

THINGS TO KNOW BEFORE YOUR ACUPUNCTURE VISIT

Please wear loose comfortable clothes that allow easy access to your skin. Jeans, tight clothing like yoga clothing, and dresses are too restrictive. Loose shorts/boxers, wide-legged pants or capris, and a tank top or bra work well. If Laura needs to “needle” an area that is not reachable because of clothing restraints (examples are thighs, chest, abdomen, upper arms) then you have the option of putting on a gown or wearing undergarments. You will be covered up and kept warm.

Please eat at least a snack before your appointment, and avoid caffeine. It’s important to not let your blood sugar drop during acupuncture or you may feel faint. Acupuncture is meant to be relaxing to the nervous system and caffeine interferes with this.

It’s important to be hydrated. Don’t drink so much water that you cannot rest comfortably for 15-30 minutes; however be aware that acupuncture works better if you are not dehydrated.

Please inform Laura if you are under the influence of any recreational drugs, alcohol, or prescription pain medicine.

Please thoroughly complete your new patient forms before your appointment. These forms also include important information about our fees and insurance billing.

We require 24 hours to cancel an appointment. The fee for missed appointments or late cancellations is \$40.

Please don’t worry about the needles. Acupuncture is relaxing for most people. Laura uses fine Japanese needles, about the width of a hair. Usually you will feel only a slight sensation upon needle insertion. You rest alone on a comfortable massage table while listening to relaxing music, for 15-45 minutes, depending on your need and ability for rest. The acupuncture needles invoke a deep relaxation response in the body, and many people even fall asleep during the session.

Allow time after your appointment to have a snack, water, and to move slowly to your next activity. Many people feel deeply relaxed after acupuncture and want to go home and rest. Some people feel light headed and need to sit for a while before driving. Other people feel very energized after acupuncture and want to be active. All these responses are fine. If possible, listen to what your body tells you to do after the session.

We will discuss your treatment plan at your visit. Visits will include advice about diet, lifestyle, herbs and supplements, if applicable.

New Patient Registration Form

Name: _____ Date: ____/____/____
first middle last

Address: _____
street city state zip

Telephone: _____
home work cell

E-mail: _____ Date of birth: ____/____/____ Age: _____

Occupation: _____ Employer: _____ Marital status: S M D W

Referred by: _____ May we thank him/her? _____

Emergency Contact: _____ Phone: _____

Health Care Practitioners / Doctors: _____

Payment & Cancellation Policies

Payment is due at your appointment. We prefer payment by cash or check, however if you need to use a credit card you may. Fees vary according to services provided, please see the cash & insurance fee schedule at the end of these forms. Our office will bill your insurance company for **acupuncture visits** if you qualify for coverage.

The office requires 24 hours notice to cancel an appointment. **You will be charged a \$40 cancellation fee for missed appointments or cancellations with less than a full 24 hours notice.** We cannot bill insurance for missed appointment fees.

We will remind you 1 – 2 days prior to your appointment by phone or email:

Not Necessary: _____

OR

Best number: _____ OK to leave a message? _____

OR

Email: _____

By signing below, I do hereby voluntarily consent to comply with the Office Payment & Cancellation Policies at Paris Healing Arts:

Signature: _____

Date: _____

Printed Name: _____

Parent or Guardian Signature: _____

Date: _____

Printed Name: _____

Acupuncture Intake & Consent Form

Name: _____ Have you had acupuncture before? _____

Please identify the health concerns that brought you to the Clinic in order of importance below:

<u>Condition</u>	<u>For how long?</u>	<u>Past treatment that helped this condition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Are you allergic to any foods, herbs, supplements or medications? If so, please list: _____

List any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking: _____

Most recent blood pressure reading: _____ / _____ When was this reading taken? _____

Current weight: _____ Desired weight: _____ Any problems maintaining weight? _____

Your history of major illnesses, accidents, hospitalizations, surgeries:

<u>Event</u>	<u>When</u>	<u>Event</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note family history of major illnesses (including diabetes, heart disease, cancer, autoimmune disease, psychological disorders, etc):

Lifestyle:

Exercise routine: _____

Relaxation practice: _____

How many hours per night do you sleep? _____ Do you wake rested? _____ Do you experience stress? _____

Do you enjoy your work? _____ Nicotine/alcohol/recreational drug use: _____

Diet:

Restrictions: _____

Emphasis: _____

Caffeinated beverages: _____ How many per day? _____

Sweets (food & beverages, including artificially sweetened): _____

How much water or non-caffeinated beverages do you drink per day? _____

Musculoskeletal:

Note any joint, muscle, tendon, or ligament pain or injury:

Note any scars from accidents, surgeries, injuries:

SYMPTOM LIST

(Please check any symptoms or conditions that currently apply to you):

Emotional/Psychological

Anxiety Depression Stress Addictions

Other: _____

Immune & Inflammation

Arthritis Seasonal allergies Autoimmune: _____

Other: _____

Eyes, Ears, Nose, Throat & Head

Sinus congestion Headaches Migraines TMJ/Jaw problems

Other: _____

Neurologic

Seizures/Epilepsy Vertigo/Dizziness Numbness/Tingling

Other: _____

Cardiovascular & Blood Circulation

Heart disease High cholesterol High blood pressure Low blood pressure Cold hands/feet

Other: _____

Gastrointestinal & Elimination

Constipation Loose stools/Diarrhea Irritable bowel Food allergies Bloating after meals

Other: _____

Respiratory

Frequent colds & flus Bronchitis Asthma

Other: _____

Kidneys & Urinary Tract

Kidney stones Frequent urinary tract infection

Other: _____

Skin

Eczema Acne

Other: _____

Endocrine

Hypothyroid Diabetes

Other: _____

Sleep & Energy

Insomnia Light sleeper Fatigue

Other: _____

Blood Sugar Regulation

Emotional eating Hypoglycemic Crave sweets

Other: _____

Men - Reproductive

Difficulty conceiving Decreased sexual energy Prostate hypertrophy or cancer

Other: _____

Women - Reproductive

Frequent Vaginal infections Breast/Uterine fibroids Endometriosis Ovarian Cyst
 Decreased sexual energy Difficulty conceiving Hormone Replacement Therapy

Other: _____
Do you have menstrual cycles? _____ Describe (regular or not, heavy or light, PMS, painful periods, clots in blood, etc.): _____

Are you pregnant now? _____ Current method of birth control: _____

of Pregnancies ____ # of Births ____ # of Miscarriages ____ # of Abortions ____

Any complications during pregnancies, births, postpartum? _____

Monthly breast exam? Y N Last Pap Smear: _____ Last mammogram: _____

Any reproductive surgeries (for cancer, hysterectomy, C-section, etc): _____

Additional

Is there anything else that is not included in this form? Use extra page if necessary.

Consent to Acupuncture Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or herbs and supplements by licensed acupuncturist Laura Paris.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are generally safe and free of side effects; however I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping: I understand that the acupuncturist may perform cupping as part of treatment. Cupping involves the use of suction cups placed on the body to modify or prevent pain perception by improving circulation. I understand that the use of this therapy may result in temporary redness or bruising, which normally disappears within a few hours, or a few days. I understand that I may refuse this therapy.

Chinese Herbs, Western Herbs, and Nutritional Supplements: I understand that Chinese Herbs, Western Herbs, and/or Nutritional Supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I should suspend taking them and call Laura Paris as soon as possible.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____

Date: _____

Printed Name: _____

Parent or Guardian Signature: _____

Date: _____

Printed Name: _____

Fees (Non-Insurance Fees)
Cash Fee Schedule Effective June 1, 2009

Acupuncture with Laura Paris

\$110 first visit, \$75 follow up visits, \$60 low-fee economic hardship follow up visits

Bodywork with Seth Paris

\$95 regular fee, sliding scale down to \$75 for economic hardship

Due to bank processing fees our payment preference is cash or checks. However if you need to use a credit card we will happily accept it.

We desire to not turn anyone away due to lack of funds. If you strongly want and need our services and cannot meet the above fee schedule, please ask us about payment alternatives, including special case fee reduction, payment plans and work trades.

Insurance Fees and Agreement (Acupuncture Only)

We will bill your insurance company for acupuncture treatment here if you have coverage. If your insurance does not pay in full within 30 days, you are responsible for payment based on the cash fee schedule above. This means if your insurance pays nothing, you pay the full cash fee. If insurance pays a lesser portion you pay the difference. **Payment is due immediately upon receipt of our bill, and a 25% late fee will be assessed for payments not received within 30 days of invoice date.** We are not in the business of haggling with insurance companies, so if they don't pay what you expect, you will have to work it out with them. We can provide any paperwork they request within reason.

This is the insurance fee schedule:

New patient office visit	\$100
Acupuncture treatment	\$150
Established patient with new problem office visit	\$100

If your insurance is through someone other than you, the following information is required for billing:

Name of Insured: _____
Relationship to Patient: _____
Insured's Date of Birth: _____

By signing below, I do hereby voluntarily consent to this Insurance Agreement:

Patient: _____

Signature: _____

Date: _____

Printed Name: _____

Parent or Guardian:

Signature: _____

Date: _____

Printed Name: _____