Initial Evaluation Form

Name:	DOB:	Gender:
Address:	City: State:	Zip:
Email:	Have you had acupuncture before? Yes No	
Phone #:	Cell:	

Occupation:

Emergency Contact Name: Phone:

How did you hear about this clinic?

What is your Main Concern?

When did you first notice symptoms?

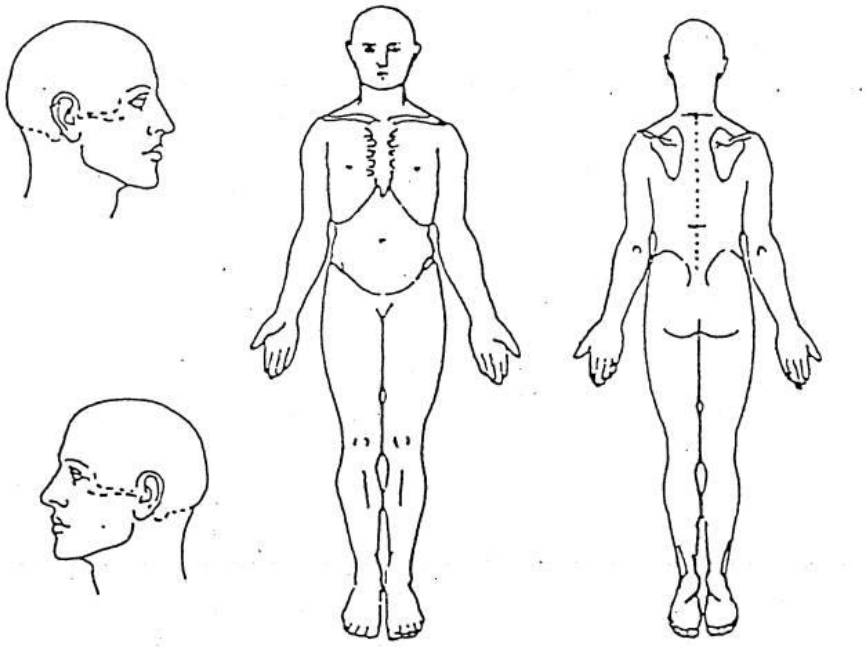
If you have been diagnosed, what is diagnosis?

What kinds of treatment or therapies have you tried?

Hospitalizations

Medications

Please mark painful or distressed areas on the charts below.



Please list all herbs and supplements you currently take:

Please list any food allergies or dietary restrictions:

Is there anything else that you feel I should know?

Notice of Privacy Policies

I am dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. Outlined here are policies we follow and rights to which you are entitled, according to state and federal law.

We gather personal and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Please be aware that during the course of our relationship we will likely use and disclose protected health information (PHI) about you for treatment, payment, and healthcare operations. PHI is identifying information about your past and present physical or mental health condition.

You may specifically authorize us to use PHI for any purpose or to disclose the health information we have about you by submitting the authorization in writing.

Marketing

David A. Trevino, L.Ac. will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, e-mails, post cards or letters, unless otherwise advised by you. You have the right to opt out of fundraising and marketing communications; please initial as indicated on the HIPAA Acknowledgement & Consent form.

Disclosure

David A. Trevino, L.Ac. may use or disclose your Protected Health Information without your express authorization only when required by law.

Patient Rights

1. Upon written request you have the right to access, review, or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information, including restricting information released to your health insurance company regarding any services/products for which you pay in full at the time of service.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.

5. You have a right to receive all notices in writing.

If you wish to make a formal complaint, send it to:

Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

I _____ give consent to David Trevino, L.Ac. for the use and disclosure of my Protected Health Information (PHI) for these specific purposes:

1. Providing treatment to me.
2. Collecting and processing payment for the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:
Protected Health Information (PHI) is any information that includes individually identifiable demographic information, including information gathered by this practice as it relates to my past, present, and future healthcare services and financial transactions. This practice may use my PHI for healthcare operations purposes, including quality assessment activities, credentialing, business management, marketing, and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to restrict certain disclosures to my health insurance provider (if applicable) regarding products or services for which I pay out of pocket and in full at the time of service.

I understand my authorization is required for uses or disclosures of my PHI for marketing purposes, for any disclosures that constitute a sale of PHI, and for any other uses/disclosures not described in our Notice of Privacy Policies.

I understand that I have the right to opt out of marketing communications. I will notify David Trevino if I choose to opt out of receiving these communications.

I understand that I have the right to be notified of any breach of my unsecured PHI.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I understand that I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

Acupuncture Informed Consent

I, _____ hereby authorize David Trevino, L.Ac. to perform acupuncture treatments on me (or the patient listed below, for whom I am legally responsible). This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Scope of Practice I understand that the scope of practice includes but is not limited to:

- Using Oriental medical theory to assess, diagnose and develop a plan to treat patient in an attempt to improve overall body function and/or to relieve pain.
- Using treatment techniques that may include:
  - Insertion of sterile acupuncture needles through the skin
  - Acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat with moxibustion or heat lamps
  - Cupping
  - Dermal friction
  - Acupressure
  - Herbal therapies
  - Dietary counseling based on traditional Chinese medical principles
  - Breathing techniques or exercise according to Oriental medical principles

Risks and Possible Side Effects:
I understand that there are possible risks to my treatment that may include the following:

- Transient bruising
- Infection
- Needle sickness (dizziness, nausea, fainting)
- Broken needles
- Sensations of heat, cold, tingling or numbness
- Skin irritation or slight bleeding at needle site
- Generalized fatigue
- Gastrointestinal disturbance from herbal remedies
- Minor burns from moxibustion (heat stimulation)
- Spontaneous miscarriage
- Pneumothorax

Treatment Outcomes
I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time.

Western Biomedical Diagnosis
I understand that it is not within the scope of practice for acupuncturists to offer Western medical diagnosis and that it is my responsibility to seek that diagnosis elsewhere. I understand that Chinese medicine is not recognized to provide primary care in North or South Carolina, consequently, if I have a western medically diagnosed condition, I may not legally receive treatment from David Trevino, L.Ac., for that condition unless I am concurrently under the care of a licensed physician.

I have / have not (Circle One) *been examined by a physician or other licensed healthcare provider with regard to my illness or injury. If yes I have informed the practitioner of the diagnosis.*

_____ _____
Physician Name & Phone Number ***Date***

_____ _____
Patient (or Guardian) Signature ***Date***

_____ _____
Witness ***Date***