Welcome to Daoist Traditions College of Chinese Medical Arts. Our Acupuncture Clinic offers treatment for a wide range of conditions with excellent and compassionate care.

Daoist Traditions College
Acupuncture Clinic

222 S. French Broad Avenue
Asheville, NC 28801
(828) 253-8669

Fees & Payment:

- **$35 for Adults (18 & older, if not a full-time student)**
- **$25 for Full-time students with a valid ID**
- **$25 for Children under the age of 18**
- **$10 for Daoist Traditions Students**
- **Herbs vary in price**

Payment for treatment and herbs is required at the time of treatment and can be made by check, cash or credit/debit card. There is a $1.00 Service Charge for payments made by credit/debit card. There is a charge of $35.00 for any returned checks. The total amount for the bounced check and the $35 fee must be paid in cash. No further service can be provided until this amount is paid.

Herbs must be picked up and paid for when they are prescribed. Please call to request herb refills, as they need to be approved by the intern(s) and supervisor.

We do not provide billing for insurance claims. Patients requiring receipts for income taxes, flex spending accounts, and health savings accounts may request these receipts at the time of service. Daoist Traditions does not issue retroactive cash receipts.

With a parent's permission, minors between the ages of 12-13 may be treated without the accompaniment of a parent or guardian. Minors under the age of 12 must be accompanied by a parent or guardian at the clinic during the entire duration of the treatment.

Appointments:
Please be aware that you may be asked to see a student intern other than the one originally scheduled. As a patient, you must accept any Clinical Intern and Clinical Assistant assigned to you without discrimination. If your regular Clinical Intern or Clinical Assistant is unavailable, this policy extends to any substitute Clinical Intern or Clinical Assistant assigned to you. We cannot notify you ahead of time if your regular Intern is absent.

All treatments take approximately 1.25 - 2 hours. Please be sure to wear loose clothes and to eat before your appointment. If you are a new patient to the clinic, plan to arrive 20 minutes before your scheduled appointment time in order to complete your New Patient Information Packet.

Cancellations:
It is important to make every effort to keep your scheduled appointment and to be on time. *If you are more than 20 minutes late, your treatment time may be shortened or we may need to reschedule your appointment.* If you need to cancel an appointment please call the clinic 24 hours prior to your appointment time. **There is a $25 charge for missed appointments without 24 hour notice and for late appointments that need to be rescheduled.**

Should you become acutely ill please make every effort to attend your scheduled appointment as acupuncture is extremely helpful for acute conditions. If there is inclement weather, please call the clinic for information about possible closure of the clinic.

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We look forward to providing you with an excellent health care experience. Suggestions, questions, and concerns regarding the clinic should be directed to the Academic Dean at 828-225-3993.
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NOTICE OF PRIVACY POLICIES (HIPAA)

The Daoist Traditions College Acupuncture Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in 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.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

The Daoist Traditions College Acupuncture Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

Disclosure

The Daoist Traditions College Acupuncture Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information:
Contact: Peter Shea, Clinic Director
Telephone: 828-225-3993
Address: 222 South French Broad, Asheville, NC 28801

To send a written complaint to the U.S. Department of Health and Human Services:
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

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HEALTH HISTORY QUESTIONNAIRE

Name: | **DOB:** | **Age:** **Height:** **Weight:**

Address: **City:** **State:** **Zip:**

Email: | **Have you tried acupuncture? Yes No**

Phone #: **Cell:** **May we leave a voicemail? Yes No**

Occupation: | **Marital status:**

Emergency Contact Name: **Phone:**

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

What is your Main Concern?

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is diagnosis?

What kinds of treatment or therapies have you tried?

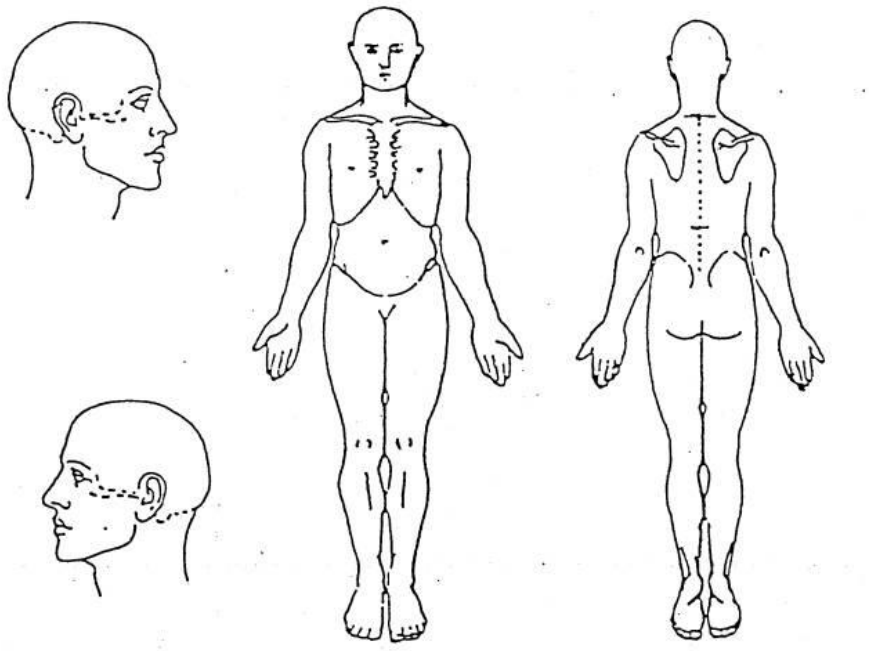
Hospitalizations/Surgeries/Accidents:

Allergies:

FAMILY HEALTH HISTORY

Family Member	*Age*	*Important Diseases/Illnesses*	*Deceased Y/N*

Please mark painful or distressed areas on the charts below.



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

LIFESTYLE

Exercise

☐ Sedentary (No exercise)

☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)

☐ Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Number of meals you eat in an average day?

Describe daily diet:

Caffeine/

Indicate # of cups/cans per day ☐ Coffee ☐ Tea ☐ Cola

Alcohol/ Drugs

☐ Tobacco _____ packs per day Type? # of years?

Do you drink alcohol? ☐ Yes ☐ No

If so, how many drinks per week?

Tobacco

Do you use recreational drugs? If yes, what type?

PERSONAL HISTORY

General	☐ Poor Appetite	☐ Weight Gain	☐ Night Sweats
	☐ Insomnia	☐ Weight loss	☐ Fever
	☐ Disturbed Sleep	☐ Sweating easily	☐ Chills
	☐ Localized Weakness	☐ Bleeding/bruising	☐ Sudden energy drop
	☐ Cravings	☐ Tremors	☐ Poor Balance
	☐ Strong Thirst		
Skin and Hair	☐ Rashes	☐ Eczema	☐ Recent moles
	☐ Ulcerations	☐ Pimples	☐ Changes in hair texture
	☐ Hives	☐ Dandruff	☐ Hair loss
	☐ Itching		
Head, Eyes, Ears, Nose, Throat	☐ Dizziness	☐ Color blindness	☐ Recurrent sore throats
	☐ Concussions	☐ Cataracts	☐ Nose bleeds
	☐ Migraines	☐ Blurry vision	☐ Grinding teeth
	☐ Glasses	☐ Earaches	☐ Sores on lips or tongue
	☐ Spots in front of eyes	☐ Ringing in the ears	☐ Facial pain
	☐ Eye pain	☐ Poor hearing	☐ Teeth problems
	☐ Poor vision	☐ Eye strain	☐ Headaches
	☐ Night blindness	☐ Sinus problems	☐ Jaw clicks
	☐ Photophobia	☐ TMJ	☐ Gum/teeth problems
Cardiovascular	☐ Dizziness	☐ High B.P.	☐ Swelling of feet
	☐ Low blood pressure	☐ Fainting	☐ Blood clots
	☐ Chest pain	☐ Cold hands or feet	☐ Difficulty in breathing
	☐ Irregular heartbeat	☐ Swelling of hands	☐ Phlebitis
	☐ Tightening in chest	☐ Palpitations	☐ Stroke
Respiratory	☐ Cough	☐ Bronchitis	☐ Frequent colds or flu
	☐ Asthma	☐ Shortness of breath	☐ Excessive phlegm
Gastrointestinal	☐ Nausea	☐ Belching	☐ Rectal pain
	☐ Vomiting	☐ Black stools	☐ Hemorrhoids
	☐ Diarrhea	☐ Blood in stools	☐ Abdominal pain/cramps
	☐ Constipation	☐ Indigestion	☐ Chronic laxative use
	☐ Gas/ Bloating	☐ Bad breath	☐ Crohn's
	☐ Parasites	☐ Diverticulitis	☐ Colitis
Genitourinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Urinary infections	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	☐ Low to no sex drive
Musculoskeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Numbness/Tingling	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	☐ Foot/ankle pains

Neuropsychological	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Underweight	☐ Overweight

MENTAL HEALTH		
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
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation: Date of last menstruation:		
Period occurs every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Hot flashes or sweating at night?	☐ Yes	☐ No
Menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Breast tenderness, lumps, nipple discharge?	☐ Yes	☐ No

MEN ONLY		
Recent kidney, bladder, or prostate infections?	☐ Yes	☐ No
Problems emptying your bladder completely?	☐ Yes	☐ No
Difficulty with erection or ejaculation?	☐ Yes	☐ No
Testicle pain or swelling?	☐ Yes	☐ No
BPH or chronic prostatitis?	☐ Yes	☐ No
Burning or discharge from penis?	☐ Yes	☐ No

Please List all medicines, herbs and supplements you currently take:

_____
_____
_____
_____
_____

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Please initial each section and sign at the bottom of the page:

Acknowledgement of Receipt of Notice of Privacy Policies

I have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Daoist Traditions College Acupuncture Clinic.

Initials:_____

Patient's Consent for the Purposes of Payment and Healthcare Operations

I give consent to the Daoist Traditions College Acupuncture Clinic to use and disclosure of my Individual Identifiable Health Information or Protected Health Information for the specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:
Protected Health Information is any information that includes:

1. Demographic Information
2. Information gathered by this practice as it relates to my past, present and future.
3. Information gathered by this office for past, present or future payments for providing the healthcare services.
4. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

Initials: _____

Acknowledgement of Receipt of Clinic Policies

The Daoist Traditions College Acupuncture Clinic provides each patient with a statement of Clinic Policies.

I have read, reviewed, understand and agree to the statement of the Office Policies for healthcare services at the Daoist Traditions College Acupuncture Clinic.

• I agree to provide at least 24 hour notice of cancellation and accept the $10 fee for missed appointments.
• I understand that I may be asked to see a clinical intern other than the one I am originally scheduled with. I agree to accept any Clinical Intern and Clinical Assistant assigned to me without discrimination.
• I understand that my clinical intern may be working with a partner and that an observing student may also be present during my sessions.
• I acknowledge that there is a $35 processing fee for bounced checks.

Initials: _____

Print Name: _____

Patient or Personal Representative Signature: _____ **Date:** _____

PLEASE RETURN THIS SIGNED FORM TO CLINIC INTERN