TOTAL HEALTH
& HEALING CENTER

Dr. Shanna C. Miller DC, CCN
Dr. Sarah E. Haggbloom, DC, ATC
Dr. Phillip Kamps, DC, CCSP
Dr. Michael Head, DC

PATIENT INFORMATION

Date: _____

Name: First_____Middle Initial_____ Last_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail_____

Marital Status: M S W D P Sex: M F

Date of birth: _____ Age _____

Employer _____ Occupation _____

Name of Spouse/Partners _____

Spouses/Partners date of birth_____

Spouses/Partners Employer_____ Occupation_____

Number of children: _____

Have you ever had chiropractic care before? _____

Where? _____

How were you referred you to this office? _____

*****Insurance (*for auto, work comp and personal injury claims*): Please present a copy of your insurance card or claim number, contact person's name, phone number, and address to send claims to the receptionist.**

Is this a work related injury? _____

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Cassie Calendine L. Ac.

Acupuncture Intake

Name_____ Date of Birth_____

Address_____ City_____ Zip Code_____

Phone_____ Email _____

How did you hear about us? _____

Have you had acupuncture before?	Y	N
Do you have a bleeding disorder?	Y	N
Do you have a pacemaker or electronic implant?	Y	N
Any signs of a cold or flu?	Y	N
Are you diabetic?	Y	N
Any chance you are pregnant?	Y	N
Are you wearing contact lenses?	Y	N
Are you currently under the care of a physician?	Y	N

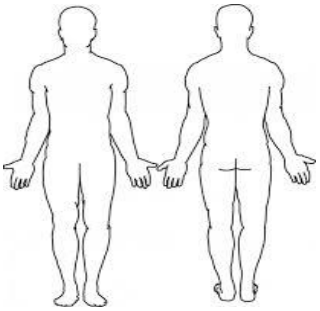
Please list any allergies:_____

Please list any medical conditions:_____

Please list current medications/vitamins/supplements:_____

Surgeries:_____

Main complaints:_____



Mark areas where you experience pain or discomfort and rate the pain below

0 1 2 3 4 5 6 7 8 9 10

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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.

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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

TOTAL HEALTH
& HEALING CENTER

NOTICE OF PRIVACY PRACTICES

Total Health and Healing Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide out patients with notice of your legal duties and privacy practices with respect to your protected health information.

There are certain times that we will disclose your healthcare information. These times include: for purposes of treatment, appointment reminders or missed appointment calls, payment, workers compensation, and health care operations. There are certain times where you can agree or object to disclosure of information. These times include: for purposes in the facility directory, persons involved in your care, and notifications to others.

Your rights:

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Total Health & Healing Center is not required to agree to the restriction that you requested.
2. You have the right to your health information received or communicated through an alternative method or sent to an alternative location.
3. You have the right to inspect and copy your health information.
4. You have the right to request that your health information be amended. However, requests have been denied and an explanation will be provided along with measures as to how to disagree with your denial.
5. You have a right to receive an accounting of disclosures of your protected health information.
6. You have a right to a paper copy of this Notice at any time upon request.

Any changes made to this notice must be presented to you. Our privacy officer is Dr. Shanna Miller and complains and concerns can be presented to him at (763) 754-1482. This paper is a modified version of our HIPPA polices. A full copy can be obtained upon request and is always displayed at the front desk.

I have read, understand, and agree to the HIPPA polices at Total Health and Healing Center.

_____ _____ _____

Patient Signature Date Witness

I am opting not to sign this agreement for the following reason(s):

_____ _____ _____

Patient Signature Date Witness

TOTAL HEALTH
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Financial Policies and Guidelines

Total Health and Healing Center is a "fee for service" practice and Payment is due at the time of service. If you have insurance, we must emphasize that, as a wellness center, our relationship is with you, not your insurance company.

As a courtesy, we can provide our patients with a coded receipt to submit for reimbursement of any chiropractic coverage. Many of our services are considered preventative/ wellness care and therefore will not be covered by most insurance. We are under no obligation to provide Doctor's notes to your insurance company.

When you schedule a personalized appointment for your healthcare needs, that time is set aside for you. If you need to reschedule your appointment, we ask that you give us a minimum of 24 hours notice. We reserve the right to charge for any appointments missed without this notice. If you have a package, we will deduct that from your total.

Due to federal guidelines, we are unable to offer discount packages to patients submitting to Medicare. Many patients who have Medicare and are on a wellness program request that we not submit so they can take advantage of the package discounts.

*Supplement discounts applied to homeopathic remedies, medical foods, and nutritional supplements. The office visit package excludes the cost of orthotics, fitness bands, etc.

If at any time during the treatment period the package owner chooses to discontinue treatments, they will be reimbursed the remainder of their balance, minus all the discounts they have received to date. If a credit card was initially used to purchase the package a 3% processing fee will be applied to return. Notice must be given in writing and reimbursement will be made in one weeks' time in the form of a check.

Prices listed include 1.8% MN care tax.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS REGARDING THE FINANCIAL POLICIES AND GUIDELINES.

PRINT NAME _____

SIGNATURE _____

DATE _____