light family acupuncture
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Patient Intake Form

Full Name: _____ Date:_____

Date of Birth: _____ Age: _____ Pronouns: _____

SS#: _____ Street Address:_____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Email Address: _____ Do not contact me via email ▢

Best way to get a hold of you: _____

In Emergency Notify: _____ Phone: _____

Physician: _____ Phone: _____

Chiropractor: _____ Phone: _____

Have you ever been treated by acupuncture? _____

How did you hear about the clinic? _____

When did the problem begin? _____

What diagnosis have you been given for this problem? _____

What type of treatment have you tried? _____

# of children? _____ # of pregnancies? _____

Regular menstrual cycle? _____ First day of last menses?_____

How many bowel movements/day? _____ Per week? _____

Number per week of: Alcoholic drinks _____ Caffeinated drinks_____ Cigarettes _____

Any dietary restrictions? *Yes* *No* If so, what?_____

History of significant illnesses, surgeries, trauma, allergies: _____

_____

Medicines including vitamins, herbs, OTC drugs taken within last 2 months: _____

_____

I have completed this to the best of my knowledge._____

Signature & Date

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Summary of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you may access this data. We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if would like to read the complete details.

I. How we may use and share health data about you:
a) Treatment – To give you medical treatment or other types of health services.
b) Payment – To bill you or a third party for payment for services provided to you.
c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
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
I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full

NOTICE OF PRIVACY PRACTICES document from Light Family Acupuncture at any time.

_____

Signature of Patient or Representative Date

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HIPAA Acknowledgement and Appointment Reminders

I acknowledge that I have been provided access to the Light Family Acupuncture "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that Light Family Acupuncture staff members 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.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners. By signing this form, I am giving Light Family Acupuncture authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____

Patient Name (print) Date

_____Melissa B. Light LAc_____6/1/12___

Patient Signature Light Family Acupuncture Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the Light Family Acupuncture the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

New Patient Information

Cancellation Policy - Treatments are by appointment, although walk-ins are occasionally accepted. Should the clinic need to close due to inclement weather or other severe circumstances, Light Family Acupuncture will post the closing or schedule change on its website at and on its main telephone voice message. If you find that you need to cancel an appointment, it is important that we receive 24-hour notice. This enables us to fill the time slot. **We reserve the right to charge the full fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment.** We will use our discretion when charging "No Show" fees. Also, the clinic reserves the right to charge the full scheduled fee for tardiness to appointments.

Payment for Clinic Services Rendered - Payment is due at the time of service and may be paid in cash, with most major credit cards, a medical savings account card, flexible spending account card or health savings accounts card. In order to keep clinic prices affordable, we do not file insurance claims of any kind and are not a Medicare/Medicaid provider. Upon request, we will provide you with a printed receipt containing the necessary information enabling you to file your claim.

Thank you for allowing us to provide you with quality health care.

_____

Patient Signature Required Date

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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, Light Family 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 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.)

I (patient's name) _____ am notifying the practitioners at Light Family Acupuncture of the following:

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

OR

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

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 symptoms related to one or more of the following conditions:

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

_____

Patient Signature Required Date

Light Family Acupuncture is not responsible for untrue statements made by patients.

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at the Light Family Acupuncture who now or in the future treat me while employed by, working or associated with or substituting for Light Family Acupuncture, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. 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 understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

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 the above named procedures and conditions of treatment. 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 at Light Family Acupuncture.

Patient's name (please print)	Patient's signature
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
Signature of Patient's Representative (if applicable)	Date Signed