Thom Heil, L.Ac.

Clinic Policies

- **Services:** Thom Heil, L.Ac., provides patients with high-quality traditional Chinese medicine, including acupuncture, herbal therapy, cupping, moxa, gua sha, tui na, and dietary or lifestyle advice. The necessary treatments will be discussed with the patient before performing them.

- **Herbal recommendations:** Herbs may be recommended and provided to patients at the time of their appointment. Chinese herbs are taken in combinations called formulas. The price of herbs will vary depending on the size of the formula and the form in which the herbs are provided. Pricing of herbs may be discussed at the time they are recommended.

- **High blood pressure:** Patients with uncontrolled high blood pressure may be required to obtain written permission from a physician before they can receive acupuncture treatments. Decisions will be made on a case-by-case basis.

- **Late arrival:** We try to accommodate late arrivals, but we may only be able to offer consultations and/or shortened treatments in the time remaining of the original appointment.

- **Appointment cancellation:** In order to best serve patients, we request that patients contact us at least **twenty-four hours** in advance if they need to cancel an appointment. The fee for late cancellations and no-shows is the **full cost** of the acupuncture treatment. The fee will be due immediately, and will be collected at the patient's next appointment.

- **Repeated cancellations:** Patients who accumulate three late cancellations and/or no-shows may only schedule same-day appointments.

- **Appropriate dress:** Patients are asked to wear comfortable, loose-fitting clothing such as sweat pants or yoga pants (not jeans) to all of their appointments in order to accommodate treatments. Patients dressed otherwise will be asked to dress in appropriate garb. Patients may need to be covered with a drape for treatment.

- **Appropriate hygiene:** Patients are requested to arrive hygienic, and not to wear heavy perfumes or scents, which may cause adverse reactions to others.

- **Contact:** For best service, please call or e-mail your acupuncturist with any questions. Thom returns calls and e-mails as quickly as possible, usually within one business day.

Thank you,
Thom Heil, L.Ac.

Patient Name (print)_____Date_____

Patient Signature _____

Thom Heil, L.Ac.

NOTICE OF PRIVACY POLICIES - January 18, 2012

Our office is dedicated to providing services with respect for human dignity. Protecting your privacy and healthcare information is fundamental to our relationship with you. This notice will remain in effect until it is replaced or amended by changes in the law.

We gather personal information and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Protected Health Information is any information that includes demographic information; information gathered by Thom Heil, L.Ac., as relates to your past, present, and future physical or mental health or condition; or past, present, or future payments for healthcare services.

You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for the treatment, payment, and healthcare operations we perform.

Without your consent or authorization, this office may disclose information about you only to the following groups for the specified purposes:

- To a public health agency, for a purpose such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- To health oversight authorities, for regulatory, licensing, and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security, or intelligence for Foreign Service, to your authorized superiors or other federal officials.

We may not use or disclose information about you for any other purpose without your authorization, provided separately from your written consent. You may submit written authorization to disclose Protected Health Information to a person or group specified by you.

Marketing
This office will not use your health information for marketing communications without your written authorization. Marketing communications may include birthday 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.

Patient Rights

- Upon written request, you have the right to access, review, or receive copies of your healthcare records.
- Upon written request, unless prohibited by law, you have the right to receive a list of items this office disclosed about your healthcare information.

- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request restrictions on the use and disclosure of your Protected Health Information for the purposes of treatment or payment for healthcare operations, but Thom Heil, L.Ac., is not required to agree to these restrictions. However, if Thom Heil, L.Ac., agrees to a restriction that you request, the restriction is binding to Thom Heil, L.Ac.
- You have the right to request that we amend your Protected Health Information. This request must be in writing.
- You have the right to receive all notices in writing.

More Information
If you have any questions or complaints, or would like to receive more information, contact Thom Heil at 872-216-9612.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to Thom Heil or by directing a letter to our attention.

If you are not satisfied with how our office handles your complaint, you may submit a formal complaint to:

DDHS (Office of Civil Rights)
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Thom Heil, L.Ac.

Acknowledgment of Receipt of
NOTICE OF PRIVACY POLICIES – January 18, 2012

I, the undersigned, have received a copy of, read, reviewed, understand, and agree to the "Notice of Privacy Policies" for healthcare services provided by Thom Heil, L.Ac.

Patient Signature: _____Date: _____

Acupuncture Intake Form

Please complete this document as thoroughly as possible. Some of the questions may seem unrelated to your condition, but they could play a major role in diagnosis and treatment. This information is CONFIDENTIAL. If you have any questions, please feel free to ask. Thank you.

CONTACT INFORMATION

Name:_____ Date:_____/_____/_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

E-Mail:_____

May we contact you to remind you about your appointments: ☐Yes ☐No

What is the best way to contact you? ☐Phone ☐E-mail ☐Text Message

EMERGENCY CONTACT

Name:_____ Phone:_____

PERSONAL INFORMATION

Occupation:_____

Birthdate:_____/_____/_____ Age:_____ Number of Children:_____

Sex: ☐Male ☐Female ☐Trans: MTF_____ FTM_____ Height_____ Weight_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partnered

Have you received acupuncture before? ☐Yes ☐No

When?_____ With whom?_____

Who should we thank for referring you our office?_____

MEDICAL HISTORY

Please list any medications and/or supplements you are currently taking:

_____

_____

_____

Please check any current or past health issues you have experienced:

☐Allergies
☐Anemia
☐Appendicitis
☐Arteriosclerosis
☐Asthma
☐Bleeding disorder
☐Blood pressure (low or high)
☐Cancer
☐Chicken pox
☐Diabetes
☐Digestive disorders
☐Emotional difficulties
☐Emphysema
☐Epilepsy
☐Fatigue
☐Gout
☐Heart disease
☐Hepatitis (A, B, C)
☐Hypoglycemia
☐Injuries
☐Insomnia
☐Intestinal parasites
☐Multiple sclerosis
☐Mumps
☐Pacemaker
☐Weight loss or gain
☐Polio
☐Scarlet fever
☐Stroke
☐Thyroid
☐Tuberculosis
☐Ulcers

Other_____
_____
_____

Sexually transmitted diseases: ☐Gonorrhea ☐Syphilis ☐HIV ☐Chlamydia ☐Herpes Date:_____

Please indicate if any of the following are true:

☐I have known allergies (please list) _____
☐I am taking coumadin/warfarin
☐I am taking lithium
☐I have a pacemaker

Please indicate the use and frequency of the following:

☐Coffee/Tea _____ ☐Tobacco _____
☐Non-medical drugs _____ ☐Alcohol _____
☐Water _____ ☐Soda _____
☐Exercise _____

MEN ONLY

Date of last prostate check-up _____ PSA results _____

Manual prostate exam results _____ Lab results _____

Frequency of urination: daytime _____ nighttime _____

Color of urine: ☐Clear ☐Murky Odor: _____

Do you experience any of the following:

☐Reduced libido ☐Excessive libido ☐Impotence ☐Genital or testicular pain
☐Urinary frequency ☐Discharge ☐Premature ejaculation

Any other concerns? _____

WOMEN ONLY

Age of first period _____ Age of last period (menopause) _____ Are you pregnant? ☐Yes ☐No

# of pregnancies _____ # of live births _____ # of miscarriages _____ # of abortions _____

Number of days between periods_____ Number of days of flow_____ Color of flow_____

Clots? ☐Yes ☐No Color of clots _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____
4th day _____ 5th day _____ + day _____

Please check if you experience any of the following related to your menses:

☐Discharge	☐Vaginal dryness	☐Headache
☐Nausea	☐Constipation	☐Diarrhea
☐Swollen breasts	☐Mood swings	☐Ravenous appetite
☐Poor appetite	☐Hot flashes	☐Night sweats
☐Increased libido	☐Decreased libido	☐Insomnia

Location of pain: ☐Lower abdomen ☐Lower back ☐Thighs ☐Other _____

Nature of pain (please indicate before, during, or after menses):

☐Cramping _____	☐Consistent _____
☐Intermittent _____	☐Stabbing _____
☐Aching _____	☐Dull _____
☐Bloating_____	☐Bearing down sensation _____
☐Burning _____	

Have you ever been diagnosed with:

☐Fibroids	☐Ovarian cysts	☐Fibrocystic breasts
☐PID	☐Endometriosis	☐other _____

Date of last: Gynecologic exam _____ Pap smear _____
Mammogram _____ Bone Density Scan _____

Results: _____
_____

SYMPTOM SURVEY

Please fill this out carefully, even if some of the symptoms seem unrelated to your current condition. Place **one check** next to the symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

SP/ST:

___ lack of appetite	___ excessive appetite	___ loose stool or diarrhea
___ digestive problems	___ vomiting	___ belching, burping
___ heartburn/reflux	___ feeling of food stuck in stomach	___ obsessive thoughts

HRT:

___ insomnia, difficulty sleeping	___ heart palpitations	___ cold hands and feet
___ nightmares	___ mentally restless	___ laughing for no reason
___ angina pains		

PAIN:

___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain or coldness in genitals

LU/LI:

___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticulitis
___ constipation
___ hemorrhoids
___ recent use of antibiotics

LV/GB:

___ eye problems
___ difficulty digesting oily foods
___ jaundice
___ gallstones
___ light colored stool
___ soft or brittle nails
___ easily angered or agitated
___ difficulty making plans/decisions
___ muscle spasms or twitching

KD/UB:

___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems

QI/XUE:

___ fatigue
___ edema
___ blood in stool
___ black tarry stool
___ easily bruised
___ difficult to stop bleeding
___ asthma
___ tendency to catch colds easily
___ hay fever
___ allergies
___ intolerance to weather changes
___ dizziness
___ tendency to faint easily
___ high cholesterol levels
___ sudden weight loss

DIET & FOOD ALLERGIES

What do you typically eat for the following meals?

Breakfast: _____
_____

Lunch: _____
_____

Dinner: _____
_____

Snacks: _____
_____

Please list any food sensitivities, allergies, or cravings you are currently experiencing:

_____
_____
_____

CHIEF COMPLAINTS

Please list your major complaint(s) in order of significance to you. Rate the severity of the complaint on a 1-10 scale, 1 being very low and 10 being very high.

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10
4. _____ 1 2 3 4 5 6 7 8 9 10

What other forms of treatment have you sought for the above complaints? Results?

_____
_____
_____

List any accidents, surgeries, or hospitalizations (include date).

_____
_____
_____

Lab results (please include copies):

_____
_____
_____

PERSONAL VIEWS

How do you feel about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	**Good**	**Fair**	**Poor**	**Bad**	
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Please list any other information that may be relevant to your medical history:

_____
_____

By signing below, you acknowledge that the above information has been filled out correctly and completely to the best of your knowledge.

_____ _____
Patient's or Guardian's signature Date

_____ _____
Acupuncturist's signature Date