nourish
healing arts studio

Consent for Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Nourish: Healing Arts Studio. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call my acupuncturist as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address:_____

Phone:_____

1551 NW 54th Street, Suite 204
Seattle, Wa 98107
206.579.1654

Fees and Policies

Fee Schedule for Payment at Time of Service

• Acupuncture-First Office Visit	$100
• Acupuncture-Return Office Visit	$85
• Facial Rejuvenation-First Office Visit	$150
• Facial Rejuvenation-Return Office Visit	$115
• Microcurrent-30 min.	$40
• Microcurrent-60 min.	$60

Payment Policies

I accept cash, check, Visa, MasterCard, American Express, and Discover

- Payment is due at the time services are provided
- Administrative Fees $65/hour

Billing Policies for Insurance

I will bill your insurance company directly under the following conditions:
(Please initial)

- _____ **Medical Insurance:** If your insurance company won't pay for the session for any reason then you will be responsible for payment in full (fee will be the same as time-of-service)

All insurance accounts not paid in full within 90 days from the date of service will be charged interest. Interest rates are 12% annually and 1% monthly. Interest is calculated on the principle amount; interest is not compounded.

24 Hour Cancellation Policy & Credit Authorization Release

We take pride in the quality of care we offer patients. In order to do this we have a strict cancellation policy. We require a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the card we have on file.

I, _____ authorize Jodie Scott, EAMP to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

_____exp. _____ O Visa / O MC

Print Name_____

Signature_____ **Date**_____

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME_____

BIRTHDATE_____ **SOCIAL SECURITY #**_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to by bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient:

X_____ _____ _____

Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

☐ Accepted _____ _____ _____

☐ Denied Signature Title Date

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Client,

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.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include*:*

- 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.

Types of information that we gather and use:

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

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (206)579-1654.

Yours truly,

Jodie Scott, L.Ac.

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Health Intake Form

Name_____ Date_____
(Last) (First) (M.I.)

Address_____
(Street Number) (City) (State) (Zip Code)

Phone: Home_____ Work_____ Cell_____

D.O.B._____ Sex M / F Email_____
(MM/DD/YYYY)

How did you hear about us? Website Healthcare Provider Friend Insurance referral HealthProfs.com Newspaper PriceDoc.com Other_____

If a friend referred you, whom may we thank? _____

Insurance Provider_____ Insurance I.D. #_____

Employer_____ Phone_____

Primary Insured_____ Primary Insured D.O.B._____

What is your main complaint today?_____

_____

When did it begin?_____

How severe is the problem?_____

Have you had any previous treatment?_____ If yes, explain_____

_____

Past Medical History (please indicate dates)

Cancer_____ High Blood Pressure_____ Rheumatic Fever _____ Asthma_____

Diabetes_____ Venereal Disease_____ Heart Disease_____ Pacemaker_____

Stroke_____ Thyroid Disease_____ Seizures_____ Hepatitis_____ H.I.V._____

Other_____

Surgeries (type and date)_____

_____

Significant trauma (i.e. auto accidents, falls, etc.)_____

_____

Birth History: # Pregnancies_____ # Births_____ # Abortions_____

Did you have any difficulties during labor?_____

Are you still menstruating?_____ If so, date of last menstruation _____

Do you practice birth control?_____ What type?_____

Allergies (drugs, chemicals, foods, plants, animals)_____

_____

Family Medical History (check all that apply)

High blood pressure___	Alcoholism___	Cancer_____	Allergies_____
Heart Disease___	Seizures___	type_____	_____
Stroke___	Asthma___	_____	_____
Arteriosclerosis___	Diabetes___	_____	_____

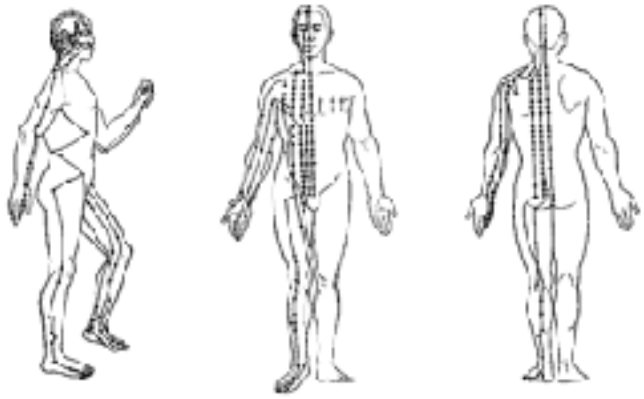
Do you experience stress on the job? (chemical, physical, psychological) Y/N

If yes, please explain_____

Do you exercise regularly?_____What types of exercise?_____

_____

Indicate the areas you want to focus on today



What are your treatment goals? _____

_____

Are you currently taking any medications? (prescription, vitamins, herbal)_____

_____

Have you ever experienced: (please circle all that apply)

General
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Edema
- Poor sleeping
- Tremors
- Poor balance
- Weight change

Skin & Hair
- Rashes
- Itching
- Ulcerations
- Eczema
- Oozing skin lesion
- Hives
- Loss of hair

EENT
- Dizziness
- Migraines
- Headaches
- Blurry vision
- Cataracts
- Earaches
- Ear discharge
- Nose bleeds
- Sinus congestion
- Concussions
- Recurrent sore throats

Cardiovascular
- High blood pressure
- Low blood pressure
- Chest pain
- Swelling of hands/feet
- Blood clots
- Fainting
- Difficulty Breathing

Respiratory
- Asthma/wheezing
- Difficulty breathing while lying down
- Phlegm
- Coughing blood
- Pneumonia
- Bronchitis

Gastrointestinal
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stools
- Black stools
- Abdominal pain
- Rectal pain
- Hemorrhoids

Genito-Urinary
- Pain on urination
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in flow
- Dribbling
- Kidney Stones
- Impotency
- Change in sex drive
- Sores on genitals

Neuropsychological
- Seizures
- Numbness
- Weakness
- Sleep disorder
- Vertigo
- Lack of coordination
- Depression
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse

Last Physical: Date:_____ Doctor:_____

Results:_____