ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Karen Anne Sigel, L.Ac. 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 below, including those working at the clinic or office listed below 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, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue**. I will notify the acupuncturist who is caring for me if I am or become pregnant.**

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, 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 condition and for any future condition(s) for which I seek treatment.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

Karen Sigel, MAOM, L.Ac, ACN ● 281-222-9588 ● karen@sigelacupuncture.com ● www.sigelacupuncture.com

FORM TO BE COMPLETED BY PATIENT
NOTIFYING THE ACUPUNTURIST OF WHETHER OR NOT PATIENT
HAS BEEN EVALUATED BY A PHYSICIAN
AND OTHER INFORMATION

(Pursuant to the requirement of 1183.6(e) of this title (relating to Denial of License; Discipline of License) and Tex. Occ Code Ann., 205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying Karen Anne Sigel, MAOM, LMT, L.Ac., ACN of the following:

I (**circle one: have / have not**) been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

I (**circle one: have / have not**) received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 2 months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

_____ _____

Signature of Patient or Authorized Representative Date

Exemptions according to Rule 183.6 (e) Scope of Practice

3) …..an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain or substance abuse.**

NOTICE OF PRIVACY PRACTICES

Dear Valued Patient,

This notice describes my 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.

In order to maintain the level of service that you expect from our office, I may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

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.

Types of information that I gather and use:

In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with me (billing transactions).
- 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, workman's comp and your employer, and other third party administrators (*e.g*. requests for medical records, claim payment information).

I value our relationship, and respect your right to privacy. If you have questions about my privacy guidelines, please call me during regular business hours at 281-222-9588.

Sincerely,

Karen Anne Sigel, MAOM, L.Ac., ACN

Patient Acknowledgment: _____

(Patient signature & date)

PATIENT INSURANCE AND BILLING INFORMATION

Name of Insured: _____ Ins. Carrier (Payer): _____

Patient ID#: _____ Insured DOB: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐Child ☐ Other: _____

Authorization

I authorize Karen A. Sigel to keep my signature and credit card information on file and to directly charge my credit card account for charges I personally incur including charges not reimbursed by insurance including herbs, supplements, cupping, co-pay, un-met annual deductible, late cancellation or no show fees and any other charges denied by the insurance carrier.

Note: Your card will only be charge for those fees actually incurred and not reimbursed by the insurance company.

Description

Said charges shall be in the form of:

[ ] All charges on date of service.
[ ] Monthly payments of $_____ for _____ months beginning _____ until the patient share of cost is paid in full.

Credit/Debit/FSA Card Information

[ ] Discover
[ ] Master Card
[ ] Visa
[ ] Other _____

Credit card number: _____ Expiration date: _____

Card holder's name (please print): _____

Code on back of card: _____

Billing address & zip code (if different from health history) _____

Card holder's signature: _____

Date: _____

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting me with your medical care. I strive to render excellent care to you, and all patients. In order to be consistent with this philosophy, I use an appointment system that sets aside ample time for each individual patient based on the patient's current needs.

If you do not show up for your appointment, or notify me by phone of your inability to keep your appointment at least one business day in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to me. With this in mind, and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

The policy is as follows:

1. Please give me one business day notice in the event that you need to reschedule your appointment. The scheduling number is **281-222-9588**.

2. If you miss an appointment or do not give one business day prior notice of cancellation, it is considered to be a missed appointment and a **$60.00 fee will be assessed to you.**

3. If you are late for an appointment, you will be seen as soon as possible, although the office visit will be limited to conclude at the originally scheduled time.

4. **As a courtesy, when time allows, I make reminder calls and emails for upcoming appointments. If you do not receive your reminder call or message, the cancellation policy is still in effect.**

If you have any questions regarding this policy, please contact me and I will be glad to clarify any questions you may have.

Thank you.

_____ _____

Patient Acknowledgement Date

PATIENT INFORMATION & HEALTH HISTORY

All questions contained in this questionnaire are
strictly confidential and will become part of your medical record.

Name :		☐ **M** ☐ **F**	**DOB:**	**Today's Date:**
Address:		**City:**	**State:**	**Zip:**
Contact phone no:	**Driver's License No. & State**		**Email Address**	
Marital status:	☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**			
Who referred you/how did you hear about us?		**Date of last physical exam:**		

Cancellation Policy – I acknowledge that I will give at least 24 hour notice of cancellation or be charged for the missed session. I will call if I anticipate being more than 15 minutes late for my appointment and understand that the appointment may need to be rescheduled if adequate time is not available for treatment. Patient initials _____.

IN CASE OF EMERGENCY

Name of emergency contact person:	**Relationship to patient:**	**Contact Phone:**
		( )

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Please check any significant health condition you currently have or have had in the past:

☐ Alcoholism/Addictions	☐ Diabetes	☐ High / Low Blood Pressure(Circle)	☐ Pace Maker
☐ Arthritis	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Rheumatic Fever
☐ Asthma/Allergies	☐ Gallstones	☐ HIV/AIDS	☐ STD/Venereal Disease
☐ Autoimmune Disease	☐ Headache/Migraine	☐ Implants/Prosthesis	☐ Stroke (CVA)
☐ Bleeding/Clotting Disorder	☐ Heart Disease	☐ Kidney disease	☐ Thyroid Disease
☐ Cancer	☐ Hepatitis B or C (Circle)	☐ Liver Disease	☐ Tuberculosis
☐ Connective Tissue Disease	☐ Herpes	☐ Neurological Disease	☐ Other:

Please list your chief medical concerns today in order of importance to you:

1.
2.
3.

Surgeries and hospitalizations:

Year	**Reason/Procedure**	**Hospital**

Blood type (please circle one) O * A * B * AB * DON'T KNOW

Please list all food, drugs or other substances for which you are allergic:

Food, Drug or Substance	**Reaction you had**

List Any Dietary Restrictions – Vegetarian Only ☐ or NO: Beef ☐ Pork ☐ Other_____

List your prescribed drugs and over-the-counter medications, supplements, inhalers, etc. (Please use a separate page if necessary)				
Drug Name	**Condition Treated**	**Start Date**	**Strength**	**Dosage per Day**

HEALTH HABITS				
Diet	Do you eat breakfast on a regular basis? ☐ Yes ☐ No			
	Rank your **salt** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **dairy** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **wheat/gluten** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **sugar** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **artificial sweetener** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **high processed/junk food** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **fried/greasy food** intake:	☐ Hi	☐ Med	☐ Low
	Rank your fresh **fruit & vegetable** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **fiber** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **water** intake:	☐ Hi	☐ Med	☐ Low
	Rank your **antacid** use:	☐ Hi	☐ Med	☐ Low
	Rank your **laxative/stool softener** use:	☐ Hi	☐ Med	☐ Low
Exercise	☐ Sedentary ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise			
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola # Cups/cans per day _____			
Alcohol	Are you concerned about the amount you drink? If yes, how many drinks per week? _____		☐ Yes	☐ No
Tobacco	Do you use tobacco? ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars		☐ Yes	☐ No
	# of years of use _____ Amount/# packs per day _____ Year quit _____			
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

Please list any significant health problems experienced by immediate family members and approximate age of onset if known

FAMILY MEMBER	AGE	SIGNIFICANT HEALTH PROBLEM	FAMILY MEMBER	AGE	SIGNIFICANT HEALTH PROBLEM

EMOTIONAL HEALTH AND WELLBEING		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY TO YOU AND ADD AS "OTHER" WHERE NOT LISTED

General
☐ Chills ☐ Dizziness
☐ Fatigue ☐Fever
☐ Forgetfulness
☐ Headache
☐ Nervous/Anxious
☐ Numbness/Tingling
☐ Shaking/Tremor

Emotion
Generally I am (check all that apply):
☐ Angry
☐ Cry Easily
☐ Depressed
☐ Give up/in easily
☐ Happy
☐ Have difficulty expressing my true feelings
☐ In a hurry
☐ Indecisive
☐ Internalize anger or frustration
☐ Irritable
☐ Restless
☐ Short attention span
☐ Other _____

Weight
☐ Recent Weight Gain
☐ Recent Weight Loss
# of lbs. _____gained/lost
Since date _____/_____

Thirst
☐ Excessive
☐ Less than normal
☐ Thirsty, but no desire to drink anything
Water preference:
☐ Cold ☐ Hot ☐ Room temp

Food Cravings or Avoid
☐ Salty ☐ Sour ☐Sweet
☐ Carbohydrates ☐Dairy
☐ Fried/Greasy
☐ Non-food substances
☐ Other _____

Energy
☐ Low
☐ Excessive
☐ Up & Down
☐ Low after eating
☐ Sleepy in the afternoon
☐ Other _____

Digestion
☐ Bloating ☐ Gas
☐ Difficulty Swallowing
☐ Heartburn ☐ Acid Reflux
☐ Indigestion ☐ Nausea
☐ Poor Appetite ☐ Pain
☐ Stomach Pain ☐ Vomiting
☐ Vomiting Blood

Bowels
Bowel movement frequency:
_____times per
☐ Day ☐ Week

☐ Black Stool ☐ Blood in
☐ Constipation ☐ Diarrhea
☐ Hemorrhoids
☐ Loose Stool ☐ Pale Stool
☐ Pain or cramps
☐ Other _____

Urinary
times per day _____
times per night _____

☐ Color – Clear
☐ Color – Dark Yellow
☐ Color – Light Yellow
☐ Color – Red
☐ Blood or Pus in Urine
☐ Difficult Urination
☐ Frequent Urination
☐ Kidney Stone or infection
☐ Painful or Burning Urination
☐ Poor Bladder Control
☐ Bladder Infection
☐ Smell: ☐Bad ☐Strong
☐ Sweet
☐ Urgency to Urinate
☐ Other _____

Cardio-Respiratory
☐ Allergies
☐ Asthma
☐ Cough - Persistent
☐ Coughing Blood
☐ Frequent colds
☐ Night Sweats
☐ Phlegm Production
☐ Recurrent Bronchitis
☐ Shortness of Breath
☐ Spontaneous Sweating
☐ Profuse sweating upon exertion

Cardio-Respiratory (cont.)
☐ Chest Pain
☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Low Blood Pressure
☐ Poor Circulation
☐ Swollen Ankles
☐ Varicose Veins
☐ Other _____
☐ Other _____

Eyes
☐ Blurred/Double Vision
☐ Cataract ☐ Dry Eyes
☐ Eyelids swollen ☐ Itchy
☐ Light Sensitivity
☐ Pain/Strain ☐ Red
☐ Poor night vision
☐ Visual Halos
☐ Tear easily ☐ Watery
☐ Other _____

Ears
☐ Ache/Pain
☐ Hearing Loss
☐ Hearing Sensitivity
☐ Ringing/Tinnitus
☐ Other _____

Nose
☐ Lost Sense of Smell
☐ Smell Sensitivity
☐ Sinus Problems
☐ Nosebleeds
☐ Other _____

Mouth
☐ Bad Breath
☐ Bleeding Gums
☐ Dry
☐ Red/Swollen Gums
☐ Sores/Spots
☐ Taste Changes _____
☐ Teeth Grinding
☐ Teeth - Loose
☐ Tender Tongue ☐ TMJ
☐ Other _____

Throat
☐ Difficulty swallowing
☐ Hoarse/ Loss of Voice
☐ Sore throat
☐ Throat that won't clear
☐ Goiter or other thyroid
☐ Other _____

Musculoskeletal
(Pain, Weak or Numb in)
☐ Hands ☐ Wrists
☐ Arms ☐ Elbows
☐ Shoulders ☐ Feet
☐ Ankles ☐ Legs
☐ Knees ☐ Thighs
☐ Hips ☐ Neck
☐ Back ☐ Spine
☐ Sciatica
☐ From cold/damp weather
☐ Other_____

Skin
☐ Bruise Easily
☐ Bruises Linger
☐ Cuts heal slowly
☐ Dry ☐ Hives ☐ Itchy
☐ Lumps located at:
_____
☐ Oily ☐ Rash
☐ Skin Disease _____
☐ Sores
☐ Other _____

Hair
☐ Dry ☐ Dandruff
☐ Falling Out ☐ Oily
☐ Premature Grey
☐ Other _____

Sleep
☐ Insomnia
☐ Snoring
☐ Sleep Apnea
☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep
☐ Toss & Turn
☐ Wake Feeling Tired
☐ Wake easily

Nails
☐ Break easily ☐ Pale
☐ Clubbed ☐ Peel
☐ Lines/Ridges ☐ Soft
☐ White or Other Spots
☐ Other_____

Body Temperature
☐Chill easily/cold aversion
☐ Cold hands/feet
☐ Warm natured/heat aversion
☐ Other _____

Karen Sigel, MAOM, L.Ac, ACN ● 281-222-9588 ● karen@sigelacupuncture.com ● www.sigelacupuncture.com

Patient Name: _____ Date: _____

MEN'S HEALTH QUESTIONNAIRE (please fill in or check the appropriate answer)				
Do you usually get up to urinate during the night? If yes, # of times _____	☐	Yes	☐	No
Do you feel pain or burning with urination?	☐	Yes	☐	No
Blood or sperm in your urine? What _____	☐	Yes	☐	No
Do you have any penile discharge?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Problems with urinary incontinence?	☐	Yes	☐	No
Have you had any urologic surgeries? What? _____	☐	Yes	☐	No
Breast Lumps?	☐	Yes	☐	No
Testicle pain or swelling?	☐	Yes	☐	No
Do you have undescended testes?	☐	Yes	☐	No
Have you ever been diagnosed with Peyronie's disease?	☐	Yes	☐	No
Have you ever been diagnosed with a varicocele?	☐	Yes	☐	No
Has your scrotum changed color (e.g. pale, darker, red, purple)? Please describe _____	☐	Yes	☐	No
Do you have a loose scrotum?	☐	Yes	☐	No
Do you have a loss of or significant thinning of pubic hair?	☐	Yes	☐	No
Do you have excessive pubic hair?	☐	Yes	☐	No
Do you have any penile pain or discomfort? If yes, please describe _____	☐	Yes	☐	No
Do you have difficulty maintaining an erection?	☐	Yes	☐	No
Do you have difficulty ejaculating?	☐	Yes	☐	No
Have you experienced premature ejaculation?	☐	Yes	☐	No
Do you regularly experience nocturnal emission?	☐	Yes	☐	No
Do you have blood in the sperm?	☐	Yes	☐	No
Do you have low testosterone levels?	☐	Yes	☐	No
Have you experienced tiredness and/or dizziness after ejaculation?	☐	Yes	☐	No
Date of last prostate and rectal exam: _____ Findings: _____				

FERTILITY
What was your sperm count: ☐ Below Normal ☐ Normal Number _____
What was the sperm motility: ☐ Below Normal ☐ Normal Notes: _____
What was the sperm morphology: ☐ Abnormal ☐ Normal Notes: _____

PLEASE DESCRIBE ANY OTHER HEALTH CONCERNS YOU MAY HAVE