File NO:_____

Welcome to

Pecan Grove Acupuncture & Wellness Clinic

Would you please take a moment to provide us with some information about yourself and your health conditions, so that we may do our best to treat you. Pecan Grove Acupuncture & Herbal Clinic considers this information privileged physician/patient communication and will hold it confidential.

Patient Information

Date: _____ Phone for follow-up:_____
Email for follow-up:_____

Name: _____
Last Name First Name Middle Name

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: Male _____ Female _____ Age: _____ Date of Birth: _____ Social Security No.: 000-00-_____

Driver's License No.: _____ □ Single □ Married □Widowed □ Separated □ Divorced

Spouse's Name: _____ Phone: _____

Patient Employed By: _____

Business Address:_____

Occupation: _____ Business Phone: _____

In case of emergency who should be notified? _____

Relationship to patient: _____ Phone: _____

Address: _____

Primary Physician: _____ Phone: _____

Address: _____

Whom may we thank for referring you? _____ Phone: _____

Patient Medical History

Name: _____

1. Diagnosis by your primary physician: _____
2. Have you ever received any treatment for this condition? Yes _____ No _____
   a. If yes, where? _____
   b. When? _____
   c. By Whom? _____
   d. What kind of treatment(s)? _____
   e. Was the result satisfactory? _____

3. List medications you are currently taking:

Medications	Strength/Dosage	How many per day	For how long?

4. Please list substance(s) that you are allergic to: _____
   _____

5. List any major surgeries you have had:

Date	Problem

6. Hospitalization other than surgery/ Significant Trauma (auto accident, falls, etc.)
   _____
   _____
   _____

7. Significant illness (please check)

Rheumatic fever ___	Heart Disease ___	Diabetes ___	Thyroid Disease ___	Cancer ___
High Blood Pressure ___	Tuberculosis ___	STD ___	Hepatitis ___	AIDS ___
Hyperlipidemia ___	Coagulopathy ___	Stroke ___	Seizures ___	

   Others _____

8. Health Habits (tobacco, alcohol, illicit drugs, special diet, exercise, exposure to toxin, etc.)
   _____
   _____

9. (Female only) Are you pregnant or do you suspect that you may be pregnant? Yes _____ No _____

10. Have you ever tried acupuncture or Chinese medicine before? Yes _____ No _____

Name: _____

Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information.

(Pursuant to the requirement of "183.6(e) of this title (relating to Denial of License; Discipline of License) and Tex. Occ Code Ann., "205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the practitioners at Pecan Grove Acupuncture and Wellness Clinic of the following:

___ Yes ___No
I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (patient's initial) Date: _____

___ 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 2 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.
_____ (patient's initial) Date: _____

Patient's signature: _____ Date: _____

Note:
Exemptions according to Rule 183.6 (e) Scope of Practice

3)….. an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse**.

PAYMENT OF SERVICES

Name: _____

Payments for all services are due on the day of service. While we do not accept insurance, we will be happy to provide you with a receipt upon request for the patient's personal use in filing for reimbursement. Acupuncture treatment coverage by insurance carriers varies by policy and company. Please check with your insurance company to determine eligibility for benefits. Acupuncture is a lawfully deductible medical expense for purposes of U.S. Federal Income Tax. Acupuncture treatment is currently not covered by Medicare.

All herbal prescriptions are prepared specifically for you. There will be **NO REFUNDS** on herbal prescriptions. Please understand that this is for the safety of you and other patients.

Please understand that in the event that you must cancel your appointment, we do ask that you kindly give us 24 hours' advance notice. Otherwise, we will be obliged to charge $25 for the missed appointment.

Patient's signature: _____ Date: _____

Department of State Health Services Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective July 20, 2015), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please be specific):

_____

_____

_____ _____

Employee Signature Date

Name: _____

ACUPUNCTURE 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, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally 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 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 potential risks of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 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.

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.

Pecan Grove Acupuncture and Wellness Clinic

Patient's signature: _____ Date: _____