Marcy Halterman, D.C, Ms.P.H.

Welcome to Our Office !

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the term. If you need any help, please ask the receptionist.

Patient Data

Date: _____

Name: _____ Sex: Male or Female Home Phone: _____

Personal Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthday: _____/_____/_____ Age : _____ Marital Status: M S W D No. of Children: _____

Social Security Number: _____ Driver License Number: _____

Employer: _____ Position: _____ Work Phone: _____

SPOUSE: _____ Employer: _____ Work Phone: _____

IN CASE OF EMERGENCY: NAME OF NEAREST RELATIVE OR FRIEND

1. _____ Relationship: _____ Phone:_____

How were you referred to our office? ___ Doctor (Name/Specialty)_____
Yellow Pages: _____(Maroon) Area Wide _____ (White) Verizon _____TV _____Radio
Person (name) _____ OTHER _____

Major events, hospitalizations, surgeries:_____

_____

_____

Allergies – (circle all that apply) Environmental Dust Pet/Animal Seasonal Chemicals Foods

If you circled any of the above, please describe: **_____**

Do you or any member of your immediate family have or had any of the following?
Please Indicate: Myself: "P" – Past "C" – Current or "F" Family

_____ HEART DISEASE	_____ OSTEOPOROSIS	_____ DEMENTIA/ALZHEIMERS
_____ HIGH BLOOD PRESSURE	_____ MULTIPLE SCLEROSIS	_____ RHEUMATOID ARTHRITIS
_____ DIABETES	_____ CONVULSIONS	_____ OSTEOARTHRITIS
_____ BLOOD CLOTS/STROKE	_____ EPILEPSY	_____ AUTOIMMUNE DISORDER
_____ VENEREAL DISEASE	_____ CONCUSSION # of times ___	_____ ANEMIA
_____ HIV	_____ CANCER – which type?	_____ FOOD SENSITIVITIES
_____ SLEEP APNEA	_____ THYROID PROBLEMS	_____ OTHER

Any other ongoing medical problems? _____

Do you exercise (*work doesn't count!)* (Circle) *Walk Run Lift Weights Cardio* How often?

Are you under a lot of stress at the present time? YES or NO _____

Please list any vitamins, laxatives, or herbs you are taking ? _____

Indicate which medications you are currently taking:
___ Nerve Pills (Anti-Depressants) ___ Pain Killers ___Insulin ___Birth Control Pills
___ Muscle Relaxants ___ Anti-inflammatory ___Anticoagulants ___ Blood Pressure Medication
___ Female Hormones ___Thyroid Medication ___Antibiotics ___ Cholesterol Medication

Current medications (drug name/what dose in mg): _____

_____

Allergies to medications (drug name and reaction)_____

Reaction location: ***Skin Local Gut Anaphylactic***

How severe was your reaction? ***Mild Moderate Severe***

Do you smoke? (Please Circle) ***Non smoker/never smoked Non smoker/previous smoker***

Few 1-3/day Up to 1 pack per day 1-2 packs per day 2 or more packs per day

What type of bed do you sleep on? (Waterbed, soft mattress, etc.) _____

What kind of pillow do you use? (Thick foam, thin goose down, etc.) _____

Do you sleep on your _____ side _____ back _____ stomach

Date and purpose of last acupuncture treatment _____
Name of last provider of acupuncture: _____
Most recent bloodwork? _____
Are you pregnant ? YES or NO Date of Last Menstrual Period ? _____

I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize the debiting of my credit or debit card to fulfill my outstanding debt(s). **I also understand that a 1.0% interest per month will be assessed on any cash balances over 30 days (ie cash account, co-payments, payment plans and personally injury/liability cases)**

NOTE Returned checks will be assessed a $25.00 fee.

Signature:_____Date: _____

NOTE: Treatment may be suspended for non- payment of services rendered.

REVIEW OF SYSTEMS:

Do you CURRENTLY have any of the following? Please circle all that apply.

Constitutional:
- Fever
- Weight change – increase/decrease
  - # of lbs _____ in _____ months
- Fatigue
- Appetite changes (increase/decrease)
- Decrease in strength/exercise tolerance

Head:
- Headaches
- Vertigo
- Head injury

Eyes:
- Recent change in vision
- Wear glasses/contact lens
- Double vision
- Eyes watering/tearing
- Dry eyes
- Eye pain

Ears:
- Change in hearing
- Deafness
- Ringing in the ears
- Dizziness
- Wear hearing aid

Nose:
- Bleeding
- Discharge

Mouth:
- Dentures
- Gingival bleeding

Chest:
- Difficulty breathing
- Wheezing
- Coughing
- Coughing up blood

Heart:
- Chest pains
- Heart palpitations/arythmias
- Shortness of breath
- Dizziness on standing

Abdomen:
- Difficulty swallowing
- Abdominal pain
- Bowel habit changes
- Vomiting

Genitourinary:
- Urinary urgency
- Painful urination
- Incontinence

Neurological:
- Muscle weakness
- Tremors
- Seizures
- Lack of muscle coordination

Psychiatric:
- Depression
- Anxiety
- Change in sleep habits
- Change in thought content

BRAZOS VALLEY ACUPUNCTURE

ACUPUNCTURE INFORMATION AND CONSENT FORM

What is Acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Your practitioner may decide to use electrical stimulation, cold laser, heat or other types of therapy to aid in your treatment. You will be advised before these other modalities are utilized.

Is Acupuncture safe?

Acupuncture is generally safe. Serious side effects are very rare – less than one per 10,000 treatments.

What are the side effects?

- Drowsiness can occur after treatment, it is advisable not to drive immediately afterwards.
- Minor bleeding, swelling, bruising, occurs in about 3-5% of treatments.
- Pain can occur in about 2-5% of cases with treatment.
- Fainting can occur in certain patients, particularly with or after the first treatment.
- Existing symptoms can worsen after treatment (usually less than 3% of patients).
- You should tell your practitioner about this, but it usually is a good sign for temporary worsening to occur.
- There is a risk of infection any time the continuity of the skin is interrupted.
- The treatment may not be effective.

Is there anything your practitioner needs to know about you?

- If you have experienced a fit, faint, or seizures in the past.
- If you have a pacemaker, internal defibrillator, or other implanted electrical device.
- If you have a bleeding disorder.
- If you are taking anti-coagulants or any other medications, including over-the-counter medications.
- If you have damaged heart valves.
- There is a higher risk for infection (i.e. diabetes, blood disorders, HIV positive).
- If you have been diagnosed as Hepatitis C positive.

SINGLE-USE STERILE NEEDLES ONLY ARE USED IN THIS CLINIC

Statement of informed consent:

I confirm that I have read and understand the above information. I have been given the time to talk with Dr. Halterman and ask questions concerning the proposed treatment. I consent to having acupuncture treatment performed on my person. I understand that I can refuse treatment at any time for any reason.

Signature:_____

Print Name:_____ Date:_____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:
(name)

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

Date Signed ____/____/____

Brazos Valley Acupuncture - Provider E-Mail Agreement

Dear _____:

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include referral and appointment scheduling requests and billing/insurance questions.
- E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail is not confidential. It is like sending a postcard through the mail. My staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment!
- E-mails may be forwarded to my staff for handling, if appropriate.

Finally, either one of us can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

PATIENT:

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

State of residence: _____