

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.



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.

## **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

## HEALTH HISTORY QUESTIONNAIRE

|                                                                    |                                           |                                         |                |                |
|--------------------------------------------------------------------|-------------------------------------------|-----------------------------------------|----------------|----------------|
| <b>Name:</b>                                                       | <b>DOB:</b>                               | <b>Age:</b>                             | <b>Height:</b> | <b>Weight:</b> |
| <b>Address:</b>                                                    | <b>City:</b>                              | <b>State:</b>                           | <b>Zip:</b>    |                |
| <b>Email:</b>                                                      | <b>Have you tried acupuncture? Yes No</b> |                                         |                |                |
| <b>Phone #:</b>                                                    | <b>Cell:</b>                              | <b>May we leave a voicemail? Yes No</b> |                |                |
| <b>Occupation:</b>                                                 | <b>Marital status:</b>                    |                                         |                |                |
| <b>Emergency Contact Name:</b>                                     | <b>Phone:</b>                             |                                         |                |                |
| <b>Who may we thank for referring you?</b>                         |                                           |                                         |                |                |
| <b>Recent Health Care Providers: Name, Date, Service Provided:</b> |                                           |                                         |                |                |

### 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:**

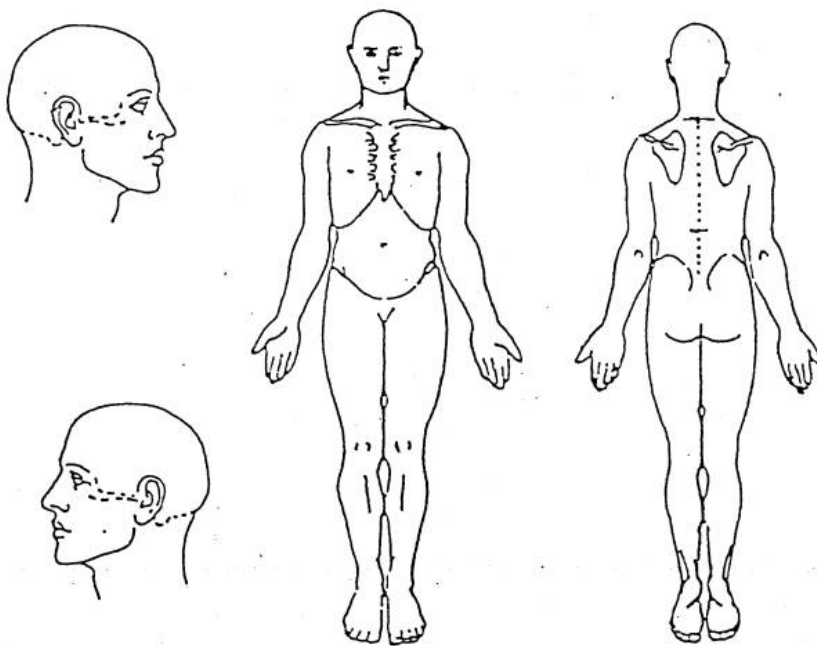
**Allergies:**

### FAMILY HEALTH HISTORY

| <i>Family Member</i> | <i>Age</i> | <i>Important Diseases/Illnesses</i> | <i>Deceased Y/N</i> |
|----------------------|------------|-------------------------------------|---------------------|
|----------------------|------------|-------------------------------------|---------------------|

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

|                      |                                                                                                                                                                                                                                                                                                                                                              |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Exercise</b>      | <input type="checkbox"/> Sedentary (No exercise)<br><input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)<br><input type="checkbox"/> Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)<br><input type="checkbox"/> Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes) |
| <b>Diet</b>          | Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Number of meals you eat in an average day?<br>Describe daily <input type="checkbox"/> diet:<br>_____<br>_____                                               |
| <b>Caffeine/</b>     | Indicate # of cups/cans per day <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola<br><input type="checkbox"/> Tobacco _____ packs per day    Type?                      # of years?                                                                                                                                 |
| <b>Alcohol/Drugs</b> | Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If so, how many drinks per week?                                                                                                                                                                                                                                           |
| <b>Tobacco</b>       | Do you use recreational drugs? If yes, what type?                                                                                                                                                                                                                                                                                                            |

## PERSONAL HISTORY

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

|                           |                                          |                                          |                                               |
|---------------------------|------------------------------------------|------------------------------------------|-----------------------------------------------|
| <i>Neuropsychological</i> | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Poor memory     | <input type="checkbox"/> Anxiety              |
|                           | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Depression      | <input type="checkbox"/> Bad temper           |
|                           | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion      | <input type="checkbox"/> Frequent mood swings |
| <i>Other Illness</i>      | <input type="checkbox"/> HIV positive    | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Eating disorder      |
|                           | <input type="checkbox"/> AIDS            | <input type="checkbox"/> Hypoglycemia    | <input type="checkbox"/> Jaundice             |
|                           | <input type="checkbox"/> Epstein-Barr    | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hepatitis            |
|                           | <input type="checkbox"/> Mononucleosis   | <input type="checkbox"/> Underweight     | <input type="checkbox"/> Overweight           |

**MENTAL HEALTH**

|                                                         |                              |                             |
|---------------------------------------------------------|------------------------------|-----------------------------|
| Is stress a major problem for you?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**WOMEN ONLY**

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

**MEN ONLY**

|                                                 |                              |                             |
|-------------------------------------------------|------------------------------|-----------------------------|
| Recent kidney, bladder, or prostate infections? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problems emptying your bladder completely?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty with erection or ejaculation?        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Testicle pain or swelling?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| BPH or chronic prostatitis?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning or discharge from penis?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

|                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Please List all medicines, herbs and supplements you currently take:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|----------------------------------------------------------------------------------------------------------------------------------------|

**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**