Amelie de Mahy L.Ac
45 Quail Court Suite 200
Walnut Creek, CA 94596

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name | Sex ☐ F ☐ M | Date

Date of birth | Age | Occupation

Main phone # | Other phone #

E-mail address | Allow email contact by Co gnk'f g'O cj { ☐ Yes ☐ No

Address: Street | City | State | Zip

Relationship status | # of children | Family physician | Chiropractor

Do you have health insurance? ☐ Yes ☐ No If yes, name of insurance company

Does your insurance cover acupuncture? ☐ Yes ☐ No ☐ ? | Who is your employer?

Emergency contact name | phone

How did you find out about our clinic? ☐ *Friends/Relatives(name)*______________________________
☐ *Direct mail* ☐ *Location or walk by* ☐ *Website* ☐ *Referred by*______________________________
☐ *Yellow Pages* ☐ *Periodicals* ☐ *Other (please specify)*

Main problem(s): ____.

What diagnosis, if any, have you received for this problem? ______________________________

When did this problem begin? ____________ What are the causes of this problem? ______________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ________________

What kind of treatment have you tried? ______________________________________

What makes this problem worse? ________________What makes this problem better? ______________

Is there anybody in your family with the same/similar problems? _________ Remarks and additional information:

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: ______________________________**Hospitalization:** ______________________________

Significant trauma: (auto accidents, sports injuries, etc) ______________________________

Allergies: (drugs, chemicals, foods, environmental):______________________________

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Amelie de Mahy.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin 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. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, 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.

Electric Stimulation: 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 and will notify Amelie if I have or receive an electronic device implantation such as a pacemaker while under his care. I will notify Amelie should I become pregnant or if I am in the process of trying to get pregnant while under her care so she

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological function. 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 the office as soon as possible.*

Acupressure/Tui-na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify of prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from thjs treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Cupping: I understand that the use of cupping commonly produces temporary bruising or redness that may last several days. I understand that I may refuse this therapy if it is recommended.

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:____ **Date of Birth**:_______________

Address:____

City: _______________________ **State**_____________ **Zip**____________ **Phone**____________________

Notice of Privacy Policies

This office is dedicated to providing service with respect for human dignity. Protection of patient privacy and healthcare information is fundamental to the clinician/patient relationship. This notice will remain in effect until it is replaced or amended by changes in law.
Personal information and health information is gathered in several ways:

- Information this practice receives from you.
- Information this practice receives from other healthcare providers.
- Information this practice receives from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of my relationship with you I will likely use and disclose health information about you for treatment, payment, and health care operations. I will only use and/or disclose your protected health information when the law allows me to do so. Any other use and disclosures will be made only with your authorization and, in those instances; you have the right to revoke that authorization. And if so, that authorization would be honored, where legal to do so, from that date forward.

Treatment: For example, from time to time, it may be decided that it is medically necessary to refer you to a specialist for additional care. That practitioner will need your medical information in order to be able to treat you.

Payment: I may disclose your healthcare information to your insurance provider for the purpose of payment or health care operations.

Health Care Operations: This practice is allowed to disclose your medical information if it is necessary for the office to function efficiently. There are also times when this office may need the help of a special vendor, such as a medical billing specialist, and I would then send your records to that vendor in order to carry on my business. You may specifically authorize me to use protected health information for any purpose or to disclose the health information by submitting the authorization in writing.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, holiday cards, thank you cards, newsletters and appointment reminders, by calls, postcards or letters.

Disclosure
This office may use or disclose your Protected Health Information when required by law. This includes but is not limited to Public Health needs, Health Oversight requirements, and issues of abuse or neglect, legal proceedings.

Patient Rights

- **Upon written request you have the right to access, review or receive copies of your healthcare records.** Exceptions are: 1) psychotherapy notes; 2) information gathered in preparation of an administrative action or proceeding; 3) data that is subject to certain provisions of the Clinical Laboratory Improvements Act. This office may deny your request (in writing) under certain limited circumstances. Generally, if this office agrees to

provide you with a copy of your records, it will be done within 15 days after you ask for it. I will charge you a reasonable, cost-based fee for the records.

- **Upon written request you have the right to receive a list of items this office disclosed about your healthcare information**. This office is required to give you that data except for any use or disclosure: 1) for treatment, payment and/or health care operations; 2) made with your authorization; 3) that I make to you; 4) for any national security or intelligence purposes; 5) made before April 14, 2003; or 6) that does not require your authorization. This office will provide the information to you (generally within 60 days) at no charge once each year, but after that, I will require that you pay a reasonable fee-based charge for the information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. You may ask that I limit the use and disclosure of your protected health information; I am not required to accept your request. If I do agree, however, I will do as you wish except in an emergency. You may submit your request to this office in writing and tell me: 1) what information you want me to limit 2) how you want me to limit that data and 3) to whom I am to limit the access to this data.
- **You have the right to request that we amend your Protected Health Information; the request must be in writing.** This office has the right to deny that request if you ask about medical information that 1) was not created by this office; 2) the information is not part of the medical or billing records; 3) is not part of the records you may access or 4) the medical information is accurate and complete. I may ask that you tell me, in writing, why you want me to amend your medical information. Generally, this office must act upon your request within 60 days after receipt of your request. If I agree to your request, I must make the appropriate amendment and follow the law regarding how and whom I inform about this amendment. If I do not agree, then I will tell you my reasons. You then have additional rights, including an appeal (by someone who did not participate in the decision not to allow you to amend your record) and you have the right to submit a written statement of disagreement.
- **You have a right to receive all notices in writing.**
- **You have the right to receive confidential communication by alternative means or at alternative locations**. Please make this request in writing. I will agree, so long as your request is reasonable, but you must tell this office how to communicate with you and you must give us a complete address or contact information.

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document. I understand that Amelie de Mahy L.Ac may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my voicemail or with anyone who answers the phone. I also understand that my clinical information may be used for educational and/or research purposes by Amelie de Mahy L.Ac. All information that can identify me personally will be removed. By signing this form, I am giving Amelie de Mahy L.Ac authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes.

I acknowledge that all information discussed during the assessment and treatment by Amelie de Mahy L.Ac will be held confidential except in the instance where my safety or the safety of others may be at risk.

____________________________________ _______________________

Patient Name (print) Date

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Patient Signature