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):

- ☐ Allergies _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Seizures _____
- ☐ Surgeries _____
- ☐ Thyroid Disorder _____
- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Heart Disease _____
- ☐ Rheumatic Fever _____
- ☐ Venereal Disease _____
- ☐ Other significant illness (describe) _____
- ☐ Accidents or Significant Trauma (describe) _____

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

_____

OTHER RELEVANT MEDICAL HISTORY:

_____

_____

_____

FAMILY MEDICAL HISTORY (please list whom):

- ☐ Allergies _____
- ☐ Cancer _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Asthma _____
- ☐ High Blood Pressure
- ☐ Other _____
  _____

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) _____

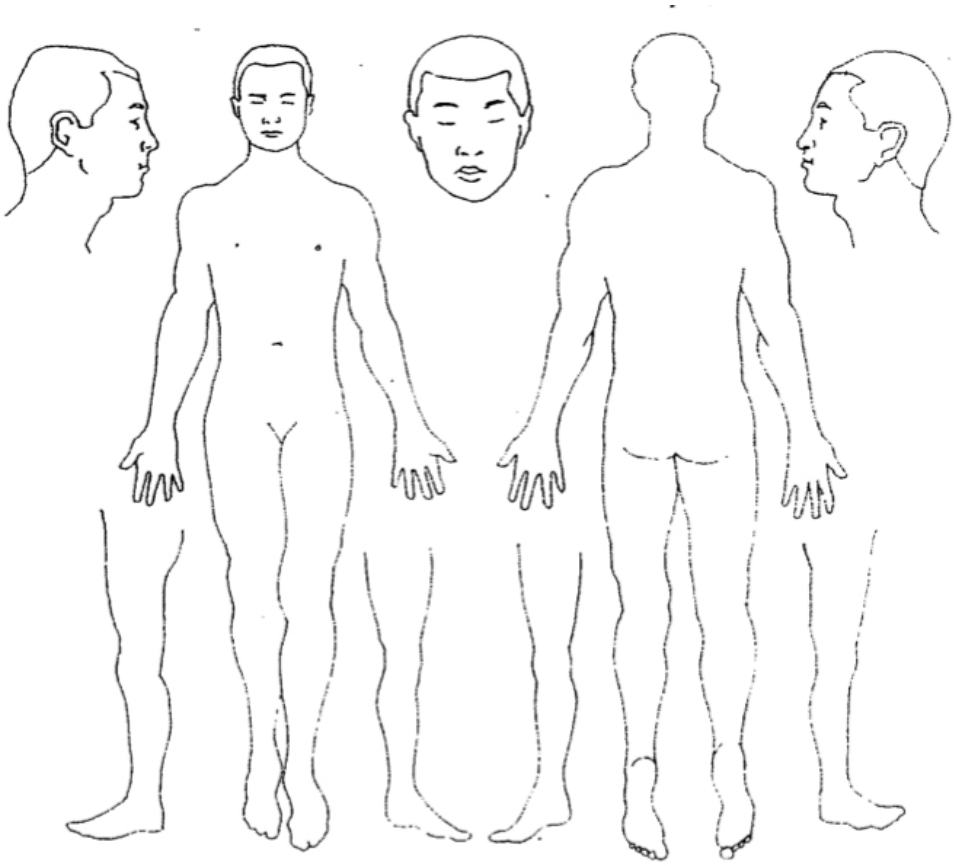
_____

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 XX XXX	little moderate strong
Swelling	
∧ ∧ ∧ ∧ ∧ ∧	slight moderate severe
Tension/Weakness	
≈ #	weak tense
Spontaneous Pain	
† †† †††	slight moderate severe
Pulsing	
o oo ooo	slight moderate 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
___ awaken 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 with so expand upon any of the above symptoms, please use the space below:

Please list any vitamins that you take regularly:

Please list any prescription medications you take regularly:

Please list any surgeries you have had, and the year it was performed:

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.