INFORMED CONSENT TO TREAT

Single Point Acupuncture, LLC

I hereby request and consent to the performance of acupuncture and other procedures within the scope of acupuncture practice, as well as energy work as defined and performed by the practitioners of Single Point Acupuncture LLC, on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working for or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office of Single Point Acupuncture or any other associated 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 (Asian Bodywork manual therapy), energetic therapy (Reiki or Medical Qigong), Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment that involves the insertion of fine, sterile needles into the body, but that it and the other services provided by this clinic may have some side effects including, but not limited to; bleeding, bruising, numbness or tingling related to the needling sites, dizziness, light headedness or fainting, aggravation of pre-existing symptoms, blisters, itching and redness. I understand that burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps, and that bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, stroke 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.

Should I wish to follow an herbal recommendation, I understand that herbs and teas need to be prepared and consumed according to the instructions provided orally and in writing. Some herbs may have an unpleasant smell or taste. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that are 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 the clinical staff member who is caring for me as soon as possible of any unusual or unexpected effects caused as a result of taking herbs. I will also notify this clinic and my practitioner if I am pregnant or wish to become pregnant.

I do not expect practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner, to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I also understand that the practitioners who treat me are not allopathic practitioners or doctors and that any treatment or advice provided by them or by anyone working in conjunction with or on behalf of them or this clinic is not a substitute for diagnosis or care by an allopathic doctor or practitioner. Rather, I understand that any services provided are solely meant to support the health process. I also understand that any results are not guaranteed.

I agree to give full and accurate information to my practitioner and this clinic regarding any past or current health conditions; including present complaints, medications, health risks or other current information as well as past hospitalizations, illnesses or surgeries. I acknowledge that this includes notifying my practitioners in as timely a manner as appropriate of any changes to my health state after the submission of this form, including any adverse reactions, questions or concerns that I may have in relation to treatment.

By signing and submitting this document, I acknowledge 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 as well as the other modalities provided, 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.

Provider Company: Single Point Acupuncture, LLC

Acupuncturist: Laura Gillis, L.Ac.

_____	_____
Patient Name (Print)	Legal Guardian Name (If Applicable)
_____	_____
Patient Or Legal Guardian Signature	Date

HIPAA Acknowledgement and Appointment Reminders Form

Single Point Acupuncture, LLC

I acknowledge that I have been provided access to the Single Point Acupuncture "Notice of Privacy Practices". I understand that I have the right to review Single Point Acupuncture's "Notice of Privacy Practices" prior to signing this document.

I understand that Single Point Acupuncture staff members may need to contact me with appointment reminders or information related to my treatments. This contact may be made by phone or email. If this contact is to be made by phone, and I am not at home, a message will be left on my phone or answering machine voicemail or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners of Single Point Acupuncture. By signing this form, I am giving Single Point Acupuncture and its support associates authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____	_____
Patient Name (Print)	Legal Guardian Name (If Applicable)
_____	_____
Patient Or Legal Guardian Signature	Date

Financial Policy and Cancellation Policy
Single Point Acupuncture, LLC

Cost of Goods and Services

I understand that I am personally and fully responsible for the cost of goods and services provided by Single Point Acupuncture LLC and that payment is due in full at the time that services are rendered. Forms of payment accepted are cash, check, Visa, Mastercard, Discover and American Express.

I also understand that I will be responsible for a $25 fee for any returned checks. Please note that Single Point Acupuncture does not accept out-of-state checks and that a driver's license id may be requested for any in-state checks.

Cancellations

I understand that Single Point Acupuncture LLC has a cancellation policy whereby I must give at least 24 hours advanced notice of cancellation of my appointment or else I will be subject to a $40 cancellation fee. I understand that Single Point Acupuncture LLC will make exceptions for inclement weather and for certain emergency situations but that it is at the discretion of the practitioners of Single Point Acupuncture to do so.

Late Arrivals

I understand that by arriving late to appointments I am disrupting my practitioner's schedule and the treatments of subsequent clients. Because of this, I understand that if I am just a few minutes late for my appointment (a few minutes to 5 minutes or so) that the appointment will likely proceed but that the appointment may have less time and that I will still be charged in full.

I also understand that if I am significantly late for an appointment (10 minutes or more) that my appointment may need to be cancelled and rescheduled. In the event that this should happen, I understand that I am subject to Single Point Acupuncture's cancellation policy and that I may be charged a $40 cancellation fee.

If you find that you may be late for an appointment or may need to cancel an appointment, please call and we will do our best to accommodate and make new arrangements for you.

_____ _____

Patient Name (Print) Legal Guardian Name (If Applicable)

_____ _____

Patient Or Legal Guardian Signature Date

Authorization for Release of Health Information (Optional)

Single Point Acupuncture, LLC

I hereby authorize Single Point Acupuncture LLC and its associates the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____
Patient's Name (Print)

_____
Name of Legal Guardian (If Applicable)

_____ _____
Patient's Signature (Or Legal Guardian) Date

Medical History Form

Last Name:	First:	Middle:	Date:
DOB:	Age:	Sex: Male ☐ Female ☐ Transgender ☐	
Profession:			
Address:			
City:	State:	Zip:	Email:
Cell Phone:	Home Phone:		Work Phone:
Emergency Contact Name:		Phone Number:	
Doctor's Name:		Phone Number:	
Doctor's Address:			
How did you hear about us?			
Have you ever had acupuncture before? Yes ☐ No ☐			
What is the primary reason for your visit today?			
Does anything make it better?			
Does anything make it worse?			
How long have you had this issue?			
What is the cause of this issue?			
Additional Info:			
Do you have any secondary health issues that you would like us to address today, if possible?			
Are there any special considerations that you would like us to know about? (e.g. sensitive to smells, fear of needles, etc.)			
Do you exercise? Yes ☐ No ☐			
If yes, what kind and how often?			
Do you smoke? Yes ☐ No ☐			
If yes, what and how often?			
Do you drink alcohol? Yes ☐ No ☐			
If yes, how much and how often?			
Do you use recreational drugs? Yes ☐ No ☐			
If yes, what, how much and how often?			
Have you ever struggled with addiction?			
If yes, please describe:			
How many hours of sleep do you get per night on average?			
Do you wake in the morning feeling rested? Yes ☐ No ☐			
Do you wake in the middle of the night? Yes ☐ No ☐ If yes, how often?			
Do you have any infectious diseases? (e.g. MRSA, TB, AIDS, etc.)			
If yes, please list and indicate for how long:			
Do you have a blood clotting disorder?			
If yes, please list and describe current treatment:			

Medical History

List any and all medications and supplements that you are currently taking, along with dosage and duration (including how long you have been taking): *Attach additional page if needed

Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:
Medication:	Dosage:	Duration:

List any and all surgeries you have had:

Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

List any chronic illnesses and diagnoses:

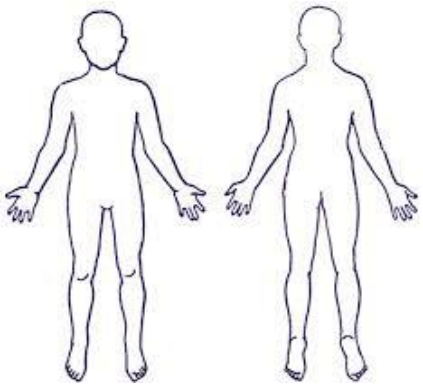
Diagnosis:	Date:
Diagnosis:	Date:
Diagnosis:	Date:
Diagnosis:	Date:
Diagnosis:	Date:
Diagnosis:	Date:

How would you describe your current state of health?

Are you currently in pain? (If yes, please indicate where and to what level) Yes: ☐ No: ☐

Level: None ☐ 1 - 2 Low ☐ 3 - 4 ☐ 5 - 6 ☐ 7 - 8 ☐ 9 - 10 ☐

Please indicate where you are experiencing pain:



Comments (e.g. notes about how long have had the pain, causes, etc.):

Medical History

Women

Number of pregnancies: | Number of live births:

Are you currently pregnant or is there a chance that you might be pregnant? Yes ☐ No ☐

If no, are you seeking to become pregnant? Yes ☐ No ☐

Have you gone through menopause? Yes ☐ No ☐ | Age:

Have you had a hysterectomy? Yes ☐ No ☐ | Age:

Are you currently menstruating? Yes ☐ No ☐

Number of days between cycles: | Days of bleeding:

Color / Shade: | Amount: Heavy Moderate Light Combination

PMS? Yes ☐ No ☐ | Painful ovulation? Yes ☐ No ☐

Clotting? Yes ☐ No ☐

Describe any unusual odor or discharge:

Please list any other irregularities that you are experiencing with your menstrual cycle:

Have you had a baby in the past 12 months? Yes ☐ No ☐

Have you ever miscarried? Yes ☐ No ☐ If yes, within the past 12 mo? Yes ☐ No ☐

Please list any other female concerns you may be having:

Men

Are you experiencing erectile dysfunction? Yes ☐ No ☐

If yes, please describe:

Do you have any groin pain, itching or irritation? Yes ☐ No ☐

If yes, please describe:

Do you experience premature ejaculation? Yes ☐ No ☐

Do you experience dribbling or any unusual discharge from your penis? Yes ☐ No ☐

If yes, please describe:

Have you ever been diagnosed with prostate problems? Yes ☐ No ☐

Are you and your partner seeking to become pregnant? Yes ☐ No ☐

Please list any other male concerns you may be having:

Please indicate any that apply:

Symptom or Disease	Past	Current	Symptom or Disease	Past	Current
Pain during sex			Herpes (genital)		
Lack of interest in sex			Herpes (mouth sores)		
Impotence			Genital Warts		
Reduction in sexual function			Trichomoniasis		
Bleeding after intercourse			Human Papillomavirus (HPV)		
Pelvic Pain			Unusual sores		
Cysts or Lumps			AIDS / HIV		
Hot flashes			Pelvic Inflammatory Disease (PID)		
Night sweats			Chronic Bladder Infections		
Mood swings			Dribbling		
Irritability			Incontinence		

Other:

Note any recent changes in relationship status:

Number of sexual partners:

Medical History

Please indicate any that apply:

Symptom or Disease	Past	Current	Symptom or Disease	Past	Current
Neck Pain			Tuberculosis (TB)		
Back Pain			Hepatitis		
Shoulder Pain			(*Note Type):		
Ankle Pain			Cancer		
Wrist Pain			Fibromyalgia		
Knee Pain			Chronic Fatigue		
Migraines or Frequent Headaches			Diabetes		
Dizziness			Hypoglycemia		
Vertigo			Neuropathy		
Fainting			Thyroid Disorder		
Seizures			ADHD		
Stroke			Panic Disorder		
Tremors			Bipolar Disorder		
Poor Balance			Schizophrenia		
Ear Pain			PTSD		
Hearing Loss			Crohn's		
Ear Ringing			Irritable Bowel Syndrome		
Poor Memory			Celiac		
Bells Palsy			Ulcerative Colitis		
Anxiety			Crohn's		
Insomnia			Irregular Heartbeat		
Depression			Hypertension		
Social Phobia			Hypotension		
Loss of Vision			Valve Disorder		
Glaucoma			Ischemia / Heart Attack		
Excessive Tearing			Palpitations		
Sinus Problems			Poor Circulation		
Nosebleeds			Edema		
Gum Problems			Multiple Sclerosis		
TMJ			COPD		
Acid Reflux / GERD			Weak Voice or Difficulty Breathing		
Nausea			Wheezing		
Abdominal Pain			Allergies		
Loss of Appetite			Speech Problems		

Other:

I attest that the information that I have provided is accurate and complete to the best of my knowledge:

Patient Signature		Date
Legal Guardian Signature		Date