Arbour
ACUPUNCTURE
1300 Hudson Lane, Suite 3, Monroe, LA 71201
318-654-7947

First Time Patient Information

NAME: _____ DATE OF BIRTH: ___ / ___ / _____ AGE: _____Y/O

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____ NAME OF EMPLOYER: _____

NAME OF SPOUSE / LEGAL GUARDIAN / EMERGENCY CONTACT PERSON

NAME:_____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____ ALTERNATIVE NUMBER: _____

LIST ANY ALLERGIES

DRUG: _____ FOOD: _____

SEASONAL: _____ CHEMICAL: _____

PLEASE INDICATE IF YOU HAVE A CARDIAC PACEMAKER, METAL PINS/SCREWS/PLATES, OR OTHER ARTIFICIAL PROSTHESES OR IMPLANTED ELECTRONIC DEVICES: _____

HAVE YOU EVER BEEN TREATED WITH ACUPUNCTURE BEFORE? (CIRCLE ONE) YES / NO

WHAT PROBLEM(S)/CONDITION(S) ARE YOU LOOKING FOR HELP WITH AT OUR CLINIC TODAY?

_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PLEASE CIRCLE ANY OF THE FOLLOWING GROUPS OR PROFESSIONS IF YOU QUALIFY AS A MEMBER:

K-12 EDUCATOR **POLICE OFFICER** **FIREFIGHTER** **ENLISTED/VETERAN OF MILITARY SERVICE**

PATIENT SIGNATURE: _____ DATE: ___/___/_____

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General Policy Notice

Welcome to Arbour Acupuncture Clinic! We look forward to working with you on your healthcare needs. This document contains important policy information that pertains specifically to you. Please read over the entire document and if you have any questions don't hesitate to ask.

Appointments
We consider an appointment to be an agreement between you and our clinic. This is a busy practice and we take pride in helping each and every person. If for any reason you cancel your appointment without giving appropriate notice we become unable to provide service to another patient during your scheduled appointment time. You are responsible for giving us a 24-hour notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice we reserve the right to charge for the appointment as a cancellation fee. To cancel an appointment you may call the clinic and leave a voice message if we are unable to take your call, or send us an email message; our phone number and email address are located at the bottom of this page.

_____ please initial

Payment
Arbour Acupuncture Clinic requires payment in full at the time services are rendered. For your convenience we accept Credit/Debit Cards, Checks, or Cash. There will be a $25.00 fee for all returned checks. It is the policy of this clinic to offer in good faith discounted rates for follow-up treatments to patients who choose to pay for multiple treatments in advance. The treatments which are paid for in advance will remain credited to the patient indefinitely to schedule at their discretion. Any refund requested for treatments paid for in advance will be given after applying the charge of undiscounted fees to any of the treatments which have already been completed. Discounts are offered at the discretion of the clinic.

_____ please initial

Insurance
Arbour Acupuncture Clinic is not a recognized provider for any insurance companies nor do we submit claims to insurance companies on your behalf.

_____ please initial

Emergencies
If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent medical concern please call the office; if it is after regular business hours (9am to 5pm, Monday-Friday), please call the clinic and speak with us or leave a message and someone will return your call the next business day. If you feel you cannot wait until the next business day it is your responsibility to seek the appropriate medical care.

_____ please initial

I have read this document completely and I understand and agree with all of its contents, demonstrated by my signature below.

Patient Signature: _____ Date: ___/___/_____

Print Name: _____

Consent To Treatment

Informed Consent and Request for Alternative Medical Care

I understand that the evaluation, diagnosis and treatment by a practitioner of Naturopathic and Traditional Chinese Medicine, and specifically by the practitioners at Arbour Acupuncture Clinic, may include but is not limited to:

- Interview and request of medical records
- Review of all medical records by the supervising physician of the practitioners at **Arbour Acupuncture Clinic**
- Physical examination
- Dietary advice and therapeutic nutrition recommendations (such as the therapeutic use of foods, diet plans, nutritional supplements)
- Acupuncture (insertion of specialized single-use, disposable, sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Botanical medicines and nutraceuticals (also referred to as supplements) such as the prescribing of various therapeutic substances including plant, mineral and animal materials; substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol) suppositories, topical creams, etc.

I understand and I am informed that in the practice of Naturopathic Medicine and Acupuncture, as with any practice of medicine, there are some potential risks with evaluation, diagnosis and treatment including, but not limited to, the following:

- Pain, discomfort, minor bruising from Acupuncture and cutaneous therapies; allergic reaction to prescribed herbs and/or supplements; an aggravation of pre-existing symptoms.

Notice to pregnant women:

- All female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

I have read this document completely and I understand and agree with all of its contents, demonstrated by my signature below.

Patient Signature: _____ Date: ___/___/_____

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Acknowledgement of Consent to Treatment

By signing below, I (print name), _____ acknowledge that I have been provided ample opportunity to read **Arbour Acupuncture Clinic's 'Consent To Treatment'** form or that it has been read to me. I have had an opportunity to ask, and I have asked, any questions I may have about the information I have read in the 'Consent to Treatment' and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

I have read this document completely and I understand and agree with all of its contents, demonstrated by my signature below.

Patient Signature: _____ Date: ___/___/_____

If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is _____ years of age.

Name of Father: _____

Name of Mother:_____

If patient is unable to consent, state the reason why:

_____

Signature of Closest Relative or Legal Guardian: _____ Date: ___/___/_____

Please Print Name: _____

Relationship to Patient:_____

Witness to Signature: _____

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment To Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

- Use and disclosure of your health information in certain special circumstances
- The following circumstances may require us to use or disclose your health information:
    a. To public health authorities and health oversight agencies that are authorized by law to collect information.
    b. Lawsuits and similar proceedings in response to a court or administrative order.
    c. If required to do so by a law enforcement official.
    d. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
    e. If you are a member of U.S. or foreign military forces (including veterans) and we are then required by the appropriate authorities.
    f. To federal officials for intelligence and national security activities authorized by law.
    g. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
    h. For Workers Compensation and similar programs.

NOTICE OF PRIVACY PRACTICES - CONTINUED ON NEXT PAGE

Notice of Privacy Practices (Continued)

Your Rights Regarding Your Health Information

- You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Arbour Acupuncture Clinic, 1300 Hudson Lane, Suite 3, Monroe, LA 71201. Note: Arbour Acupuncture Clinic must respond to this request within 30 days.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Arbour Acupuncture Clinic, 1300 Hudson Lane, Suite 3, Monroe, LA 71201.You must provide us with a reason that supports your request for amendment. Note: We must respond within 60 days. The Privacy Officer or the patient's provider will usually do this. If the provider believes the information is complete and accurate, the provider can refuse to make any changes.
- You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Arbour Acupuncture Clinic.
- If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint about our practice/consultation service, contact Arbour Acupuncture Clinic. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Arbour Acupuncture Clinic.

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I (print name), _____ acknowledge that I have received, read or had read to me, understood, and accepted **Arbour Acupuncture Clinic's Notice of Privacy Practices**.

Signature of Patient/Legal Guardian: _____ **Date:** ___/___/_____

Printed name if signed on behalf of the patient: _____

Relationship to patient: _____

Witness to Signature: _____

Do you wish to be contacted via email? (circle one) **Yes / No**

E-mail Address: _____

Revisions (if any):

_____

_____

_____

_____

FOR OFFICIAL USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

_____

_____

_____

_____

_____

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Review of Systems

Please check all of the following that apply to you or list any issues that you are currently struggling with under the indicated heading. If you do not experience any problems leave the box unchecked or write 'normal' in the blank.

Head, Nose, & Throat: ❑ Headache ❑ Dizziness/Fainting ❑ Dental/Gum Disease ❑ Nasal Discharge ❑Sinus Congestion ❑ Hoarseness ❑ Sore Throat

Lungs: ❑ Shortness of Breath ❑ Cough ❑ Asthma ❑ Other:

❑**Phlegm:** Amount_____ Color _____ Odor_____ Quality: ❑ Thin/Runny ❑ Thick/Sticky

Heart: ❑ Palpitations ❑ Irregular Pulse ❑ Murmur ❑ Other:

Perspiration: ❑ Night Sweats ❑ Day Sweats ❑ Other:

Temperature: ❑ Fever ❑ Chills ❑ Hot Hands ❑ Hot Feet ❑ Cold Hands ❑ Cold Feet ❑ Other:

Appetite: ❑ Normal ❑ Poor ❑ Excessive ❑ Specific Cravings_____ ❑Other:

Thirst: ❑ Normal ❑ Thirsty ❑ No Thirst

Digestion: ❑Normal ❑Abnormal tastes ❑Reflux ❑Bloating/Gas ❑Nausea ❑Vomiting ❑Flatulence

Bowel Movement: ❑ Normal Frequency: ____x/day ❑ Constipation ❑ Diarrhea

Urination: ❑Normal Frequency: ____x/day ❑Abnormal color ❑Abnormal odor ❑Infrequent ❑Incontinence

Sleep: ❑ Normal Hours per night:_____ ❑ Hard Falling Asleep ❑ Hard Staying Asleep

Hearing:	**Vision:**	**Energy:**	**Emotions:**	**Sexual Libido:**
❑ Normal	❑ Normal	❑ Normal	❑ Normal	❑ Normal
❑ Poor	❑ Poor	❑ High	❑ High	❑ Excessive
❑ Tinnitus/Ringing	❑ Sensitive	❑ Low	❑ Low	❑ Impaired

OB/GYN:

❑ Current Pregnancy # of Past Pregnancies _____ # of Childbirths ____ ❑Menopausal at age: ____y/o

Menstruation: First menstruation at age: ____y/o Cycle length: ____days Duration of menses: ____days

Amount: ❑Normal ❑Light ❑Heavy Quality: ❑Normal ❑Thin ❑Think/Sticky ❑Clotting

PMS Symptoms: ❑ Cramping/Back pain ❑ Headache ❑ Breast soreness ❑ Irritation/Depression