Performance And Recovery Acupuncture

www.PARacupuncture.com

512. 900. 8494

Please Print

Last Name: _____ First name: _____ M.I._____

Gender:_____ Date of Birth: ___/___/____ Driver's License #:_____

Street Address:_____ City:_____

State:_____ Zip Code: _____ Cell phone: _____

Email (for appointment confirmations): _____

Acupuncture Request and Consent

I hereby request that the licensed acupuncturist(s) of Performance and Recovery Acupuncture (PAR Acupuncture) to treat me. I also authorize him/her to perform on me the treatment known as "Acupuncture" as his/her judgment may indicate, and further authorize him/her to use whatever therapeutic methods he/she may see fit, regardless of whether these methods are commonly and generally accepted and practiced in this community. I understand that acupuncture may include.

1) The non-surgical, non-incisive insertion of disposable needles in specific locations on the body;

2) Th recommendation of herbal dietary supplements;

3) The recommendation of energy-flow exercises or other prescribed forms of movement:

4) The collection of data and information regarding the functioning of various physical processes, by interrogation, observation, palpation, and other methods specific to the practice of acupuncture; and

5) The use of localized heat and/or electrical stimulation, whether alone or in combination with the other

The Acupuncturist has clearly explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards, and the possibilities of complications during or as a result of treatment. I understand the meaning of the term "complications", and in giving my consent to th treatment, I have in mind the Acupuncturists clear explanation. In the event that any unforeseen condition arises in the course of treatment, and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different than this now contemplated, I also request and authorize him/her to perform such treatments, use such procedures, or otherwise act in accordance with his/her professional opinion.

The Acupuncturist has made no guarantee or representation as to the results that may be obtained.

I understand that I am fully liable for payment of expenses associated with the acupuncturist's provision of acupuncture in accordance with the request and consent, and agree to pay or cause beyond the normal capabilities of the Acupuncturist, I understand that I may be referred to other competent practitioners including, but not limited to medical physicians or other practitioners.

_____ I also agree to give 24 hours notice if I am unable to make my scheduled appointment. I fully understand I may be charged the treatment fee if I miss an appointment without giving 24 hours of notice.

Patient/Guardian Signature: _____ **Date:** _____

PERFORMANCE AND RECOVERY ACUPUNCTURE
www.PARacupuncture.com
512. 900. 8494

Please Print

Medical Evaluation, Referral, or Recommendation

(Pursuant tot he requirements of 22 T.A.C 183.7 of the Texas State Board of Acupuncture Examiners' rule and Tex. Occ. Code Ann.205.351, governing the practice of acupuncture)

I *(name)*_____, am notifying the acupuncturist of the following:

_____**Yes** _____ **No,** I have been evaluated by a physician for the condition being treated within 12 (twelve) months before the acupuncture was performed.

_____**Yes** _____ **No,** I have been evaluated by a chiropractor for the condition being treated with 30 days before the acupuncture was performed.

Note: In the case of patients seeking treatment for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse: a referral by a physician, dentist, or chiropractor is not required.

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/Guardian Signature: _____ Date:_____

PERFORMANCE AND RECOVERY ACUPUNCTURE

www.PARacupuncture.com

512. 900. 8494

Notice of Privacy Policies

Performance and Recovery Acupuncture (PAR Acupuncture) is dedicated to providing service with respect for human dignity. Protecting your privacy and health care 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:

1: Information we receive from you.
2: Information we receive from other health care providers:
3: Information we receive from third-party payers.

This information is used for treatment, payment, and health care operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and health care operations.

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

Marketing: This office will NOT use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, or appointment reminders by calls, postcards, or letters. This office may send you information to support your health care, information about alternative treatments, and health-related services that may be of interest to you. Please advice this office if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you do not wish to receive such communication, you must advise our office in writing at our contact address.

Disclosure: This office may use or disclose your Protected Health Information when required by law. Without your consent or authorization, this clinic may disclose information about you only for the following purpose:

- To a public health agency, for the purpose such as controlling a disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate government authority.
- If you are incapacitated or it appears necessary to prevent serious harm to you or others.
- To health oversight authorities for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirement and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the united states military, national security or intelligence, or foreign service, to your authorized superiors or other authorized federal officials.

We may not disclose information about you for any other purpose without your written authorization, provided separately from your wirtten consent.

Patient Rights

- Upon written request you have the right to access, review or receive copies of your health care records.
- Upon written request you have the right to receive a list of items this office disclosed about your health care information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office. If you are not satisfied with how this office handles your personal information, you may submit a formal complain to DHHS (office of Civil Rights), 200 Independene Ave., S. W., Room 509F HHH Building, Washington, D.C 20201.

I, _____(printed name) **have read, reviewed, understand, and agree to the Notice of Privacy Policies for health care and/or other services provided through this office.**

Patient/Guardian signature: _____

PERFORMANCE AND RECOVERY ACUPUNCTURE
www.PARacupuncture.com
512. 900. 8494

PATIENT'S CONSENT
FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ (printed name) give consent to Performance And Recovery Acupuncture to use and disclose my individual identifiable health information or Protected health Information for the following specific purposes:

1: Providing treatment to me:
2: Relating to the payment of the service this office has rendered to me:
3: The general administrative operations this practice provides to me.

Protected Health Information is any information which includes:

1: Demographic information;
2: Information gathered by this practice as it relates to the past, present or future physical or mental health or condition.
3: Information gathered by this office for past, present or future payments for providing the health care services;

I understand I have the right ot request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or health care operations of the Clinic, but the Clinc is not required to agree to these restrictions. However, if the clinic agrees to a restriction that I request, that restriction is binding on the Clinic.

I understand I have the right to read and discuss the notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

Patient/Guardian signature:_____ Date:_____

PERFORMANCE AND RECOVERY ACUPUNCTURE
www.PARacupuncture.com
512. 900. 8494

Medical History

Please describe current health problem(s) for which you are seeking treatment. If you are not seeking a medical treatment please write, "Not Medical":

_____

_____

Date problem began: _____

Please Circle any significant illness(es) you have:

Cancer	Diabetes	Hepatitis	Seizures
Heart Disease	Pace-maker	High Blood Pressure	HIV
Emotional Disorder	Stroke	Low Blood Pressure	Other: Please indicate

Other:_____

What treatment(s) have you been receiving for the above condition(s)?

_____

Any accidents, surgeries, or hospitalizations? (include date)

_____

What medications and/or vitamins and/or herbal supplements are you taking?

_____

What are you doing to take care of yourself currently?

_____

Patient name:_____

Patient/Guardian signature: _____ Date:_____