LA Herbs & Acupuncture

Wellness through ancient wisdom

Patient Confidential Information Date_____

Patient Name_____

Address_____

City_____ State_____ Zip Code_____

Primary Phone_____ Other Phone_____

Email Address_____

Age_____ Date of Birth_____/_____/_____

Sex Male/Female Marital Status S/M/D/W/Cohab

Referral Source_____

Place of Birth_____

Occupation or Profession_____ Employer_____

Emergency Contact_____ Relation_____

Phone_____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to , L.A. Herbs & Acupuncture, An Integrative Medical Corp.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ,L.A. Herbs & Acupuncture, An Integrative Medical Corp. reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp may email to me appointment reminder cards and patient statements. I have the right to request that L.A. Herbs & Acupuncture, An Integrative Medical Corp. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to L.A. Herbs & Acupuncture, An Integrative Medical Corp use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____

Patient's Name _____ **Date** _____

Print Name of Patient or Legal Guardian_____

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 the patient named below for whom I am legally responsible) by the licensed acupuncturist(s) 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, included those working at L.A. Herbs & Acupuncture, An Integrative Medical Corp., whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Chinese herbal medicine and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herb

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 only sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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.

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

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.

Patient Signature _____**Date**_____

Patient representative_____**Date**_____

L.Ac_____**Date**_____

First name: **Last name:** **Height:** **Weight**

Chief complaint:

Are you a cancer patient or caretaker? If you are a caretaker, please skip to question 5.

What is your primary medical diagnosis?

When were you diagnosed with cancer?

Please briefly describe cancer treatments you have been going through or completed.

Do you have any other medical conditions or diagnosis?

Please list the medications you have been taking:

Please describe your chief complaint:

Beside chief complaint, what other symptoms or issues would you like to get help for?