PATIENT INFORMATION & HEALTH HISTORY

Union Traditional Chinese Acupuncture & Herb

780 Simms Street, Suite 203

Golden, Colorado 80401

Tel: 303-593-0917

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire. These information is important for the maintenance of your account and determination of the best treatment plan for you, and all your information will be confidential. Do not hesitate to ask if you have any question. Thank you.

Full Name_____ Date _____

Gender: Female_____ Male _____ Birth Date _____ Age _____

Address _____City _____ State _____ Zip_____

Phone: Home _____ Work _____ Cell _____

E-mail_____ May we contact you via e-mail? Yes _____ No _____

Marital status: Married _____ Single _____ Widowed _____ No. of children _____

Emergency contact: Name _____ Phone _____

Family Physician _____ Occupation _____

Have you ever been treated by acupuncture before? Yes _____ No _____

How did you know about our clinic?

Patient or Doctor Referral (name) _____ Website _____

Direct Mail _____ Location or walk by _____Others (please specify) _____

Current Chief Complaints_____

_____

Complaints Secondary _____

Major Surgeries_____

Major Trauma_____

Any Known Allergies (Drugs, Chemicals, Foods) _____

Drugs Currently Taking _____

Are you experiencing pain/ discomfort in any area of your body? Yes_____ No_____

Describe Your Painful or Distressed Areas_____

Please rate your pain level.

1 2 3 4 5 6 7 8 9 10 (from mild to Severe)

Please check all of the below conditions that apply: (This is not a detailed history)

_____Severe bleeding disorders	_____A tendency to bleed or bruise easily
_____ Heart attack	_____ Heart pacemaker
_____ Stroke	_____ High blood pressure
_____Tendency to faint	_____ Thyroid problems
_____ Diabetes	_____ Hepatitis
_____ AIDS or HIV positive	_____ Pregnancy
_____ Smoke	_____ Consume alcohol

Goals: What would you most like to achieve with acupuncture treatment?

_____

_____

Other Issues Needs to Discuss: _____

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Patient Signature_____ Date_____

Patient Representative Signature_____

Relationship to Patient_____ Date_____

FINANCIAL AND APPOINTMENT CANCELLATION POLICY

Full payment is expected at the time of service unless other arrangements have been made in the writing prior to treatment. We accept checks, cash and major credit cards. All returned checks will incur a $20.00 (twenty dollars) fee, which will automatically be charged to your account.

Please notify our clinic if you need to cancel an appointment at least 24 hours prior to the time scheduled. If your appointment is not cancelled within 24 hours timeframe or you miss your appointment, you will be charged a $35.00 missed appointment fee.

Signature of Patient _____ Date _____

Patient Representative _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION

Union Traditional Chinese Acupuncture & Herb

We create and obtain the privacy of the health information in providing care and services to you. Our clinic respects your privacy, and we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

We have a Notice of Privacy Practice that provides a description of our treatment, payment activities, and healthcare operations in details, please request a copy of this Notice and read it before you sign this consent.

For treatment, our staff may obtain and record your medical information and we use them to help decide what care may be used for you, and we may disclose your health information to a physician or other healthcare provider providing treatment for you to help them stay informed your care.

For payment, we may use or disclose your health information to obtain payment for services we provide to you, for example, our submission of your health information to a billing agent for processing claiming payment, our submission of claims to third-party payer or insurance for claims review, determination for benefits, and payment.

For healthcare operations, we may use and disclose your health information in connection with our healthcare operations, include quality assessment and improvement activity, reviewing the competence or qualifications for healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may change our Notice of Privacy Practices if necessary, and those changes may apply to any of your protected health information that we store. You may get a revised copy at any time in our office.

You can revoke this Consent at any time by giving us your written notice of your revocation, and we may decline to treat you if you revoke this Consent.

I have read this consent and understand it. I give my consent to your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

Name (printed) _____

Signature_____ Date_____

(If applicable) Personal Representative's Name_____

Relationship to Patient_____ Date _____

CONSENT FORM FOR TRADITIONAL METHODS

I hereby request and consent to the performance of acupuncture treatments within the scope of practice of traditional Chinese acupuncture and Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by Shuhong Hua L.Ac. Dipl.Ac. Dipl. O.M. I also authorize her to perform on me the treatment known as acupuncture as her judgment may indicate and authorize her to use whatever therapeutic methods she may see fit. Whether or not such methods are commonly and generally accepted and practiced in this community.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical-stimulation, guasha, acupressure, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising 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 disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur.

The herbs prescribed are considered safe in the practice of Oriental medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that the herbs prescribed and given by the acupuncturist must be taken according to the practitioner's instruction only. I agree to inform the acupuncturist about any other herbs, medications or supplements that I am taking currently or during future courses of treatments. If any discomfort is noticed while taking the prescribed herbs, I understand to discontinue use and notify the office immediately.

I do not expect the clinic staff to be anticipated and explain all possible risks and complicated of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have carefully read and understand all of the above information and am fully aware of what I am signing. By voluntarily signing below, I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature of Patient _____ Date _____

Patient Representative _____ Date _____

MANDATORY DISCLOSURE STATEMENT

Union Traditional Chinese Acupuncture & Herb

Shuhong Hua L.Ac. Dipl.Ac. Dipl.O.M.

780 Simms Street, Suite 203, Golden, CO 80401

Telephone: 303-593-0917

This Disclosure is in compliance with the state of Colorado, Department of Regulatory Agencies, Colorado Revised Statutes Title 12 Article 29.5. All rules and regulations set forth by the Department of public health are strictly adhered to by this clinic, including proper cleaning and sterilization of needles used in practice of acupuncture, and the sanitation of acupuncture office.

The practice of acupuncture is regulated and licensed by the Department of Regulatory Agencies. Any complaints regarding acupuncture services should be directed to the director of the Division of Professions and Occupation in the Department of Regulatory Agencies at 1560 Broadway, Suite 1350, Denver, CO 80202. The phone number is 303-894-7800.

I use only disposable needles and keep proper sanitation of acupuncture office in accordance with the regulations promulgated by the Department of Health. Every patient is entitled to receive information about the methods of therapy, technique used, and duration of the therapy, if known. Patient may seek a second opinion from another health care 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 Professions and Occupations in the Department of Regulatory Agencies.

Education and Experience

- Bachelor in Traditional Chinese Medicine (TCM, 1984-1989), Shaanxi University of Traditional Chinese Medicine, Shaanxi, China
- Sixteen years (1989 - 2004) of practice with both TCM and integrative medicine in China
- Five years (2010 - 2014) of practice with Traditional Chinese Medicine in Denver Colorado.

License and Certification

- Colorado state license for practicing acupuncture, #1603
- NCCAOM Diplomate of Acupuncture, #29305
- NCCAOM Diplomate of Oriental Medicine, #29305
- Note: None of the above have ever been suspended or revoked.

Fee schedule

- Initial Evaluation FREE
- Acupuncture Treatment $75.00
- Custom Herbal Formula, per 100g $60.00 (plus sales tax)
- A full schedule of TCM modalities and additional fees that may apply is available at the clinic. Fee are subject to change without prior notice.
- A 24 hour cancellation is greatly appreciated if you are not able to keep your appointment.

Patient's Signature _____ Date _____