DATE:

PATIENT INFORMATION	CONTACT INFORMATION
Name	**Telephone**
Address	**Email**
Age **Birthdate**	**Emergency Contact Name**
Occupation	**Emergency Contact Telephone**
How did you hear about us?	

HEALTH HISTORY
What are your primary concerns for coming in for treatment? **1.** **2.**
List all medications or vitamins that your are currently taking.
List all serious illnesses, accidents, or surgeries in the last year.

Check symptoms that <u>CURRENTLY</u> apply:

- ❑ History of fainting
- ❑ Dizziness
- ❑ Fatigue
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Asthma
- ❑ Blurred/failing vision
- ❑ Hearing loss
- ❑ Ringing in ears
  - ❑ High pitch
  - ❑ Low pitch
- ❑ Cough
- ❑ Sore throat
- ❑ Fever
- ❑ Bruise easily
- ❑ Itching/rash
- ❑ Night sweats
- ❑ Tend to feel hot easily
- ❑ Tend to feel cold easily

- ❑ Blood in urine
- ❑ Low libido
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Diarrhea
- ❑ Constipation
- ❑ Indigestion/heartburn
- ❑ Nausea
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Amenorrhea (period has stopped)
- ❑ Menopause
- ❑ History of Miscarriage
- ❑ PCOS
- ❑ Undergoing fertility treatments

Could you be pregnant?

Have you had acupuncture before?

By signing below I agree that the information on this form is correct to the best of my knowledge.

_____ _____

Signature
(Guardian Signature if Minor)

Patient's Name

Tempe

Community Acupuncture

WWW.TEMPEACU.COM

We Have a Sliding Scale...

We offer treatments on a sliding scale of $17-$35. New patient treatments are $25. You decide what you can pay, what you can afford that day. **You will receive the same treatment regardless of what you pay on the scale.** Our sliding scale is put in place so that you are able to come in as often as needed.

We Treat in a Community Room…

The treatment room is a quiet space for you and others. Maintaining this reservoir of calm, requires very little talking in the clinic space-including us. A private room is available upon request for intake, if needed for special circumstances.

Welcome to our community! Enjoy your AcuNap!

Please make sure cell phones are turned completely off before entering the treatment room. You may leave your cell phone on to use as a personal music device with the use of headphones. Thank you for your cooperation!

For privacy reasons there is absolutely **NO TEXTING, PHONE CALLS, OR TAKING PICTURES**, while in the treatment room.

I understand the cell phone policy and will refrain from having my cell phone on pr in silent/vibrate mode. I will turn my phone completely off, or put it in airplane mode, BEFORE entering the treatment room. I will not use my cell phone for texting, calls or camera use of any kind while in the treatment room.

_____

Patient's Name

_____ _____

Signature Date

Informed Consent to Acupuncture Treatment

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Traditional Chinese Medicine. I am hereby informed that the treatment methods are all generally safe, but there may be some side effects or risks. There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting and aggravation of symptoms existing prior to acupuncture treatment. As with any invasive procedure there is a risk of puncturing organs (extremely rare). At the site of the needle insertion there may be soreness, numbness, tingling, or swelling. There is a small risk of infection at the needle site. TCA uses one-time use, sterile disposable needles. In no case is a needle ever reused.

I understand the acupuncturist may recommend herbal supplements. I understand I must stop taking any herbs and notify the clinic immediately if I experience adverse reactions. Any supplements recommended shall be obtained from a third party supplier. As such TCA is not responsible for the quality of ingredients in these formulas.

I will not walk around the clinic in bare feet, I will not leave my chair while needles are inserted, I will alert the staff if I see a needle on the floor but I will not touch it, I will not remove my own needles, I will not sit in a chair that does not have a white bucket placed upon the chair. I understand while in treatment I may signal for attention. I will do my required self check that all needles have been removed before leaving the treatment room.

Tempe Community Acupuncture does not provide primary care. If I am pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection or have been prescribed anticoagulant medications. By signing below I state that I have informed my acupuncturist of such conditions.

I understand that I have the right to refuse any part of treatment. I do not expect my practitioner to be able to anticipate and explain all the possible complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during course of treatment, based upon the facts then known. I understand that no guarantee of cure or improvement in my condition is given or implied. I have read or have had read to me, this informed consent form. I have also had the opportunity to ask questions about its content, and by signing below, I agree to a course of treatment. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) I seek treatment for which I seek treatment with this practitioner. I understand that the treatment here is not a replacement for medical care.

With this knowledge, I voluntarily consent to the above procedures.

_____ _____

Patient's Name Date

_____

Signature (Guardian Signature if minor)

Payment Policy

Payment is due at the time of service and may be paid by cash, check, Visa, Mastercard, or American Express. We do not file insurance claims of any kind and are not a Medicare/Medicaid provider. All sales are final, we do not offer refunds for services performed, unused gift certificates, unused treatment credits, packages, etc. It is the patient's responsibility to maintain record of payment amounts if needed.

Cancellation Policy

Tempe Community Acupuncture works to make our service available to as many people as possible and at the most affordable rates. With respect to this goal we ask for 4 hours advance notice if you need to cancel or reschedule. You may cancel/reschedule by phone, using our online scheduling system, or by voicemail.

There is a $15 cancellation fee for missed appointments that are cancelled/rescheduled with less than 24 hours notice. If there are any treatment credits on the account, 1 treatment credit will be deducted from the account in lieu of the cancellation fee.

Thank you for your understanding!

I affirm that I have read the payment and cancellation policies.

Privacy Policy

TCA takes the right to your privacy seriously. We do not disclose any personal, health, financial, or any other information about you, or the services we provide to you to any third parties without your request or permission.

_____ _____

Patient's Name Date

_____

Signature (Guardian if minor)