Marshall Acupuncture
& Herb Clinic

Welcome to Our Clinic!

Marshall Acupuncture and Herb Clinic strives to provide high-quality, individually focused healthcare to each of our patients. In order to provide the best care possible, we have some clinic policies in place that require your support.

Scheduling and Payment Policies

• A 24 hour notice is required for cancellation or rescheduling, otherwise you will be billed for the full cost of the appointment time. If the appointments have been purchased as a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.
• Office hours are by appointment.
• If you are late to your appointment, that appointment will be shortened in order to complete the treatment at the scheduled time.
• Full payment is expected at time of service. We accept cash, check, and major credit cards. We are able to provide you with a receipt upon request. There is a $25 fee for returned checks.
• We are not responsible for any billing associated with your insurance. A receipt for your office visit will be provided upon request; you have the option to check with your insurance carrier to see if reimbursement is possible.

Our Fees:

Acupuncture Services:

New Patient Acupuncture (105 min) *Your first visit includes an extra 45 minutes of consultation.*	$170
Acupuncture Treatment (60 min)	$85
Facial Rejuvenation Acupucture (90 min)	$150
Extended Treatment (90 min)	$130
Herbal or Health Consultation (35 min)	$45
Yi Jing consultation (60 min) *Chinese astrology & numerology*	$100
New Patient, 12yrs and under (60 min)	$85
Acupuncture Treatment, 12yrs and under (30 min)	$45

ACKNOWLEDGEMENT OF RECEIPT OF CLINIC POLICIES

I have read, understood, and agree to the office policies for healthcare services at Marshall Acupuncture and Herb Clinic:

_____

Signature Date

NOTICE OF PRIVACY POLICIES (HIPAA)

Callan Welder and Marshall Acupuncture Clinic are dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Appointment Reminders

We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

Disclosure

The Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1.Upon written request you have the right to access, review or receive copies of your healthcare records.

2.Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.

3.You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

4.You have the right to request that we amend your Protected Health Information; the request must be in writing.

5.You have a right to receive all notices in writing.

If you have questions, complaints or want more information:

Contact: Marshall Acupuncture and Herb Clinic Telephone: 828-649-9601

Address: 177 Baileys Branch Rd., Suite 2, Marshall, NC 28753

To send a written complaint to the U.S. Department of Health and Human Services: DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services provided by Callan Welder and Marshall Acupuncture Clinic.

_____

Signature/Date

INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists at Marshall Acupuncture and Herb Clinic. I understand that acupuncturists practicing in the state of North Carolina 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 practitioner. I understand that I may refuse any of the following treatments at any time:

Acupuncture: I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, 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 may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

Moxibustion: Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin, intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa.

Electro-Acupuncture: I understand that I may receive electro-acupuncture, which involves the stimulation of acupuncture points with a mild electric current. This treatment is stimulating but not typically painful or shocking. I am aware that certain adverse side effects may result from this treatment., including, but not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

Gua Sha/Cupping: I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soupspoon. Cupping applies localized suction to the skin with glass cups, drawing the superficial muscle layer into the cup. Both are used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, soreness, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

Acupressure/Tui Na Massage: I understand that I may receive acupressure or tui na massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: I understand that Chinese herbs may be recommended as part of my treatment. 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 effects may result from taking these substances. These may 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. If I associate any concerns with the use of the herbal substances, I should stop use immediately and call my acupuncturist.

Dietary & Exercise Advice: In conjunction with my treatment, I may be given advice and suggestions concerning changes in diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Suggestions concerning physical activity and exercises may also be included in my treatment. I will communicate with my practitioner about any difficulties I may have with specific dietary or exercise recommendations.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with acupuncture or herbal medicine.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information. 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 Relationship to patient, if applicable

Marshall Acupuncture & Herb Clinic

177 Baileys Branch Rd., Suite 2
Marshall, NC 28753
(828) 649 - 9601
www.marshallacupuncture.com

Patient Health History

Please complete this questionnaire as thoroughly as possible so we can create the best treatment plan for you. All your answers will be held absolutely confidential. If you have any questions about this form, please ask.

Name: _____ Date: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Weight: _____ Height: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Marital Status: single married divorced widowed partnered

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about Marshall Acupuncture & Herb Clinic? _____

_____

Have you ever used Chinese medicine for your health care? _____

If so, for what reason? _____

_____

MAIN CONCERNS

Please indicate your top 3 health concerns and how long you have been experiencing them:

1. _____
2. _____
3. _____

Western Medical Diagnosis, if any: _____

What goals would you like to achieve with our sessions? _____

_____

GENERAL HISTORY

How many hours of sleep do you average each night? _____ Do you experience: ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Wake up groggy, unrested ☐ Nightmares ☐ Vivid dreams ☐ No dreams

How many bowel movements do you average per day or week? _____

Are your bowel movements: ☐ Well-formed ☐ Loose/broken ☐ Small pebbles ☐ Skinny ☐ Difficult to pass

Please list any medications, vitamins or supplements you are taking: _____

_____

_____

List any serious illnesses, accidents or surgeries and the date they occurred: _____

_____

_____

Do you have any infectious diseases: Y / N If yes, please identify: _____

EMPLOYMENT

Occupation:_____ Company Name: _____

Most of the day is spent: ☐ Sitting ☐ Standing ☐ Very active

Do you enjoy your work? Y / N What activities/hobbies do you most enjoy doing? _____

_____

How would you rate your energy level on a scale from 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale from 1-10, with 10 being the highest: _____

FAMILY MEDICAL HISTORY

Please check any condition that applies to your immediate family. Then put a F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) next to the condition.

☐ Diabetes _____ ☐ Seizures _____ ☐ Heart Disease _____ ☐ Stroke _____

☐ Cancer _____ ☐ Allergies _____ ☐ Mental Illness _____ ☐ Asthma_____

☐ Kidney Disease_____ ☐ Lung Disease _____ ☐ Substance Abuse_____

☐ Other:_____

PERSONAL HEALTH HISTORY

Please check any that you have or have had in the past year.

MUSCLE/JOINT/BONES

☐ Tremors	☐ Arthritis	☐ Swollen Joints	☐ Cramps
Pain, weakness, numbness in: ☐ Back		☐ Feet	☐ Hips
☐ Neck/shoulders	☐ Arms or legs	☐ Hands	☐ Other: _____

EYES, EARS, NOSE, THROAT, RESPIRATORY

☐ Asthma/wheezing	☐ Enlarged glands	☐ Hoarseness	☐ Persistent cough
☐ Blurred or failed vision	☐ Eye dryness or irritation	☐ Gum trouble	☐ Ringing in ears
☐ Shortness of breath	☐ Frequent colds	☐ Nose bleeds	☐ Sinus problems
☐ Earaches	☐ Hay fever/allergies	☐ Hearing loss	☐ Headaches/migraines

SKIN & HAIR

☐ Itching/rash	☐ Dry skin	☐ Sweats easily	☐ Bruise easily
☐ Boils	☐ Sensitive skin	☐ Eczema	☐ Hair loss
☐ Slow wound healing	☐ Psoriasis	☐ Brittle hair or nails	☐ Acne

GENITO/URINARY

☐ Blood/pus in urine	☐ Inability to control urine	☐ Kidney disease	☐ Painful urination
☐ Frequent urination	☐ Kidney stones	☐ Lowered libido	☐ Urinary dribbling

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High/low blood pressure
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Swelling of ankles
- ☐ Irregular heartbeats
- ☐ Blood clots
- ☐ Palpitations/fluttering
- ☐ Heart murmurs
- ☐ Fainting
- ☐ Stroke

GASTROINTESTINAL

- ☐ Belching, gas, bloating
- ☐ Food allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Abdominal pain/cramps
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Gallbladder trouble
- ☐ Hemorrhoids
- ☐ Acid reflux/GERD
- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Liver disease
- ☐ Bad breath

EMOTIONAL/MENTAL

- ☐ PTSD/Trauma
- ☐ Depression
- ☐ Frequent crying
- ☐ Obsessive/compulsive
- ☐ Anxiety/Stress
- ☐ Mood swings
- ☐ Loneliness
- ☐ Eating disorder
- ☐ Addiction
- ☐ Excessive fear/worry
- ☐ Lack of motivation
- ☐ Pessimistic thinking
- ☐ Panic attacks
- ☐ Angry outbursts
- ☐ Suicidal thoughts

OTHER

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Colon polyps
- ☐ Dizziness
- ☐ Breast lump
- ☐ ADD/ADHD
- ☐ Fatigue/tiredness
- ☐ Cancer
- ☐ Night sweats
- ☐ Diabetes

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Prostate trouble
- ☐ Testicular pain/swelling
- ☐ STDs _____
- ☐ Penile discharge
- ☐ Interrupted urination
- ☐ Sexual difficulties

FOR WOMEN ONLY

- ☐ Bleeding between cycle
- ☐ Clots in menses
- ☐ Scanty menstrual flow
- ☐ STDs _____
- ☐ Heavy flow
- ☐ Extreme menstrual pain
- ☐ Breast tenderness
- ☐ Painful intercourse
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Ovarian cysts
- ☐ Excessive/odorous vaginal discharge
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Fibroids

Could you be pregnant? Y / N

Is there anything else that you would like us to know before your treatment? _____

_____

_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature: _____ Date: _____