

 **Ashland Holistic Health** 

325 A St., Ste #1 ASHLAND OR 97520
PH (541) 482.1650 www.ashlandholistichealth.com

THANK YOU FOR FILLING THIS OUT SO WE MAY BETTER SERVE YOUR CHILD! Today's Date: ___/___/___

CHILD'S Name _____ (_____) Male ___ Female ___ Age: ___ Birth Date ___/___/___
LAST FIRST (prefers to be called)

PARENT'S INFO:

Name _____

Mailing Address _____ City _____ State ___ Zip _____

Home Address (if different) _____

Phone #s: Cell _____ Home _____ Work _____

E- mail _____

Occupation _____ Employer _____

EMERGENCY CONTACT: Name _____ Phone # _____

Does child have Acupuncture Insurance? ___ No ___ Yes Ins. Co.

Whom may we thank for referring you? _____

Child's Main Health Issue(s) you wish to address _____

What was initial cause? _____

How long has child had this/these condition(s)? _____

Is it getting worse? ___ Yes ___ No Does it bother child's: ___ Sleep ___ Play ___ School ___ Other: _____

What seems to make it better? _____ What seems to make it worse? _____

Other therapies child has tried or is trying to help this condition _____

Has child had acupuncture before? ___ Yes ___ No Chinese Medicine? ___ Yes ___ No

Please tell the story of this condition (use the back side of this page if necessary): _____

In general, I feel my child's overall health is: ___ Excellent ___ Good ___ Fair ___ Poor

Rate child's following on scale of 1 (poor) to 10 (great): ___ Sleep ___ Energy Level ___ Appetite ___ Digestion

Elimination regular? ___ Yes ___ No Any gas, bloating or other discomfort after eating: ___ Yes ___ No

Height _____ Weight _____ Blood Type _____ Blood Pressure _____

Comments on any of the above: _____

To the best of your knowledge, has child ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? _____

Any foreign residence or travel in last two years? _____

Current /Recent Health Care Providers

<u>Name</u>	<u>Dates</u>	<u>Care Provided</u>
_____	_____	_____
_____	_____	_____

Allergies

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc. _____

Vaccinations

Antibiotic Use

<u>When</u>	<u>For What Reason</u>
_____	_____
_____	_____

Medications - Please list all prescription and over-the-counter medications child is currently using

<u>Medication</u>	<u>What it's for</u>	<u>For how long?</u>	<u>Strength</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Supplements/Herbs Were these recommended by: practitioner parent both

<u>Supplement/Herb</u>	<u>Brand Name</u>	<u>Potency (mg, IU, etc)</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Accidents/Injuries - briefly describe

Hospitalization/Surgery

<u>Date</u>	<u>Hospital</u>	<u>Doctor</u>	<u>Diagnosis/Operation</u>
_____	_____	_____	_____
_____	_____	_____	_____

Mark the following "1" if current "2" if past

- | | | |
|--|--|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> migraines |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> sciatica | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> frequent cold/flu | <input type="checkbox"/> dribbling urine | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> painful urination | <input type="checkbox"/> poor sleep |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> scanty urination | <input type="checkbox"/> hypoglycemia |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> blood in urine | <input type="checkbox"/> severe mood swings |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> frequent depression | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> eye problems | <input type="checkbox"/> overweight |

- ___ allergies
- ___ sinus congestion
- ___ colitis
- ___ jaundice
- ___ hepatitis
- ___ parasites
- ___ gas
- ___ bloating

- ___ photophobia
- ___ dizziness
- ___ night sweats
- ___ hearing problem
- ___ tinnitus
- ___ memory difficulty
- ___ anxiety
- ___ frequent anger

- ___ underweight
- ___ eating disorder
- ___ gum/teeth problems
- ___ lots of fillings
- ___ TMJ
- ___ concussion
- ___ heartburn/acid indigestion
- ___ frequent frustration

FEE POLICY

- Payment may be made by cash, check, Visa, Master, or Discover; returned checks are subject to a \$25 fee
- We require 24-hr. notice for appointment cancellation and reserve the right to charge for appointments canceled without said notice
- We want everyone to be able to receive necessary treatment. If unusual circumstances or hardship prevents you from continuing treatment, please speak with our Office Manager.

Client / Representative NAME (Printed)	Client / Representative SIGNATURE	Date
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INSURANCE ELIGIBILITY

I, the undersigned, do hereby authorize payment directly to this office for all the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance, and also responsible for monitoring my own insurance benefit usage.

I hereby authorize Jenn Collins, L.Ac., Molly Romero L.Ac., and Ashland Holistic Health to release all information necessary to secure these benefits. I authorize the use of this signature on all my insurance submissions.

Client / Representative NAME (Printed)	Client / Representative SIGNATURE	Date
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INFORMED CONSENT STATEMENT

Jenn Collins, L.Ac. and Molly Romero, L.Ac. are Oregon Licensed Acupuncturists, both holding a Masters of Science in Oriental Medicine as well as national certification in acupuncture through the National Commission for Certification of Acupuncturists.

Under Oregon law, acupuncture is defined as an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by stimulation of specific points by insertion of needles, with scope of practice including traditional and modern Oriental medical and acupuncture techniques of diagnosis & evaluation, use of an extensive herbal pharmacopoeia, vitamins, minerals, dietary advice, as well as Oriental massage, exercise and related therapeutic methods.

Jenn Collins, L.Ac. and Molly Romero, L.Ac. are not medical doctors. They do not claim to diagnose, treat or cure any medical conditions or pathologies nor prescribe medicine nor in any way represent themselves as so doing. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not for your care is your right, and acupuncturists at Ashland Holistic Health assume no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that:

- *no claims are made for acupuncture, herbal medicine, nutritional or dietary recommendations to treat or cure any medical condition*
- *all information given is for educational purposes only*
- *there is no implied or stated guarantee of success or effectiveness of any specific treatment plan or guidelines*
- *I am free to act upon or disregard the recommendations of Jenn Collins, L.Ac. and/or Molly Romero, L.Ac. as I so choose.*

I hereby release Jenn Collins, L.Ac., Molly Romero, L.Ac., and Ashland Holistic Health from any and all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints.

I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of Jenn Collins, L.Ac. and/or Molly Romero, L.Ac. to participate in a professional relationship with her pursuant to the statements herein.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

PRIVACY POLICY

This notice will remain in effect until it is replaced or amended by changes in law.

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.

We receive personal information and health information in several ways: from you, from other healthcare providers, and 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, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representation you choose to have your protected health information.

You may specifically authorize us to use protected health information for any purpose or to disclose your 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

This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders by telephone, post cards, or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Client Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of your healthcare information that this office has disclosed.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- Upon written request you have the right to amend your Protected Health information.
- You have the right to receive all notices in writing.

If you have any questions, complaints or want more information, please contact our Office Manager at the phone number/address listed at the top of this page. You may submit a written complaint to the U.S. Department of Health and Human Services.

I, the undersigned, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. A copy of these Privacy Policies may be obtained upon request.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date