Inez Coppola, L.Ac.

251 N. Main Street, White Salmon, WA 98672
Phone: (509)596-1074

Patient Information

Name:_____
last first middle

Address:_____
street city state zip

Phone:_____ Can I leave you a message? Y / N Text? Y / N

Email:_____ May I email you? _____

What is the way you preferred to be contacted? _____

Date of Birth:_____ Age:_____

Sex: Male / Female Gender: Male / Female / Other:_____

preferred pronouns: her/she he/him they/them other_____

Sexual orientation: _____Marital status: S M D W other: _____

Occupation:_____ Hours per week?_____ Retired? _____

Employer:_____

In case of emergency, call:_____
name number relationship

Have you had acupuncture before? yes/no

If *yes* where and when was your last treatment?_____

What brings you in today (chief complaint)? _____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

Referred by: _____

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Earth Body Wellness Center. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that if I receive *direct moxibustion* as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Herbs: I understand that herbal substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Inez Coppola, LAc as soon as possible.*

Gua Sha / Cupping: I understand that gua sha is the rubbing of a flat edged tool along the skin to produce a local bruise to help in the flushing of pathogens. I understand that this bruising may last for a few days, and the skin may be sensitive to the touch. I understand that cupping is the draining of pathogens under the skin by way of a suction created by oxygen deprived glass cups. Cupping may leave marks or bruises that could last for a few days.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage/ shiatsu massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that I have the right to refuse any treatment offered to me and ask for treatment alternatives at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

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HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Inez Coppola, LAc for the purposes of **treatment, payment and healthcare operations,** or as otherwise required by law.

• I acknowledge that Inez Coppola, LAc has provided me with a copy of Notice of Privacy Practices which describes how medical information about be may be used and disclosed, and how I can access this information. I have a right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed copy of the Notice of Privacy Practices.

• I have the right to request restrictions to the usage and disclosure of my protected health information.

• I have the right to request an alternative to the standard method of communication of my protected health information.

• I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Inez Coppola, LAc may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Inez Coppola, LAc at the following address:

PO Box 793 White Salmon, WA 98672

- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Inez Coppola, LAc by phone at: **509.596.1074**

- I am aware that Inez Coppola, LAc reserves the right to change the terms of Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Inez Coppola, LAc will make available a revised Notice of Privacy Practice for my review.

_____ _____

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_____ _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by Law: We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation. Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500

Other permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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Statement Of Financial Responsibility

I understand and agree to the following general responsibilities:

- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the Inez Coppola, LAc to release information necessary to secure payment.

- Financial options extended to me are based on the personal identification information and documentation I have provided.

- I understand that there will be **a minimum $50 fee** (and up to the full amount of the scheduled session) for any appointment **not cancelled within 36 hours** of the scheduled appointment**.**

- Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

_____ _____

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_____ _____

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Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Are you under the care of a physician now? Y /N If yes who?_____

When and where did you last receive health care?_____

For what reason? _____

Please identify your primary health concerns in order of importance:

1. _____

How does this condition affect/limit you? _____

2. _____

How does this condition affect/limit you? _____

3. _____

How does this condition affect/limit you? _____

Please list any foods, drugs/medications, topical (skin), airborne, plants or essential oils you are hypersensitive or allergic to (please include reaction):_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:_____

_____

_____

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Family History

Check those applicable	Father	Mother	Brother(s)	Sister(s)	Spouse	Children
Age (if living)						
Health (good/poor)						
cancer						
diabetes						
heart disease						
high blood pressure						
stroke						
mental illness						
asthma/hay fever/hives						
kidney disease						
age (at death)						
cause of death						

Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/____When was this reading taken? _____

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you?_____

Do you have any infectious diseases? Y / N If yes, please identify: _____

Hospitalizations and Surgeries:

Reason(s) and date(s) occurred:_____

_____

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason(s) and date(s) occurred:_____

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For the following sections please circle **C** for any symptoms that you are *currently* experiencing and circle **P** for any symptoms you have experienced in the *past*:

Emotional

Mood Swings	C / P	Nervousness	C / P	Mental Tension	C / P
Depression	C / P	Anxious	C / P	Fearful	C / P
Grief	C / P				

Energy and Immunity

Fatigue	C / P	Slow Wound Healing	C / P	Chronic Infections	C / P

Head, Eye, Ear, Nose, and Throat

Impaired Vision	C / P	Eye Pain/Strain	C / P	Glaucoma	C / P
Glasses/Contacts	C / P	Tearing/Dryness	C / P	Impaired Hearing	C / P
Ear Ringing	C / P	Earaches	C / P	Headaches	C / P
Sinus Problems	C / P	Nose Bleeds	C / P	Frequent Sore Throats	C / P
Teeth Grinding	C / P	TMJ/Jaw Problems	C / P	Hay Fever	C / P

Respiratory

Pneumonia	C / P	Frequent Colds	C / P	Difficulty Breathing	C / P
Emphysema	C / P	Persistent Cough	C / P	Pleurisy	C / P
Asthma	C / P	Tuberculosis	C / P	Shortness of Breath	C / P

Other Respiratory Problems: _____

Cardiovascular

Heart Disease	C / P	Chest Pain	C / P	Swelling of Ankles	C / P
High Blood Pressure	C / P	Palpitations/Fluttering	C / P	Stroke	C / P
Heart Murmurs	C / P	Rheumatic Fever	C / P	Varicose Veins	C / P

Gastrointestinal

Ulcers	C / P	Changes in Appetite	C / P	Nausea/Vomiting	C / P
Epigastric Pain	C / P	Passing Gas	C / P	Heartburn	C / P
Belching	C / P	Gall Bladder Disease	C / P	Liver Disease	C / P
Hepatitis B or C	C / P	Hemorrhoids	C / P	Abdominal Pain	C / P

Genito-Urinary Tract

Kidney Disease	C / P	Painful Urination	C / P	Frequent UTI	C / P
Frequent Urination	C / P	Heavy Flow	C / P	Kidney Stones	C / P
Impaired Urination	C / P	Blood in Urine	C / P	Freq. Urination at Night	C / P

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Female Reproductive/Breasts

Irregular Cycles	C / P	Breast Lumps	C / P	Breast Tenderness	C / P
Nipple Discharge	C / P	Heavy Flow	C / P	Vaginal Discharge	C / P
Premenstrual Problems	C / P	Clotting	C / P	Dark Thick Blood	C / P
Bleeding Between Cycles	C / P	Menopausal Symptoms	C / P	Difficulty Conceiving	C / P
Painful Periods	C / P				

Menstrual/Birthing History:

Age of First Menses: _____ # of Days of Menses: _____

Length of Cycle: _____ Birth Control Type: _____

# of Pregnancies: _____ # of Live Births: _____

# of Abortions: _____ # of Miscarriages: _____

Menopause: Y / N /in progress

Male Reproductive

Sexual Difficulties	C / P	Prostrate Problems	C / P	Testicular Pain/Swelling	C / P
Penile Discharge	C / P				

Musculoskeletal

Neck/Shoulder Pain	C / P	Muscle Spasms/Cramps	C / P	Arm Pain	C / P
Upper Back Pain	C / P	Mid Back Pain	C / P	Low Back Pain	C / P
Leg Pain	C / P				

Joint Pain (if so, where?): _____

Neurologic

Vertigo/Dizziness	C / P	Paralysis	C / P	Numbness/Tingling	C / P
Loss of Balance	C / P	Seizures/Epilepsy	C / P		

Endocrine

Hypothyroid	C / P	Hypoglycemia	C / P	Hyperthyroid	C / P Diabetes
Mellitus	C / P	Night Sweats	C / P	Feeling Hot or Cold	C / P

Other

Anemia	C / P	Cancer	C / P	Rashes	C / P
Eczema/Hives	C / P	Cold Hands/Feet	C / P		

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Major Traumas:_____

Abuse (physical, emotional, sexual)_____

_____

Lifestyle:

Do you typically eat at least three meals per day? Y / N If no, how many? _____

Exercise routine (type/frequency): _____

Do you have a spiritual belief/practice?_____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Do you enjoy work? Y/N

Why/Why not? _____

Nicotine/alcohol/caffeine/recreational drug use use:_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Interests and hobbies: _____

What wellness goals would you like to achieve in 6 months? _____

_____

One Year?_____

_____

Is there anything else you would like me to know? _____

_____