Infinite Wellness Acupuncture
Heather Douglas L.Ac
1512 Grand Ave. #210 GWS, CO 81601

(970)930-1809
Fax:(970)404-1833

PATIENT INFO:

Name:_____
Date: _____
Address: _____
City, State & Zip: _____

Primary phone: _____

Work phone: _____

Is it okay to reach you at any of these phone #s?
□ Yes □ No
Email:_____
Check here to opt out of email updates: ____

Age: _____ Birth Date: _____
Gender: _____ Pronoun: _____
Height: _____ Weight: _____

Filing status: Married or Single: _____
Yearly Household Net Income: _____
Occupation: _____
Company name: _____

Primary physician name & Practice Location:
_____
Emergency Contact Name: _____
Relationship: _____
Phone #: _____
How did you hear about us? _____

What are the top two primary health concerns that you want to address today?
1: _____
2: _____

HEALTH HISTORY:

Do you have a history of any blood borne illnesses? □ Hepatitis (type_____) □ HIV/ AIDS

Average hours ours do you average a night of sleep? ____
Any sleep complaints (wake often, hard to fall asleep, etc.)? _____

How many meals do you average a day? _____
How many snacks do you average a day? _____

Please give a rough estimate of how much of your diet is *processed foods* (Added preservatives & chemicals, prepackaged foods & fast food)?
_____%
How much is *whole foods*? (One ingredient food items: Meats, Starches/ Grains, Healthy Fats, Fruits & Veggies)? _____%

Are there any food items or groups you avoid?
_____
Are there any that you limit? _____

How much water do you average a day? _____

Average number of bowel movements daily? _____
Do you have any urinary complaints? □ Yes □ No

Do you have an exercise regimen, if so explain:
_____

Circle your stress level: mild, moderate or severe.
Please list the top 3 stressors in your life:
_____
Do you practice any type of relaxation practices, if so explain? _____

Do you drink caffeine, alcohol, use tobacco or any recreational drugs? If so, how much and often for each: _____
_____

Are you currently taking any pain medications or blood thinners? (including aspirin) □ Yes □ No
List all prescription medications, herbs or food supplements you are taking: _____
_____
_____
_____
_____
List all diagnosis, serious illnesses, accidents, or surgeries: _____
_____
_____
_____
_____
List any known allergies: _____
_____
When was your last complete medical exam? ____

Circle any immediate family history illnesses:
Diabetes, High Blood Pressure, Stroke, Cancer, Heart Disease, Kidney disease. Other? _____
_____

Have you ever had acupuncture before? □ Yes □ No

This information is correct to the best of my knowledge.

PRINTED NAME:
_____
PATIENT SIGNATURE:
_____
(Or Patient Representative)

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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 the acupuncturist who now or in the future treat me. I understand the methods of treatment may include, but are not limited to, acupuncture, Chinese and Western herbal medicine, nutritional counseling, cupping, tui na, moxibustion and gua sha. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or dietary changes.

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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage 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. If I suspect that I am pregnant, or have any blood borne or communicable diseases, I will immediately inform the acupuncturist.

I understand that while this document describes the major risks of treatment, other side effects 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, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

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.understand that I have the choice to accept or reject treatment at any time. 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.

PRINTED NAME_____ Date_____

PATIENT SIGNATURE:_____ (Or Patient Representative)

Education and Experience: Heather Douglas earned her Master of Science in Acupuncture at the Colorado School of Traditional Chinese Medicine, located in Denver, CO in 2015. This was a 28 month accelerated masters with 2265 hours. She is certified as a Licensed Acupuncturist by the Colorado State Boards, which includes certification in Clean Needle Technique, and has also received her Acupuncture Certification through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). Heather's training includes other modalities of healing through Chinese Medicine, including; gua sha, bloodletting, cupping, electroacupuncture, auriculotherapy, tuina, and dietary and lifestyle recommendations.
She holds an associate of science degree and certificate in Holistic Health, along with an associate of arts degree from Front Range Community College in Fort Collins, CO, is a reiki master and has trained in various forms of hands-on energy healing since 2010. To further assist the healing process, Heather continues to study with a prominent Colorado acupuncturist for an additional modality, an energetic reading.
She continues her education even further with certified continuing education courses.
None of her licenses or certifications have ever been suspended or revoked. The clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including proper sanitation of the acupuncture clinic, and use of the Clean Needle Technique. Only single-use, disposable, factory sterilized needles are utilized.

Cancelation Policy: I ask for a 48 hours notice.
Please call or text (970) 930-1809 for a late cancellation, please don't notify me through an email.
If it's **less than 48 hours you'll be charged half the cost of the missed appointment.**
Then if it is **less than 24 hours you will be charged the full amount of the missed appointment.**

Fee Schedule: *Same day payment discount:* We offer a sliding scale, so you pay what you can afford. Our view is that health is a right and not a privilege, so making affordable health care and preventable health care (monthly treatments) a reality for many people is a priority for us. Below are guidelines to what amount you will be charged based on your yearly income. I may require verification of income.

MARRIED/ COMBINED INCOME

Yearly Household Net Income	*Treatment Fee*
$0 - $30,000	$50
$30,000 - $60,000	$60
$60,000 - $90,000	$70
$90,000 -$120,000	$80
$120,000-$150,000	$90
Above $150,000	$100

SINGLE/ ONE INCOME

Yearly Household Net Income	*Treatment Fee*
$0 - $20,000	$50
$20,000 - $45,000	$60
$45,000 - $70,000	$70
$70,000 - $95,000	$80
$95,000 - $120,000	$90
Above $120,000	$100

Add 3% tax. Discount: Tax waived when paying with cash or check

Additional $20 charge for Estim, Cupping, Tuina or Gua Sha

Pediatrics (13 years and younger) & energetic reading only visits: take 50% off what the parent(s) qualify for.

Patient's Rights: The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
-The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Licensure Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

I have read and understand this document.

PRINTED NAME_____ Date_____

PATIENT SIGNATURE: _____ (Or Patient's Representative)

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This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT**:** Your health information may be disclosed for treatment or to a physician or other healthcare provider providing treatment to you.

PAYMENT**:** Disclosure of your health information may be used to obtain payment for services we provide to you. It may also be disclosed to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

HEALTH CARE OPERATIONS: Disclosure of your health information for our health care operations including: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. Disclosure of your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.

ON YOUR AUTHORIZATION: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

FAMILY AND FRIENDS: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up supplements for you.

COURTESY CALLS & APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointments, reminders, courtesy calls, etc. via voicemail, email, postcards, and letters.

PUBLIC BENEFIT**:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease/statistic & child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes

YOUR RIGHTS - YOU HAVE THE RIGHT TO:

- Request a copy of our Privacy Practices Notice at any timeand obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Revoke authorizations, in writing, that you made previously in regards to your protected health information
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information

OUR RESPONSIBILITIES - WE HAVE THE RIGHT TO:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practicesand abide by the terms of this notice

PRINTED NAME_____ Date_____

PATIENT SIGNATURE:_____ (Or Patient Representative)