Initial Intake

Thank you for taking the time to fill this out carefully. Though some questions might seem irrelevant to your condition, every piece of information helps to form a complete diagnosis. Oriental medicine treats the whole person, not just disease. All information will be confidential. If you have any questions, please ask.

Patient Information

First_____ Last_____ Birthday_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____

Email Address: _____

Emergency Contact:_____ Phone Number _____

Referred By _____

Main Concern(s):

_____

_____

Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

I have completed this form correctly to the best of my knowledge.

Signature:_____ Adult Patient Parent or Guardian

Print Name:_____ **Date:** _____

Round Rock
Acupuncture

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Round Rock Acupuncture 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 requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient name),_____I am notifying Round Rock Acupuncture of the following:

____ Yes ____No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

OR

____ Yes ____No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is_____, and the most recent date of chiropractic treatment prior to acupuncture treatment is_____. After being referred by a chiropractor, if **after 60 days 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 to follow this advice.

OR

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 one of the following conditions:

_____Chronic Pain
_____Weight Loss
_____Smoking Cessation
_____Alcoholism
_____Substance Abuse

_____ _____
Patient signature (required) Date

Round Rock Acupuncture is not responsible for untrue statements made by patients.

Informed Consent to Oriental Medical Health Care
RoundRock Acupuncture

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Charleen Ryszkowski L. Ac. or other licensed acupuncturists who now or in the future treat me at Round Rock Acupuncture.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 effects and risks may occur. I further understand that I need to stay still while the needles are in place to prevent injury or trauma to my body. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally 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. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications 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 and administrative 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.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Cancellation Policy

Thank you for choosing Round Rock Acupuncture clinic. Please contact us at least **24 hours** to cancel or reschedule your appointment. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours. Thank you for your time and understanding.

Signature_____ **Date**_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

We understand that medical information about you and your health is personal. Protecting your privacy and healthcare information is fundamental in the course of our relationship.

In administering your health care, we gather and maintain information that may include non-public personal information:

- From your patient record, including diagnostic information, as well as the care and services you receive.
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- About your financial transactions with us (billing transactions).

Disclosure of Information

In order to maintain the level of service that you expect from our office, we may need to share limited information for treatment, payment and healthcare operations. For example:

- **Treatment:** We may disclose medical information about you to other health care practitioners who are involved in your care. We may also share medical information about you in order to coordinate different types of treatment or to assist you and your physician or other health care providers in providing appropriate care for you.
- **Payment:** A receipt or bill may be sent to you or a third party payer that includes information that identifies you, as well as your diagnosis, medical information, procedures, herbs prescribed and supplies used.
- **Health Care Operations:** We are allowed to disclose your medical information if that is necessary for our office to function efficiently, safely, and in accordance with the law.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your medical information, you may cancel that permission in writing, at any time. Once we receive written notice that you are canceling permission we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Patient Rights

Your health record is the physical property of Round Rock Acupuncture, PLLC, however you have the right to:

- Inspect and request a copy of your health record.
- Request communications of your health information by alternative means or to alternative locations. We will accommodate reasonable requests.
- Request a restriction on certain uses and disclosures of your information. However, we are not required by law to agree to a requested restriction.
- Request that we amend your health record as provided by law.
- Obtain an accounting of certain disclosures of your health information as provided by law.
- Obtain a paper copy of this notice of information practices upon request.

You may exercise your rights by providing us with a written request.

Privacy Safeguards

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

We will not use or disclose your health information without your written authorization, except as described in this notice or as permitted by law.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change.

For More Information or to Report a Problem

We value our relationship and respect your right to privacy. If you have questions regarding your privacy guidelines or would like additional information, please contact: Round Rock Acupuncture, PLLC at 512-763-0616. If you believe your privacy rights have been violated, you may file a written complaint with Round Rock Acupuncture, PLLC or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and consent to the "**Notice of Privacy Practices**" of Round Rock Acupuncture, PLLC. I understand that I may receive a copy of the above "Notice of Privacy Practices" and may ask any questions about the notice prior to signing this document.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Privacy Representative/Date