abdominal Distention/Bloating
- ☐ Abdominal Cramping/Pain
- ☐ Gas
- ☐ Nausea/Vomiting
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Incontinence/Urgency
- ☐ Constipation
- ☐ Difficulty with bowel movement
- ☐ Hemorrhoids
- ☐ Parasites
- ☐ Blood in stool
- ☐ Other_____ _____

Urination– check all that apply.

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgency to Urinate
- ☐ Incontinence/Leakage
- ☐ Decreased Urination
- ☐ Waking Often to Urinate
- ☐ Discharge or Cloudy Urine
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Other_____ _____

Men's Health– check all that apply.

- ☐ Genital Sores/Rash
- ☐ Erectile Dysfunction
- ☐ Decreased Libido
- ☐ Excess Libido
- ☐ Other_____

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Women's Health– check all that apply.

- ☐ PMS
- ☐ Painful Periods
- ☐ Heavy Flow
- ☐ Light Flow
- ☐ Clots
- ☐ Discharge
- ☐ Irregular Periods
- ☐ Absent Periods
- ☐ Menstrual Cramps
- ☐ Past Miscarriage
- ☐ Fertility Issues
- ☐ Endometriosis
- ☐ Other_____ _____

Have you been pregnant or given birth in the past 3 years?

- ☐ Yes
- ☐ No
- ☐ Maybe / Not Sure

Age of first period _____Age at menopause (if applicable) _____

By signing below, I certify that the information I have provided is correct and accurate to the best of my knowledge.

Patient or Legal Guardian Name: _____

Signature: _____

Date (mm/dd/yyyy): _____