

## Welcome to Acupuncture Together of Austin!

**We have a sliding scale** of \$15-40. You decide how much to pay. There is a one-time \$10 paperwork fee for your first appointment.

**We treat in a community setting** using reclining chairs in a quiet, soothing space. Treating patients in a community setting has many benefits. It's easy for friends and family members to get treatments together, and many patients find it comforting.

**Frequent or regular treatments are the key to good results.** Tim or Ashley will suggest a course of treatment based on experience treating different conditions. If you don't come in often enough or long enough, acupuncture may not work as well for you. The purpose of our sliding scale is to make it affordable for you so that you can get the number of treatments you need.

### Guidelines for the treatment:

Please speak softly or whisper.

Cell phones must be off, in silent mode, or left in your car.

Please do not wear cologne, perfume, or strong smelling body products.

Feel free to bring things to make yourself more comfortable during your treatment, such as an iPod or phone with music or meditations to listen to.

Wear loose clothing that can be pushed or rolled up to expose your legs and arms. (Shorts and tank tops are good if the weather allows).

Don't come to your treatment feeling very hungry or with a very full stomach.

No alcohol or recreational drugs prior to your appointment.

Please arrive on time.

### Treatment Plan Guideline:

**9 - 10 out of 10** on the pain scale - every day until we see some change

**7 - 8 out of 10** on the pain scale - 3 x week for 2-3 weeks

**5 - 6 out of 10** on the pain scale - 2 x week for 2-3 weeks

**Mild/chronic issues** - 1 x week for 8 -10 weeks

**Very long-term/chronic** - 2 x week for 8 -10 weeks

**Stress and related symptoms** – 1-2 x week until you feel better

**Wellness and Prevention** - 2 x per month, esp. before travel, seasonal changes, or times of higher stress

### Our Commitment to You

We want our clinic to be a peaceful, welcoming space for you. We will provide a safe environment with skilled practitioners. We hope that Acupuncture Together will play an important role in keeping you feeling as healthy as possible.

### Informed Consent to Acupuncture Treatment

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Oriental Medicine. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks.

**Potential Side Effects:**

At the site of needle insertion there may be **soreness, numbness, tingling, bruising, swelling, or nerve damage**. A person might also experience weakness, fainting, organ puncture (extremely rare), and infection - although Acupuncture Together uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to acupuncture treatment and appearance of new symptoms. The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

*I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy.*

The procedures have been explained to me and I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied. I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to a course of treatment in Oriental Medicine. 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 with this practitioner.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Important Note about Receiving Acupuncture in Texas

In the state of Texas, acupuncture and Oriental medicine are not considered "primary health care". As a result, Acupuncture Together is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

Unless you seek treatment for chronic pain, smoking cessation, alcoholism, substance abuse, or weight loss - Texas acupuncturists are required to determine that a patient has been evaluated for the condition being treated by a physician or dentist within the last 12 months, or referred by a chiropractor within the last 30 days.

So, for us to treat you legally, and not be at risk of losing our license, you either need an evaluation by a doctor or dentist, or a chiropractic referral for the condition being treated and to provide proof to us. If you cannot provide proof of an evaluation or referral you have to indicate that you have been evaluated or referred on the form provided below.

I (patient's name) \_\_\_\_\_, am notifying Acupuncture Together of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.  
 Yes  No

I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.  
\_\_\_\_\_ (initials of patient) Date: \_\_\_\_\_

Or

I have received a referral from my chiropractor within the last 30 days for acupuncture.  
 Yes  No

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- Chronic pain
- Smoking addiction
- Weight loss
- Alcoholism
- Substance abuse

\_\_\_\_\_  
Patient Signature Required

\_\_\_\_\_  
Date

**Privacy Policy**

This notice describes how Acupuncture Together protects your health information and what rights you have regarding it. We are obligated by law to give you notice of our privacy practices. Please review them carefully.

**Right to Notice** As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Acupuncture Together can use your protected health information for treatment, payment, and health care operations.

- a) Treatment – We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- b) Payment – We may use and disclose your health information to obtain payment for services that we provide to you.
- c) Health care operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization** Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization through our practice at any time.

**Emergency Situations** In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using our professional judgment. We will only disclose health care information that is directly relevant to the person’s involvement in your health care.

**Marketing** We will not use your health information for marketing communications without your written authorization.

**Required by Law** We may also use or disclose your health information when we are required to do so by law.

**Abuse or Neglect** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people’s health and safety.

**National Security** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

**Appointment Reminders** We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

**Your Rights as a Patient**

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

**Legal Requirements** Acupuncture Together is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted within our office.

**Complaints** It is always our utmost goal to treat our patients with care and respect. If, however, you have complaints regarding the way that your protected health information is handled, you may submit a complaint to our office. We hope that you always let us know what we may do to improve your patient care. You may also send a written complaint to the U.S. Department of Health and Human Services.

I understand that Acupuncture Together may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I acknowledge that I have read Acupuncture Together’s Privacy Policy.

Patient name \_\_\_\_\_ Date \_\_\_\_\_

Patient signature \_\_\_\_\_

Please complete this questionnaire as thoroughly as possible. Even though some of the questions may seem unrelated to your condition, they may play a contributing role in your treatment. All information provided is strictly confidential.

Name \_\_\_\_\_ Today's date \_\_\_\_\_

Address \_\_\_\_\_ City State Zip \_\_\_\_\_

Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_ Age \_\_\_\_\_

Email \_\_\_\_\_ Have you had acupuncture before? \_\_\_\_\_

Occupation \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency contact: name/relationship/phone \_\_\_\_\_

What are you seeking treatment for? List your top 3 complaints in order of importance:

#1 \_\_\_\_\_

#2 \_\_\_\_\_

#3 \_\_\_\_\_

Please list with dates any hospitalizations, serious injuries, surgery or other serious medical problems which have required a doctor's care:

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

List prescription or over-the-counter medications, supplements, vitamins, or herbs you are taking:

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

Are you allergic to anything? \_\_\_\_\_

Check all that apply:     vegetarian/vegan     eat a lot of sweets     smoke cigarettes

Please indicate if you have or have had any of the following:

- Epilepsy/Seizures
- Heart attack
- Hepatitis A/B/C
- HIV / AIDS

- Bleeding disorder or hemorrhage
- Pacemaker
- Fainting
- Diabetes

**What have you had in the last 6 months more than once or twice?**

- headache / migraine
- dizziness
- ringing in ears
- hearing loss
- earache
- jaw pain / TMJ
- eye pain / strain
- excessive tearing
- dry / red / inflamed eyes
- nose bleeds
- loss of sense of smell
- sores in mouth/on tongue
- dry mouth
- recurrent sore throat
- swollen glands
- strange taste in mouth
- persistent cough
- production of phlegm
- wheezing
- shortness of breath
- coughing up blood
- frequent colds
- frequent sinus infections
- chronic allergies

- bruise easily
- slow wound healing
- low appetite
- excessive hunger or thirst
- nausea/vomiting
- belching, gas or bloating
- abdominal pain
- indigestion
- acid reflux / heartburn
- stomach ulcer
- jaundice
- gall bladder trouble
- blood in stool
- hemorrhoids (piles)
- constipation
- diarrhea
- weight loss/gain

- spontaneous sweating
- night sweats
- chills/fever
- aversion to heat or cold
- cold hands/feet
- hot flashes

**Pain, weakness, or numbness in:**

- arms / hands
- legs / knees / feet
- back / hips / shoulders
- whole body aches
- tremors or shaking
- joint stiffness
- swollen joints
- muscle spasms / cramps
- sprains or strains

- fatigue
- stress/anxiety
- poor sleep / insomnia
- palpitations
- depression
- mood swings
- poor memory
- excessive worrying
- nightmares
- easily startled
- excessive anger
- excessive fear

- low /high blood pressure
- high cholesterol
- irregular / rapid heartbeat
- blood clots
- swelling of ankles
- varicose veins
- chest pain
- rash, itching, hives
- dry skin
- acne, boils, infections
- hair falling out
- weak/brittle nails

- frequent urination
- poor bladder control
- burning when urinating
- dark /cloudy urine
- scanty urine or dribbling
- frequent UTI
- blood in urine
- kidney stones

**For Men:**

- prostate problems
- testicular pain/swelling
- penile discharge
- erectile dysfunction
- fertility problems

**For Women:**

- may be pregnant
- peri-menopausal
- completed menopause
- partial / total hysterectomy
- chronic vaginal infections
- frequent yeast infections
- endometriosis
- ovarian cysts
- uterine fibroids
- uterine prolapse
- PMS
- bleeding between periods
- severe menstrual cramps
- painful ovulation
- heavy/scanty periods
- painful breasts
- age of first period
- # of days periods last
- # of pregnancies
- # of miscarriages
- # of vaginal births
- # of c-sections

 Length of menstrual cycle  
 \_\_\_\_\_

 First day of last period  
 \_\_\_\_\_

The information I have provided is true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_