Acu-Vision Therapy ®
141 Kinderkamack Road
Park Ridge, N.J. 07656
201-690-6696

Acupuncture informed Consent

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of Acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at the acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations.

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to Acupuncture treatment.

The potential benefits: Acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve the bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

_____ _____

Printed Name Patient Signature

_____ _____

Witness Date

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Name: _____ Phone: _____

SS No: _____ Date of Birth: _____

Marital Status: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____ Cell-Phone Provider: _____

Employed/Retired: _____ Occupation: _____

Employer Address: _____

Medical Information

What is your current Medical Ailment _____

Date Ailment first occurred: _____

Drugs/Medications: _____

Major Illnesses: _____

Patient Signature: _____ Date: _____

I irrevocable assign to Acu-Vision Therapy, LLC all my rights and benefits under any insurance contracts for payment for services rendered to me by Acu-Vision Therapy, LLC to be released to Acu-Vision Therapy, LLC. I irrevocably authorize Acu-Vision Therapy, LLC to file insurance claims on my behalf for services rendered to me. I irrevocable direct that all such payments go directly to Acu-Vision Therapy, LLC. I irrevocably authorize Acu-Vision Therapy, LLC to act in my behalf and report any suspected violations of proper claims practices to proper regulatory agencies. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

_____ _____ _____

Signature of Patient / Guardian (If Minor) Witness Date

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HEALTH INFORMATION PRIVACY ACT

It is necessary for us to explain to you the new Federal Health Insurance Portability and Accountability Act (HIPAA) Laws written to protect the confidentiality of your health information. We do not want you to be concerned that your personal information might be unnecessarily made available to others outside our office. We are committed to maintaining the complete confidentiality of our patient's health information. When we use the term "personal information, "we mean financial, health, and other information about you that is nonpublic, which we obtain so that we can provide you with health care treatment. When we use "health information, "we mean information that identifies you and relates to your medical history (i.e; the health care you receive or the amounts paid for that care). This notice will become effective on April 14, 2003.

Due to the use of the telephone answering machine, fax machines, computers and the Internet, the government has sought to standardize and protect the privacy of the electronic exchange of your health information. We are required by law to put in writing, the policies, and procedures we use to ensure the protection of your health information everywhere it is used. Copies of our privacy policy will be provided, free of charge, to any patient who requests a copy there of.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for, and been voluntarily given, your written permission.

Patient Signature: _____

Date: _____

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Patient History(Confidential)

Name: _____ **Date:** _____
Birth Date: _____ **Age:** _____ **Sex:** _____ **Allergies:** _____

Symptoms you are experiencing now or have experienced in the past 3 months

General
__ Chills __ Fever
__ Hot Flashes
__ Night Sweating
__ Day Sweating
__ Irritability
__ Easily Stressed
__ Easily Angered
__ Depression
__ Anxiety
__ Sadness/Grief
__ Fatigue
__ Cold Hands, Feet
__ Tremors
__ Poor Sleep
__ Poor Memory
__ Disorientation
__ Fainting
__ Headaches
__ Migraines
__ Bleeding Gums
__ Earache
__ Ear Ringing
__ Loss of Hearing
__ Sinus Problems
__ Hay Fever
__ Vision Problems
__ Difficulty Swallowing
__ Rash or Itching
__ Bruises Easily
__ Non-Healing Sores

Gastrointestinal
__ Nausea
__Vomiting
__ Indigestion
__ Constipation
__ Diarrhea
__ Belching
__ Abdominal Pain
__ Abdominal Bloating
__ Weight Gain __ Loss
__ Ulcers
__ Bad Breath
__ Parasites
__ Blood in Stools
__ Hemorrhoids
__ Poor Appetite
__ Gas
__ Excess Thirst
__ Excess Hunger
__ Hernia
__ Others

Neuropsychological
__ Seizures
__ Concussion
__ Dizziness
__ Loss of Balance
__ Areas of Numbness
__ Lack of Coordination
__ Disorientation

Respiratory
__ Cough
__ Asthma
__ Bronchitis
__ Painful Breathing
__ Shortness of Breath
__ Coughing Blood
__ Excess Phlegm

Cardiovascular
__ High Blood Pressure
__ Low Blood Pressure
__ Irregular Heartbeat
__ Chest Pain
__ Palpitations
__ Phlebitis
__ Blood Clots
__ Varicose Veins

Genito-Urinary
__ Pain on Urination
__ Urgent Urination
__ Frequent Urination
__ Inability to Hold Urine
__ Decreased Urine Flow
__ Blood in Urine
__ Waking Up to Urinate
__ Kidney or __ Urinary Stones

Musculoskeletal
__ Muscle Weakness
__ Muscle Cramps
__ Muscle Atrophy
__ Spasms
__ General Aches
__ Arthritis
__ Joint Instability
__ Injuries

Women Only
Date of Last Menses ____
__ Age of First Menses
__ Bleeding Between Periods
__ Unusual Color, Character
__ Heavy or __ Light
__ Irregular Periods
__ Painful Periods
__ Clots During Menses
__ PMS
__ Vaginal Discharge
__ Vaginal Sores
__ # of pregnancies
__ # of Births
__ Miscarriages
__ Abortions
__ Difficult Births
__ Fertility Problems
Birth Control? _____
What type? _____
__ Breast Lumps
__ Painful Intercourse
__ Low Sex Drive

Men Only
__ Lump on Testicles
__ Lump on Breasts
__ Penis Discharge
__ Penis Sores
__ Erection Diffulty
__ Impotence
__ Low Sex Drive
__ Other

List Major Diseases: _____

List Major Surgeries: _____

Current Medication(s): _____

Patient Signature or Guardian: _____ Date Signed: _____