



## HEALTH OFFERINGS, INC.

Lisa C. Smith, L.Ac., Dipl. Ac. (NCCAOM)

VA License #0121000050

PO Box 8361

Richmond VA 23226

### **Informed Consent for Acupuncture Treatment and Care**

I, \_\_\_\_\_, hereby request and consent to the performance of acupuncture and TCM procedures within the scope of practice for acupuncture in the state of Virginia by licensed acupuncturist, Lisa C. Smith of Health Offerings, Inc. for me or the person for whom I am legally responsible. Licensed acupuncturist, Lisa C. Smith of Health Offerings, Inc. has discussed the nature and purpose of my treatment with me.

\_\_\_\_\_ **I understand that if I'm having a Medical Emergency I should call 911 or go to the nearest emergency room.**

#### **Treatment (please initial each):**

\_\_\_\_\_ I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion (heat therapy), cupping (manual therapy), Tui Na (Chinese medical massage), Chinese and Western herbal supplements, and diet and food therapy, and lifestyle recommendations.

\_\_\_\_\_ I understand that acupuncture is a medical procedure performed by inserting filamentous needles through the skin.

\_\_\_\_\_ I understand that I should not move while needles are being inserted, retained, or removed.

\_\_\_\_\_ Acupuncture is not meant to be a substitution for standard medical care, and I agree to see my primary care physician or specialist within six months of starting acupuncture treatment.

\_\_\_\_\_ I will inform Health Offerings Inc. of any and all prescription medicine I am taking. I will inform Health Offerings Inc. prior to treatment if I am currently taking a prescribed pain medication. I will not arrive under the influence of recreational drugs or alcohol.

\_\_\_\_\_ I understand that acupuncture may be considered an investigative treatment in the United States. I also understand that no claims are made for acupuncture or herbs to cure any specific disease. Furthermore, I understand that all information given is for educational purposes only and that there are no guaranteed results. I do not expect Health Offerings, Inc. to be able to anticipate and explain all risks and potential complications of treatment, but to exercise her professional judgment during the course of treatment.

\_\_\_\_\_ I understand there are some possible side effects of the above treatments including but not limited to temporary pain or discomfort, bruising, slight bleeding, swelling, or a temporary aggravation of symptoms known as a healing reaction which typically subsides within 24-48 hours.

\_\_\_\_\_ I understand that Lisa C. Smith, L.Ac of Health Offerings, Inc. follows VA state law and uses ONLY disposable, one time use acupuncture needles.

\_\_\_\_\_ I have truthfully disclosed my complete medical history regarding blood borne, contagious diseases such as HIV/AIDS and hepatitis.

\_\_\_\_\_ Female Patients: I will inform Health Offerings, Inc. immediately should I become pregnant.

**Female Patients:**  I am pregnant;  I am NOT pregnant    **Date:** \_\_\_\_\_

## General Information and Office Policies

### Appointments and Cancellations (please initial each):

\_\_\_\_\_ I understand that all treatments are by scheduled appointment only.

\_\_\_\_\_ I understand that if I am more than 15 minutes late for my appointment I will have to reschedule.

\_\_\_\_\_ I understand that if I need to change or cancel my appointment I must do so at least 24 hours in advance.

\_\_\_\_\_ *I understand that if I cancel a scheduled appointment less than 24 hours in advance, or if I don't show up for a scheduled appointment, I will be required to pay in full for the missed appointment. (The only exceptions that will be made are for sudden illness, emergency situations, or snowstorms.)*

\_\_\_\_\_ I understand that Lisa C. Smith Lac. of Health Offerings, Inc. does not text or email with her patients.

\_\_\_\_\_ **Payment:** I understand that payment is due at the time of service. Payment may be made in the form of Cash, Check, American Express, Discover, Visa or MasterCard. There is a \$30.00 charge for returned checks.

\_\_\_\_\_ **Insurance:** I understand that Health Offerings, Inc. does not accept insurance as a method of payment. Health Offerings, Inc. does not file insurance claims or accept third-party insurance payments. However, acupuncture is frequently covered by Health Savings Accounts (HSAs) and Medical Savings Accounts. The IRS recognizes acupuncture as a deductible medical expense so save your receipts if you itemize your taxes. If you plan to submit insurance claims, please contact your insurance provider for your coverage information which would include: the number of visits allowed per year, amount of the copay, if required. If you do choose to pursue reimbursement, it is helpful to obtain the applicable ICD-10 diagnostic codes

from your physician. Lisa C. Smith, L.Ac. of Health Offerings, Inc. will create a SuperBill for you to submit.

### Medical Records

\_\_\_\_\_ I understand that all records are secured to protect patient privacy by Health Offerings, Inc. and are confidential. My file will be kept for six years from the date of my last treatment. After this time, my records will be destroyed. No electronic records are created or available. This office follows all applicable HIPAA compliance procedures. A signed Medical Records Release form is required prior to the release of any patient records requested by courts or insurance companies, and a Consent to Confer is required between other members of the health care team prior to any confidential discussion of my case. You may submit a written request at any time to review your chart or request a copy of your medical records for acupuncture care as dictated by Virginia law. This is subject to copy fees.

\_\_\_\_\_ I understand that any forms requiring more than 15 minutes to complete for insurance companies and/or attorneys/self are subject to my hourly rate billed in 10 minute increments due upon completion.

\_\_\_\_\_ I have read all the above (or have had it read to me), and I have had the opportunity to ask questions regarding the above information. I agree to all the above and intend for this consent to cover the duration of all treatments unless I revoke this agreement in writing.

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Representative Party \_\_\_\_\_  
(e.g. Power of Attorney, Guardian, Parent for minor - if necessary)

Acupuncturist's Name \_\_\_\_\_ Date \_\_\_\_\_

Acupuncturist's Signature \_\_\_\_\_

## HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be kept absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the comments section. Thank you.

Name: _____	
Street: _____	City: _____ State: _____ Zip: _____
Age: _____	Height: _____ Weight: _____ Email: _____
Home Phone: _____	Work: _____ Cell: _____
Date + Place of Birth: _____	Social Security #: _____
Occupation: _____	Marital Status: _____
Emergency Contact /Phone: _____	
Primary Care Physician: _____	OBGYN: _____
Other Specialist or Healthcare Provider(s): _____	
Have you tried acupuncture or Chinese herbal medicine before? _____	

Comments section. Thank you.

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: \_\_\_\_\_

To what extent does this problem affect your daily activities (work, sleep, eating, etc)? \_\_\_\_\_

How long has it been since you first noticed any symptoms? \_\_\_\_\_

Have you been given a diagnosis for the problem by a physician? \_\_\_\_\_

If so, what is the diagnosis? \_\_\_\_\_

What kinds of treatment have you tried? \_\_\_\_\_

PAST MEDICAL HISTORY (Please include dates):

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies _____                                  | <input type="checkbox"/> Cancer _____           |
| <input type="checkbox"/> Diabetes _____                                   | <input type="checkbox"/> Hepatitis _____        |
| <input type="checkbox"/> High Blood Pressure _____                        | <input type="checkbox"/> Heart Disease _____    |
| <input type="checkbox"/> Seizures _____                                   | <input type="checkbox"/> Rheumatic Fever _____  |
| <input type="checkbox"/> Surgeries _____                                  | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Thyroid Disorder _____                           |   |
| <input type="checkbox"/> Other significant illness (describe) _____       |   |
| <input type="checkbox"/> Accidents or Significant Trauma (describe) _____ |   |

Birth History (prolonged labor, forceps delivery, C-section, etc) \_\_\_\_\_

OTHER RELEVANT MEDICAL HISTORY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY MEDICAL HISTORY (please list whom):

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____    | <input type="checkbox"/> Stroke _____              |                                      |
| <input type="checkbox"/> Seizures _____  | <input type="checkbox"/> Asthma _____              |                                      |
| <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> High Blood Pressure _____ |                                      |

OCCUPATION: \_\_\_\_\_

Occupational stress factors (physical, psychological, chemical): \_\_\_\_\_

LIFESTYLE:

Do you follow a regular exercise program? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Please describe your average daily diet: \_\_\_\_\_

Please check any of the following habits that apply. Indicate how much and how often you consume them:

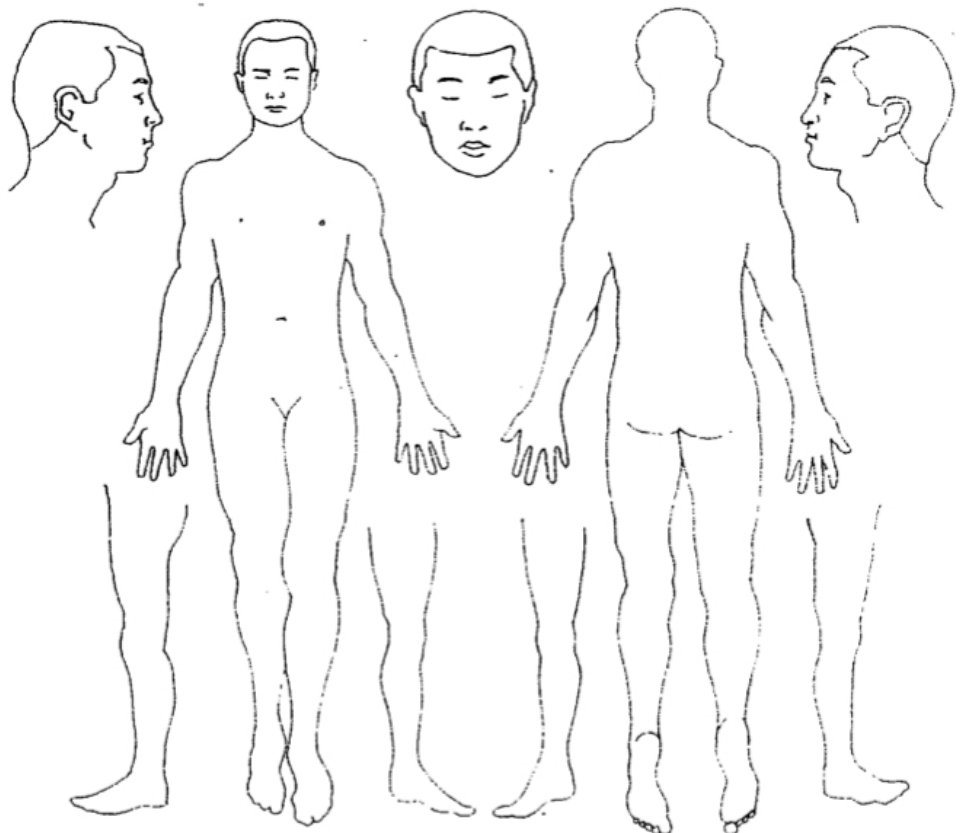
- Cigarette smoking \_\_\_\_\_  Coffee, Tea, or Cola \_\_\_\_\_  Alcoholic beverages \_\_\_\_\_

Medications taken within the last two months (including vitamins, drugs, herbs, etc) \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

INDICATE PAINFUL OR DISTRESSED AREAS (or circle appropriate adjectives):

Symbol	Reaction
Pain on pressure	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/Weakness	
≈	weak
#	tense
Spontaneous Pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	severe
Temperature	
-	colder
+	hotter
Physical	
⊗	sores
▽	rashes
⇒⇐	spasms



The following is a list of symptoms which you may or may not experience. Please indicate as follows:

       = never experience        o   = occasionally experience        +   = frequently experience

SECTION 1: QI

A. Deficiency

- catch cold easily
- fatigue easily
- shortness of breath
- sweat easily
- dizziness
- hard to project voice
- dull headache

B. Stagnation

- intermittent dull pain
- bloating &/or fullness
- sighing
- sensation of object caught in throat
- moodiness prior to menses

C. Rebellious

- cough &/or asthma
- vomiting
- belching, hiccups

D. Prolapse

- organ prolapse
- dizziness
- constant fatigue
- shortness of breath
- chronic diarrhea
- descending sensation

SECTION 2: XUE

A. Deficiency

- dizziness
- pale face & nails
- blurred vision
- palpitations
- numbness
- women: scanty menses

B. Stagnation

- localized sharp pain
- lumps, mass or tumor
- large red spots under skin
- women: painful menses
- irregular periods

C. Heat

- feverish
- irritable
- bleeding
- red, painful skin eruptions
- women: heavy menses

SECTION 3: YANG

A. Excess Heat

- feverish
- sweat easily
- thirsty
- constipation
- red face
- sore throat, mouth
- dark, scanty urine
- irritable

B. Deficient

- cold body & limbs
- low sex drive
- always tired
- sleep a lot
- water retention
- edema

SECTION 4: YIN

A. Excess Cold

- always cold
- frequent clear urine
- diarrhea
- abdominal pain
- worse with pressure
- symptoms relieved by heat or hot drinks
- clear discharge

B. Deficient

- feverish at night
- night sweats
- dry mouth/throat
- feverish palms and soles of feet
- irritable
- insomnia
- flushed cheeks

SECTION 5: JING

- premature gray hair loss
- tooth loss
- impotence
- no sex drive
- memory loss
- infertility

SECTION 6: BF

- hoarse voice
- dry mouth/skin
- dull, dry hair
- thirsty
- dry stools
- scanty urine
- dry eyes, nose

SECTION 7: WIND

A. External

- sneezing
- clear runny nose
- dislike of wind
- body & head achy
- nasal congestion
- chills & fever
- neck & shoulders achy

B. Internal

- spasms & tremors
- dizziness or vertigo
- stroke

- stiffness
- numbness
- convulsions
- seizures
- paralysis

SECTION 8: DAMP

- heaviness
- bloat & swelling
- edema
- nausea
- lack of thirst
- milky discharge
- loose stools
- weight gain

SECTION 9: PHLEGM

- chest fullness
- cough up mucous
- have to clear throat often
- decreased appetite
- wheezing
- dizziness
- mucous in stool

SECTION 10: LUNGS

- allergies, hay fever
- cough/asthma
- shortness of breath
- chest fullness/pain
- awoken 3-5 am
- grief & sadness
- crying a lot
- skin problems
- bronchitis
- sinusitis
- decreased sense of smell

SECTION 11: L.I.

- constipation
- burning sensation in anus
- hemorrhoids
- colitis
- diverticulitis
- recent antibiotic use
- blood in stool

SECTION 12: HEART

- palpitations
- anxiety
- insomnia
- excess dreams
- chest pain
- arm pain
- sores or ulcers on tongue
- hysteria
- forgetfulness
- nightmares
- laughing for no apparent reason

SECTION 13: S.I.

- bearing down sensation in groin or scrotum
- abdominal pain
- burning urination

SECTION 14: LIVER

- rib or flank pain
- depression
- frustration
- excess anger
- migraine headache
- vertigo
- ear ringing
- eyes red, painful
- poor vision
- poor nail growth

- soft or brittle nails
- headache on top of head
- jaundice
- hepatitis
- spasms or muscle twitch
- high cholesterol
- high blood pressure

SECTION 15: G.B.

- right trunk pain
- gall stones
- yellowing of skin
- bitter taste in mouth
- alternate chills & fever
- nausea
- vomit bitter fluids
- acid regurgitation
- frightens easily
- indecisive
- insomnia
- headache on side of head
- difficulty digesting
- oily foods
- light colored stool

SECTION 16: SPLEEN

- appetite low/none
- diarrhea
- abdominal bloat
- nausea
- bleeding
- organ prolapse
- worry too much
- obsessive in work relationships
- easily bruised
- sudden weight loss

SECTION 17: ST

- stomach ulcer
- stomach pain
- acid regurgitation
- nausea/vomiting
- swollen, painful gums
- bad breath
- always hungry
- headache on forehead & behind eyes
- heartburn
- indigestion
- gas
- feeling of retained food
- black "tarry" stool

SECTION 18: KIDNEY

- pain & weak low back
- knee problems
- deafness
- ear ringing
- sciatica
- incontinence of urine
- nocturnal emission
- sexual problems
- hair loss
- brittle bones
- osteoporosis
- infertility
- poor memory
- constant fear
- frequent clear urine
- scanty dark urine
- difficult urination

SECTION 19: U.B.

- painful burning urine
- bladder/kidney stones
- bloody/cloudy urine
- headache back of head

SECTION 20: L.S.

- overuse of alcohol
- smoke marijuana
- use cocaine
- smoke tobacco
- poor diet
- overeat
- use pharmaceuticals (list): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

SECTION 21: MEN

- prostate problems
- hernia
- pain or cold in genital area

SECTION 22: WOMEN

- pregnant?
- pre-menstrual pain or discomfort
- irregular cycle
- long cycle (+28 days)
- short cycle
- clotting
- light flow
- heavy flow
- light color
- dark color
- swelling/painful breasts

COMMENTS: If you currently have or previously had any health problems or surgeries which are not listed above, or if you wish to expand upon any of the above symptoms, please use the space below:

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## **Recommendations for Examination by a Physician**

I, Lisa C. Smith (VA lic#0121000050) recommend to you

\_\_\_\_\_ that you be

examined by a physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment.

*(Code of Virginia §54.1-2956.9, 18 VAC 85-110-10)*

\_\_\_\_\_  
Acupuncturist Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(On a separate sheet)

Instructions to Licensed Acupuncturist:

- The patient must sign and date the form.
- Make a copy of this form and retain the original in the patient's chart. Give a copy of the signed form to the patient.
- If the patient does not understand English, make sure the form is translated to the patient or provide the form in the patient's language.