Bree Dellerson, MS, L.Ac
Diplomate of Oriental Medicine (NCCAOM)
www.banyanacupuncture.com
425-698-7889

BANYAN ACUPUNCTURE

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other 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 (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage 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. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been 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 a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all by records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show 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 and other procedures, and have had an opportunity to ask questions. I intend this intent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patients with bleeding disorders or pacemakers, as well as pregnant patients, should inform the practitioner prior to receiving treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Bree Dellerson, MS, EAMP regarding cure or improvement of my condition. I hereby release Bree Dellerson, MS, L.Ac. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Signature of patient (or guardian if under 18) Date

Bree Dellerson, MS, EAMP. received a Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in 2008. She passed the National Board Examination by the National Committee for the Certification of Acupuncturists (NCCAOM) and is designated a Diplomate of Oriental Medicine. She is currently a Licensed Acupuncturist in the State of Washington, holding Acupuncture License number AC60067336.

updated 9/13

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BANYAN ACUPUNCTURE

OFFICE POLICIES AND PROCEDURES

Initial Appointments:

- All initial paperwork must be completed and signed prior to your scheduled appointment. Please arrive at least 15 minutes early to fill out paperwork. If you fax a copy, originals should be brought to our office at your visit.
- Any changes in scheduled first appointments must be made at least 2 business days in advance. Missed or late changed appointments will be charged at the full visit rate.

Cancellations and Changes:

- As a courtesy, our office will call or email you to confirm your appointment at least 1 business day in advance.
- If you cannot keep a scheduled appointment, you must notify us a minimum of 1 business day prior to your scheduled time, or you will be charged for the missed appointment.
- Patients who forget their appointment or cancel less than 1 business day prior to their appointment **will be required to pay the cost of one treatment.** If you have purchased a treatment package, then that treatment will be dedcuted from your series. Please understand that a missed appointment could have gone to a patient on the waiting list. Reminder calls from our offic are made as a courtesy. Patients are responsible for their scheduled appointments.
- We understand that situations occur where it is in the best interest of both the client and provider to terminate the relationship. In these cases, we will do our best to refer the client to someone who may better meet their needs. However, we do maintain the option to deny services to anyone at any time.

Your Visits:

- As a courtesy to patients with allergies and chemical sensitivities, please refrain from wearing perfumes or heavily scented products when in our office. Please turn off or silence your cell phone while in our office.
- We value our patients' time. In order to keep on schedule, we request that you arrive on time for your appointments. If you are more than 15 minutes late for a scheduled appointment, we may not be able to see you and will treat it as a missed appointment. Please allow sufficient travel time and take traffic conditions into consideration.
- Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.

Herbs, Supplements & Prescriptions:

- If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.

Payment:

- Payment is due at the time of your appointment, unless alternate financial arrangements have been made.
- Accepted methods of payment are check and cash. Credit cards are accepted with an additional 3% fee.
- If there are non-sufficient funds (NSF) to cover checks written, it is our policy to charge a $35 processing fee.

Insurance:

- In order to help control your health care costs, our office does not directly bill insurance companies. A "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you for each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services and conditions may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. Our office does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

I have read, understand, and agree to the appointment punctuality and cancellation notice request.

Signature _____ Date _____

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BANYAN ACUPUNCTURE

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Bree Dellerson, respects your privacy. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

The law protects the privacy of the health information I create and obtain in providing my care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations. State law requires me to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of my health care team will be recorded in your medical record and used to help decide what care may be right for you.
- I may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- In order to help control your health care costs, our office does not directly bill insurance companies. A "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you for each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services and conditions may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. Our office does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

For health care operations:

- I use your medical records to assess quality and improve services.
- I may use and disclose medical records to review the qualifications and performance of my health care providers and to train my staff.
- I may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services.
- I may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan
  - audit functions, including fraud and abuse detection and compliance programs.
  - accounting, legal, risk management and insurance services;

Your Health Information Rights:

The health and billing records I create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice;
- Ask me to restrict certain uses and disclosures. You must deliver this request in writing to me. I am not required to grant the request. But I will comply with any request granted;
- Request and receive from me a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice")
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. I have a form available for this type of request.
- Have me review a denial of access to your health information-except in certain circumstances;
- Ask me to change your health information. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records.
- When you request, I will give you a list of disclosure of your health information. The list will not include disclosures of third-party payors. You may receive this information without charge once every 12 months. I will notify you of the cost involved if you request information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give me your request in writing.
- Cancel Prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometime you can not cancel an authorization if its purpose was to obtain Insurance.
- For help with these rights during normal business hours, please contact: **Bree Dellerson at Banyan Acupuncture, 425-698-7889.**

My Responsibilities:

I am required to:
- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

I have the right to change my practices regarding the protected health information I maintain. If I make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting my office to pick one up.

To Ask for Help or Complain:

If you have questions, want more information, or want to report a problem about the handling of you protected health information, you may contact: **Bree Dellerson**. If you believe your privacy rights have been violated, you may discuss your concerns with me. You may also deliver a written complaint to Bree Dellerson. You may also file a complaint with the U.S. Secretary of Health and Human Services. I respect your right to file a complaint with me or with the U.S. Secretary of Health and Human Services. If you complain, I will not retaliate against you.

Other Disclosures and Uses of Protected Health Information:

Notification of Family and Others

- Unless you object, I may release health information about you to a friend or family member who is involved in your medical care. I may also give information to someone who helps pay for your care. I may tell your family or friends your condition and that you are in a hospital. In addition, I may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, I will not use or disclose it.

I may use or disclose your protected health information without your authorization as follows:

- With Medical Researchers; if the research has been approved and has policies to protect the privacy of your health information. I may also share information with medical researchers preparing to conduct a research project.
- To funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.
- To the Food & Drug Administration relation to problems with food, supplements and products.
- To Comply With Workers' Compensation Laws – if you make you makes workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
  -to prevent or reduce a serious, immediate threat to the health or safety
  -to protect health and safety
  -to report vital statistics such as births or deaths
  -to public health or legal authorities
  -to prevent or control disease, injury or disability
- To Report suspected Abuse or Neglect to public authorities
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when I receive a subpoena, court order or other legal process, or you are the victim of a crime.
- For Health & Safety Oversight Activities. For example, I may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask me to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require me to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, I may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

NOTICE OF PRVACY PRACTICES – ACKNOWLEDGEMENT

I keep a record of the health care services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

The Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or Legally authorized individual signature

Date

This form will be retained in your medical record.

PATIENT HEALTH HISTORY
CONFIDENTIAL

Date: _____

Full name: _____ Age: _____ Gender: _____

Address: _____ Height: _____ Weight: _____

_____ Date of Birth: _____

_____

Home phone: _____ Email address: _____

Work phone: _____ How do you prefer to be contacted? _____

Cell phone: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Emergency phone: _____

How did you hear about Banyan Acupuncture? _____

Have you had acupuncture before? ❑ Yes ❑ No If yes, where and when? _____

Please list the concerns that brought you here today:

	SYMPTOM	DATE FIRST NOTICED
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you been previously treated for these symptoms? ❑ Yes ❑ No If yes, by whom?

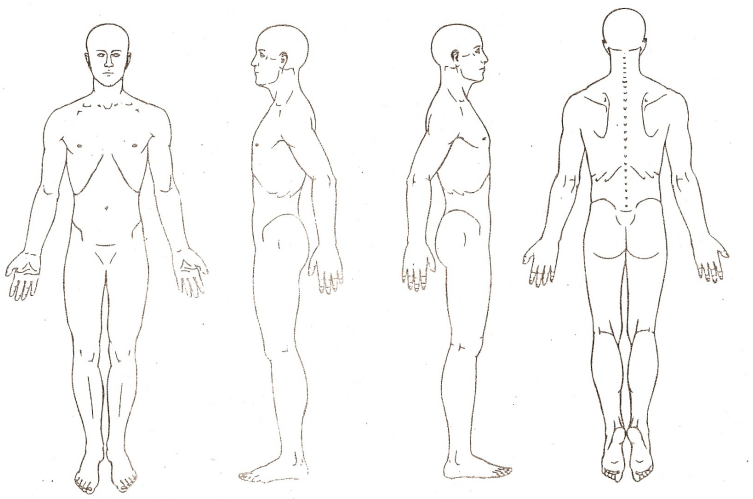
What was the diagnosis? _____

What was the treatment result? _____

Please list any allergies or sensitivities: _____

Please indicate where your symptoms are occurring:

BANYAN ACUPUNCTURE



Please describe any serious illnesses, trauma, or surgeries you have had: _____

_____

Please check any of the following medications you are currently taking or have taken within last 3 months:

❑ Allergy medication	❑ Chemotherapy	❑ Oral Contraceptives	❑ Ulcer Medication
❑ Antacids	❑ Cortisone	❑ Pain Medication	❑ Other:
❑ Anti-inflammatory	❑ Heart Medications	❑ Radiation	_____
❑ Antibiotic /Anti-fungal	❑ High Blood Pressure	❑ "Recreational" Drugs	_____
❑ Antidepressants	❑ Hormones	❑ Relaxants	_____
❑ Anti-diabetic/insulin	❑ Laxatives	❑ Sleeping Pills	_____
❑ Aspirin / Tylenol / Advil	❑ Lithium	❑ Thyroid	

What dietary supplements do you take regularly? _____

_____

Please describe your typical diet:

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

Do you: *(circle day or week, as appropriate)*

Use tobacco _____ packs per day/week How many years have you smoked? _____

Drink coffee _____ cups per day/week Drink black tea _____ cups per day/week

Drink alcohol _____ cups per day/week Drink sodas _____ cups per day/week

Do you exercise? ❑ Yes ❑ No If yes, please describe what kind and how often: _____

How would you describe your home life? _____

_____

Please describe any that apply:

	YOUR HISTORY	FAMILY HISTORY
Heart disease		
Cancer		
Hypertension		
Thyroid disorder		
Hepatitis		
Tuberculosis		
HIV/AIDS		
STDs		
Diabetes		
Seizures		
Stroke		
Neurological disorders		
Other (please specify)		

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NAME: _____

General *(check all that apply)*

PAST	NOW	CONDITION
❑	❑	fatigue
❑	❑	insomnia
❑	❑	fevers
❑	❑	chills
❑	❑	nightsweats
❑	❑	sweats easily
❑	❑	catch cold easily
❑	❑	other:

Skin/Hair

PAST	NOW	CONDITION
❑	❑	rashes/hives
❑	❑	itching/dryness
❑	❑	eczema
❑	❑	acne
❑	❑	jaundice
❑	❑	hair/nail changes
❑	❑	tumors/lumps
❑	❑	bleed/bruise easily
❑	❑	other:

Head & Neck

PAST	NOW	CONDITION
❑	❑	dizziness/vertigo
❑	❑	fainting
❑	❑	headaches
❑	❑	trauma
❑	❑	neck stiffness
❑	❑	enlarged lymph nodes
❑	❑	other:

Eyes

PAST	NOW	CONDITION
❑	❑____	glasses/contacts
❑	❑	blurred vision
❑	❑	poor night vision
❑	❑	spots/floaters
❑	❑	dryness
❑	❑	cataracts
❑	❑	pain/inflammation
❑	❑	discharge
❑	❑	other:

Ears

PAST	NOW	CONDITION
❑	❑	infection
❑	❑	ringing
❑	❑	decreased hearing
❑	❑	other:

Nose, Throat, Mouth

PAST	NOW	CONDITION
❑	❑	nosebleeds
❑	❑	sinus infections
❑	❑	post nasal drip
❑	❑	recurring sore throat
❑	❑	bleeding gums
❑	❑	tongue/mouth sores
❑	❑	strong thirst
❑	❑	difficulty swallowing
❑	❑	jaw clicks
❑	❑	other:

Respiratory

PAST	NOW	CONDITION
❑	❑	asthma
❑	❑	bronchitis
❑	❑	frequent colds
❑	❑	chest pain/tightness
❑	❑	COPD
❑	❑	pneumonia
❑	❑	cough
❑	❑	coughing blood
❑	❑	phlegm production
❑	❑	other:

Cardiovascular

PAST	NOW	CONDITION
❑	❑	high blood pressure
❑	❑	low blood pressure
❑	❑	palpitations
❑	❑	chest pain/tightness
❑	❑	blood clots
❑	❑	anemia
❑	❑	irregular heartbeat
❑	❑	cold hands/feet
❑	❑	swelling hands/feet
❑	❑	other:

Gastro-Intestinal

PAST	NOW	CONDITION
❑	❑	nausea
❑	❑	vomiting
❑	❑	frequent belching
❑	❑	gas
❑	❑	poor appetite
❑	❑	excessive appetite
❑	❑	indigestion/reflux
❑	❑	bad breath
❑	❑	weight change
❑	❑	gall bladder disorder
❑	❑	other:

Urination

PAST	NOW	CONDITION
❑	❑	kidney stones
❑	❑	pain with urination
❑	❑	frequent urination
❑	❑	blood in urine
❑	❑	night urination
❑	❑	urgency to urinate
❑	❑	unable to hold urine
❑	❑	other:

Defecation

PAST	NOW	CONDITION
❑	❑	diarrhea
❑	❑	constipation
❑	❑	undigested food
❑	❑	blood in stool
❑	❑	mucus/stringy stool
❑	❑	hemorrhoids
❑	❑	pain or cramps
❑	❑	other:

Musculoskeletal

PAST	NOW	CONDITION
❑	❑	stiff neck/shoulders
❑	❑	low back pain
❑	❑	back pain
❑	❑	muscle spasm/cramps
❑	❑	sore/cold/weak knees
❑	❑	joint pain
❑	❑	other:

Male

PAST	NOW	CONDITION
❑	❑	pain/itching genitalia
❑	❑	genital lesions
❑	❑	genital discharge
❑	❑	impotence
❑	❑	weak urinary stream
❑	❑	testicle pain/swelling
❑	❑	other:

Neurological

PAST	NOW	CONDITION
❑	❑	seizures
❑	❑	tremors
❑	❑	numb/tingling limbs
❑	❑	stroke
❑	❑	speech problems
❑	❑	paralysis
❑	❑	other:

Infection Screening

PAST	NOW	CONDITION
❑	❑	HIV
❑	❑	TB
❑	❑	hepatitis
❑	❑	gonorrhea
❑	❑	chlamydia
❑	❑	syphillis
❑	❑	genital warts
❑	❑	herpes: oral/genital
❑	❑	other:

Psychological

PAST	NOW	CONDITION
❑	❑	depression
❑	❑	anxiety/stress
❑	❑	irritability
❑	❑	easily angered
❑	❑	treatment for emotional/psycho-logical problems
❑	❑	other:

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NAME: _____

MENSTRUAL HISTORY

Age at which menses began: _____

Date of last menstrual period: _____ Are your periods regular? ❑ Yes ❑ No

How many days do you bleed? _____ How many days between cycles? _____

Are your periods painful? ❑ Yes ❑ No How long does the pain last? _____

How heavy is the bleeding? ❑ Light ❑ Medium ❑ Heavy

What color is the blood? ❑ Light red ❑ Red ❑ Bright red ❑ Dark red ❑ Purple ❑ Brown ❑ Black

Are there clots? ❑ Yes ❑ No What size are they? _____

Do you spot between periods? ❑ Yes ❑ No

Do you ovulate on your own? ❑ Yes ❑ No On what days do you ovulate? _____

Do you take oral contraceptives? ❑ Yes ❑ No Have you ever had an IUD? ❑ Yes ❑ No

Date of last pap smear? _____ Have you ever had an abnormal pap smear? ❑ Yes ❑ No

Do you experience PMS? ❑Yes ❑No

What are your PMS symptoms:

❑ Bloating ❑ Irritability ❑ Breast Tenderness ❑ Low Back Pain

❑ Headaches ❑ Acne ❑ Cramping ❑ Loose stools prior to onset of menses

❑ Other: _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children have you had?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many D&C's have you had?	_____	_____

Do you get yeast infections regularly? ❑ Yes ❑ No Any history of STDS? ❑ Yes ❑ No

Have you every had a cervical biopsy, operation, cauterization or conization? ❑ Yes ❑ No

Have you ever been diagnosed with:

❑ Chlamydial infection ❑ Endometriosis ❑ Polycystic ovaries ❑ Pelvic Inflammatory Disease

❑ Pelvic adhesions ❑ Pelvic abnormalities ❑ Uterine fibroids ❑ Uterine polyps