地 Earth
医 Medicine
術 Art/Skill

Global Healing Arts

Carolini DuCray MSTCM, CMT, LAc
Acupuncture, Oriental Medicine, Jin Shin Jyutsu, Health and Wellness

Confidential Patient Intake

Today's Date _____/_____/_____

Name_____ Date of Birth____/____/_____ Sex: M / F

Address_____

City/ State/Zip_____

Telephone: (home)_____ (Work)_____ (cell)_____

email:_____ Emergency Contact:_____

Relationship_____Phone#_____

Primary Care Physician:_____ phone#_____

Occupation:_____ Employer:_____

How did you hear about us?_____ Referred by:_____

Have you ever had acupuncture? Y / N When?_____

What are you seeking treatment for?_____

_____

_____

What other treatments, if any, have you received for this?_____

_____

What makes your condition better?_____

What makes it worse? _____

Do you have any known allergies/and or food sensitivities? Please list_____

_____

_____

Are you taking Coumadin/ Warfarin/ Plavix? (circle) Y/ N Do you have a pacemaker? Y / N

Personal Health History: (check all that apply)

____ Digestive issues

____ Blood Disorders _____

____ Cancer or Tumors _____

____ Diabetes Type_____

____ Emotional Disorder_____

____ Hemophilia

____ Hepatitis _____

____ High / Low Blood Pressure

____ HIV

____ Heart issues

____ Infectious Disease_____

____ Immune Disorders_____

____ Respiratory Disorders_____

____ Rheumatic Fever

____ Seizures / Epilepsy

____ Sexually Transmitted Infection_____

____ Stroke

____ Tuberculosis

____ Other_____

____ NONE OF THE ABOVE

List any significant illness, surgery, or hospitalizations you have had (with date):_____

_____

_____

_____

_____

List any medications / supplements / herbs that you are currently taking (with dosage):_____

_____

_____

_____

_____

Please indicate the use and frequency of the following:

Coffee / Black Tea_____ How Much_____

Tobacco____ packs per day _____ How Many Years?_____

Alcohol / How Much _____ How Often_____

Soda / What kind?_____How much/ how often_____

Recreation Drugs_____ How Often_____

Marijuana ___How Much_____ How Often_____

Carolini DuCray MS, CMT, LAc 1140 Jackson Gate Rd, Jackson, CA 95642 (209) 223-3803

PAIN

Do you have pain or tightness? Where?_____ Pain level /10

Recent Injury?_____How long have you had this?_____

Is this from an auto accident or work related?_____ Date of Injury:_____

Please describe the pain: (type, quality)_____

_____

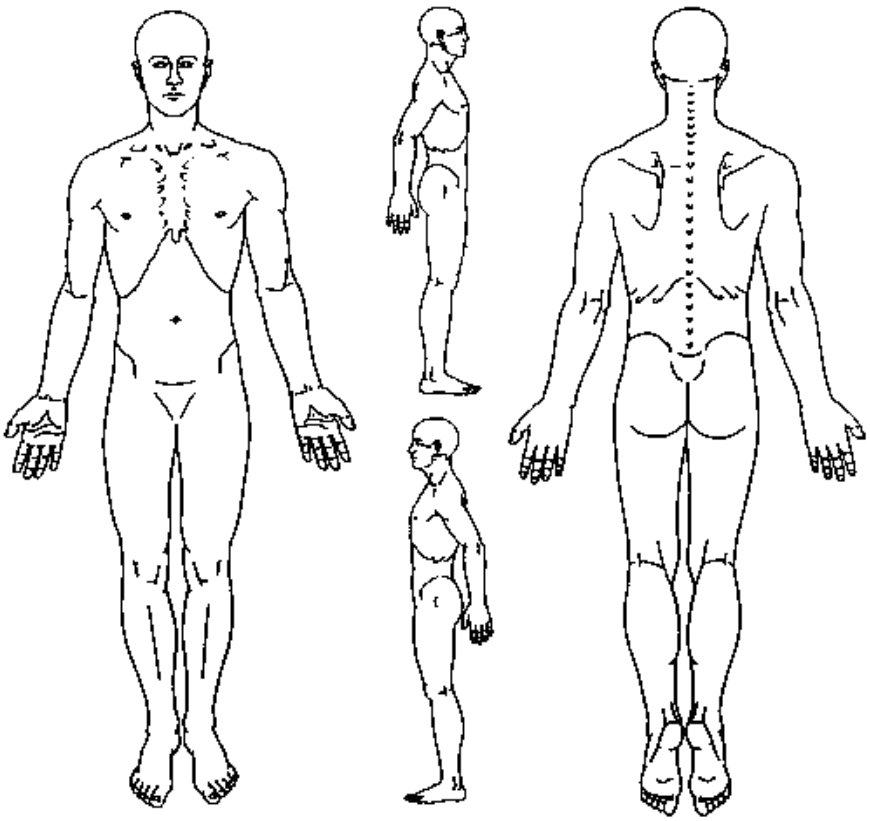
_____

What, if anything, makes it better:_____

Worse:_____

Better / Worse in the morning Better / Worse with movement Better with heat / cold

Pain Diagram (please mark all areas of pain on diagram below)



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HIPPA Notice

Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information are being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workers comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that:

1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business
2) relates to the past, present, or future physical or mental health of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above:

Signed_____ Date_____

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily 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 above 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 above, including those working at the clinic or office listed above 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), Jin Shin Jyutsu (acupressure), Chinese herbal medicine, nutritional and lifestyle counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear if heated cups are used.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my practitioner of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my 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 consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment. Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have 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 for treatment.

Signed_____ Date_____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name:_____

Insurance Company:_____

I hereby instruct the above named insurance company to pay by check or direct deposit made out to and/or mailed directly to:

Carolynn DuCray MS, LAc
PO Box 631
Jackson, CA 95642

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy or by a 3rd party payer who would otherwise pay me directly, as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND/OR CLAIM.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by the insurance policy.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney for the purpose of securing payment under this policy of insurance.

Signature of Policy Holder or Claimant:_____
Date:_____