Academy for
Five Element Acupuncture

PATIENT INFORMATION

Last Name	First Name (Legal)	Middle Initial	Preferred Name

Today's Date	DOB	Legal Gender (*see note at bottom) ☐ M ☐ F	Pronouns

Street Address	City	State	Zip

Cell Phone	Work Phone	Best # to reach you

Email	How did you hear about us?

Occupation	Who may we thank for referring you?

EMERGENCY CONTACT

Name of relative or friend to contact in an emergency	Relationship to you

Cell Phone	Work Phone

INSURANCE INFORMATION

Acupuncture is not covered by all insurance plans. Verification takes up to 14 business days. All clinic fees are due at the time of service. Claims are submitted weekly. If your insurance company pays the claim, then your fee will be reimbursed by check.

Insurance Company Name	Insurance Company Contact Number (on back of card)

Policy #	ID #

Name of Insured (if not you)	Relationship to Insured	Insured DOB

Claim # (If accident-related)	Date of Accident/Injury

Patient Signature	Date Signed

Guardian Signature (if minor patient)	Date Signed

** While the Academy recognizes a variety of gender identities, many insurance companies and legal entities do not. The name/gender you have listed must be the name used on documents pertaining to insurance billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

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LIST OF MEDICATIONS

Patient Name _____ DOB _____ ☐ Initial Date _____

☐ Update Date _____

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Medication (brand and/or generic name)	Dose	How often do you take this medicine?	Reason for taking	Started when?	Stopped when?	Who prescribed it?

Check here if using additional pages ☐

Intern signature _____

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ACUPUNCTURE AND CHINESE HERBAL MEDICINE
INFORMED CONSENT TO TREAT

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, Tui-Na (Chinese massage), 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions providedorally and in writing. The herbs may have 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 understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

I voluntarily permit my intern practitioner to submit my treatment sheets to Academy personnel for purposes of recordkeeping and academic instruction. I understand that a coding system is used so that my full name is not includedon forms used for academic instruction. I have been informed that I may stop treatment at any time. By signing this form, I am acknowledging that I have received and accept the terms of HIPAA Privacy policies, Payment of Services, Cancellation of Appointment and Unattended Clinic Appointments.

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.

Acupuncturist Name	Misti Oxford-Pickeral	Acupuncturist Signature	Misti Oxford-Pickeral
Patient Name (Print)			DOB
Patient Signature			Date Signed
Guardian Signature (if minor patient)			Date signed

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COVID INFORMED CONSENT TO TREAT

:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

Initial Below

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at thistime. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affectedby COVID-19; or 2) Domestically within the United States by commercial airline, bus, ortrain. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. however, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Name (Print)	DOB
Patient Signature	Date Signed
Guardian Signature (if minor patient)	Date Signed

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INFORMED CONSENT TO TELEHEALTH

To better serve the needs of patients, our services may be available by telehealth (two-way interactive video communication and electronic transmission). This consent explains telehealth care. If you have any questions, please ask your provider.

I understand that I may be evaluated and treated via telehealth and agree to the following:

TELEHEALTH SERVICES
Telehealth involves transmission of video or digital photographs of me, and/or details of my health ("Transmitted Data"). All Transmitted Data is sent via electronic means to my provider(s) to facilitate health care services. I understand that:

- Telehealth is different from traditional care in that the patient and provider do not meet physically in-person;
- Patients will be informed of any additional personnel that are to be present, seen or unseen, during the encounter. Patients must inform their Provider of any person other than the patient who is present. Patients have the right to exclude anyone from either location;
- Patients have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment, however, equivalent in-person services might not be available at the same location or time as telehealth services. A refusal to participate in telehealth will not affect rights to future care or benefits to which a patient may otherwise be entitled;
- Patients have the right to follow-up with their provider as necessary with questions or concerns;
- Benefits of telehealth include that the patients and providers can continue health care services when an in-person appointment is not possible or is inconvenient. The provider can also visualize some of the client's environment. Telehealth may also minimize exposure to illness;
- There are also risks involved in telehealth including, without limit, losing the ability to; a) perform aspects of a physical examination (for example listening to the patient's heart and lungs or verifying vital signs); b) read physical or vocal cues/tones, and facial expressions; and c) provide immediate emergency physical services/care;
- Additionally, technical issues may disrupt the visit. There are also risks to preserving confidentiality including the risk that communications may be overheard; and that communications may be accessed by unknown third-parties; 8) Patients shall have to access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

CONFIDENTIALITY
All confidentiality protections required by law or regulation will apply to my care. Although confidentiality extends to communications by text, email, telephone, videoconference and other electronic means, providers cannot guarantee that those communications will be kept confidential and/or that a third-party may not gain access to such communications.

With electronic communication, there is always a risk that communications may be compromised, unsecured, and/or accessed by a third-party. To help maintain confidentiality when engaging in electronic health services, it is important that all sessions be conducted in a confidential place. This means that clients agree to participate in telehealth only while in a room or area where other people are not present and cannot overhear the conversation. Do not have sessions in public places. Sessions may not be recorded and patients must seek written permission before recording any portion of the session and/or posting any portion of sessions.

EMERGENCIES
Telehealth is not appropriate if I am experiencing an emergent health care situation. If am experiencing an emergency, I understand that it is my responsibility to immediately call 911. If an emergency develops during telehealth services, I understand that it is my responsibility to immediately inform my telehealth provider, call 911 and stay connected with my telehealth provider (if possible) until help arrives.

I have read and agree to the terms in the Telehealth Consent. I understand that telehealth is not a substitute for in person health care services. I understand that telehealth is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact 911.

Patient Name (Print)	DOB
Patient Signature	Date Signed
Guardian Signature (if minor patient)	Date signed

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APPOINTMENT REMINDER AUTHORIZATION

Our clinic provides text message and voice message appointment reminders. We maintain the confidentiality of your information while using this system. We will NOT send out any texts unless you have explicitly consented, and text/voice call messages will be for appointment reminders only. We ask that you not rely solely on this service for remembering your appointment. The responsibility of attending and cancelling appointments still rests with you, but we do hope this will make things easier. Please indicate below the best way to reach you for appointment reminders. You may choose more than one, however, if all are initialed you could receive up to three reminder messages.

_____
(Initial)

TEXT MESSAGE

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically via text message to my cell phone. I understand that this service Is offered free of charge, however, standard text messaging rates from my mobile carrier may apply. I will receive a text reminder 24 hours before the scheduled appointment.

Cell/Text Message Number: _____

I will contact the clinic immediately with any change in my cell phone number.

_____
(Initial)

VOICE MESSAGE

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically via voice messaging. If I am unavailable to answer the telephone, I give the Academy permission to leave a message on my answering machine or with the person answering the telephone. I will receive a reminder 24 hours before the scheduled appointment.

Voice Message Number: _____

I will contact the clinic immediately with any change in my voice message number.

_____
(Initial)

EMAIL CONTACT

Yes, I authorize Academy for Five Element Acupuncture to send appointment reminders electronically to the email address listed here. I will receive an email one week before the scheduled appointment time and a second email 36 hours before the scheduled appointment time. (The Academy is unable to vary this).

Email address (please print clearly): _____

I will contact the clinic immediately with any change in my voice message number.

Patient Name (Print)	DOB
Patient Signature	Date Signed
Guardian Signature (if minor patient)	Date Signed