acupuncture together

Name_____ Date_____

Address_____City/State/Zip_____

Phone_____ Email_____

Age_____ Occupation _____Have you had acupuncture before? _____

Emergency contact name/phone _____

How did you hear about us? _____

What are you seeking treatment for?

_____

_____

Please list with any hospitalizations, injuries, surgery or other medical problems which have required a doctor's care in the last 10 years:

_____

_____

List prescriptions, over-the-counter medications, or supplements you are taking:

_____

_____

Are you allergic to anything? _____

Please mark all that apply:

__ epilepsy/seizures
__ Hepatitis A/B/C
__ HIV / AIDS
__ bleeding disorder or hemorrhage
__ pacemaker
__ fainting
__ taking blood thinners
__ mental illness

Is there anything else you would like us to know about you? _____

_____

_____

Informed Consent to Acupuncture Treatment

I understand that Acupuncture Together provides acupuncture in a community setting. Common side effects of acupuncture treatment in a community room include deep relaxation, falling asleep, and snoring. I understand that if I need to be woken up at a certain time, I will let the acupuncturist know. I understand that I might be too relaxed to drive immediately after treatment. If other people's snoring bothers me, I understand that I need to use earplugs or headphones. I understand that at times, someone else might be sitting in my favorite recliner. I understand that community acupuncture involves actual community with a wide variety of people, and may at times require some flexibility, patience, or understanding from me.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Oriental Medicine. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks.

Potential Side Effects:
At the site of needle insertion there may be **soreness, numbness, tingling, bruising, swelling, or nerve damage**. A person might also experience weakness, fainting, burns, spontaneous miscarriage, organ puncture (extremely rare), and infection - although Acupuncture Together uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to acupuncture treatment and appearance of new symptoms. The herbal and nutritional supplements recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. 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 with Acupuncture Together.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy.

Signature_____

Date: _____

Cancellation Policy

If you have an appointment scheduled with us, we are saving a chair just for you.

With respect for our intention to offer high quality acupuncture at affordable prices, we ask for 12 hours of advance notice if you must cancel or reschedule an appointment. This gives us time to fill the vacant slot in our schedule, and helps us keep rates affordable. You may cancel or reschedule an appointment by phone or by using our online appointment scheduler. You may also leave us a voicemail outside of regular business hours.

Please note that there is a $20.00 fee for appointments that are cancelled with less than 12 hours notice, and also for missed or “no-show” appointments. There are exceptions for emergencies.

Thank you for your understanding.

~Acupuncture Together Staff

I affirm that I have read the cancellation policy and that I am aware of the $20.00 fee for cancellations less than 12 hours before the appointment and also for missed appointments/no-shows.

Patient name _____

Date signed _____

In the state of Texas, acupuncture and Oriental medicine is not considered *"primary health care".* As a result, Acupuncture Together Austin 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 the statements is no.

(Pursuant to the requirements of 22 TAC 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to the Scope of Practice and Tex. Occ. Code Ann., 205.351, governing the practice of acupuncture.)

I (patient's name) _____am notifying Acupuncture Together Austin of the following:

PLEASE CHECK ONLY ONE "YES" BOX AND THEN SIGN FORM AT BOTTOM:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.

☐ Yes ☐ No

I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

☐ 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.)

☐ Yes ☐ No

If no box was checked "yes" above, PLEASE ANSWER THIS SECTION:

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 cessation

_____Weight loss

_____Alcoholism

_____Substance abuse

_____ _____
Patient Signature Date