



**Privacy Policy:**

Community Acupuncture Studio understands that your personal health information is very sensitive. We will not disclose your information to others unless you sign a release form, or unless the law requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing & payment information relating to these services. There is a \$10 processing fee for the photocopying and release of your records.

**Safeguards in place at our office include:**

Limited access to facilities where this information is stored. Strict policies and procedures for handling any personal, financial and medical information. Requirements for all associates, employees and volunteers that may come in contact with personal or medical information to comply with privacy laws and our privacy policies. All medical files and records are kept on file for ten years in a secure filing system, after which time they will be destroyed.

**Types of information that we gather and use:**

About your financial transactions with us. Information about your medical history, treatment and any letters to or from other health care practitioners. Information from health care providers, insurance companies, and other third party administrators (e.g. requests for medical records, procedures, or ICD-9 codes).

**Examples of use of private information for Treatment and Health Operations:**

We may provide information to acupuncturists treating you at Community Acupuncture Studio. We may use medical records to assess quality, effectiveness, and to improve services and procedures. We may contact you to follow up on your care or remind you of an appointment. We may use the financial information to evaluate the fiscal performance and financial sustainability of Community Acupuncture Studio.

**We value our relationship with you, and respect your right to privacy.**

If you have any questions call us during our regular business hours at (360) 943-6730.

By signing below you acknowledge that you have read and understand this information clearly AND that you have been offered a copy of our privacy policy which is also available on our website [www.cas-olympia.com](http://www.cas-olympia.com)

**Financial Policy:**

The charge for Acupuncture treatments is based on a suggested sliding scale. YOU, the patient, decide where you fit on the scale, no questions asked. We realize that everyone’s situation is unique, and the purpose for having this sliding scale is to separate the issues of money and getting treatment, while making acupuncture accessible to more people

| <b>Annual Income</b>   | <b>First Visit</b> | <b>Follow Up</b> |
|------------------------|--------------------|------------------|
| <b>Less than \$20K</b> | \$30               | \$20             |
| <b>\$20K-\$25K</b>     | \$35               | \$25             |
| <b>\$25K-\$30K</b>     | \$40               | \$30             |
| <b>\$30K-\$50K</b>     | \$45               | \$35             |
| <b>\$50K or more</b>   | \$50               | \$40             |

Community Acupuncture Studio does NOT receive any Federal or State Funding for the services we provide.

**We accept Cash or Check only**, please come prepared. Payment is due at check-in prior to the treatment. The fee for any checks returned with insufficient funds is \$30 in addition to the fee for the treatment.

**Cancellation Policy:**

Community Acupuncture Studio asks for 24-hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment. All appointments cancelled, missed, or rescheduled with less than 24 hours notice are subject to a **\$10 fee**. If appointments have been paid for in advance, the missed or cancelled appointment will be deducted from the number of remaining appointments.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



**Patient Notification of Scope of Practice, Qualifications and Informed Consent**

I, the undersigned, hereby authorize the licensed acupuncturist working at Community Acupuncture Studio to perform the following procedures. Outlined in the legal scope of practice of licensed acupuncturists in Washington State (RCW 18.06.130, WAC 246.803.300), includes the following:

- Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
- Moxibustion;
- Acupressure;
- Cupping;
- Dermal friction technique;
- Infra-red;
- Sonopuncture;
- Laserpuncture;
- Point injection therapy (aquapuncture); and
- Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
- Breathing, relaxation, and East Asian exercise techniques;
- Qi gong;
- East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
- Superficial heat and cold therapies.

**I recognize the potential benefits and risks of these procedures described below, which include but are not limited to:**

- **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.
- **Potential Risks:** Discomfort, pain following the treatment, minor bruising, blistering, bleeding, infection, numbness or tingling at or near the site of the procedure, temporary discoloration of the skin, broken needle, needle sickness, possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax.

Patients with severe **bleeding disorders** or **pacemakers** must inform the practitioner prior to receiving treatment. It is strongly recommended that **pregnant** patients also notify the practitioner prior to treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Community Acupuncture Studio or any of the employees or associates regarding cure or improvement of my condition. By signing below I acknowledge that I have read the above consent to treatment, have been informed about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I hereby release Community Acupuncture Studio and all employees and associates from any and all liability, which may occur in connection with the treatments and above-mentioned procedures. I understand that I am free to withdraw this consent and to discontinue participation in these procedures or treatments at any time.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_

**Qualifications:** Gianna McManus, MSA, L.Ac. received a Master's of Science Degree in Acupuncture in 2008 from Bastyr University, located in Kenmore, WA. She passed the National Board Examination by the National Committee for the Certification of Acupuncturists (NCCAOM) and is designated a Diplomat of Acupuncture. She became Licensed in 09/2008 and currently holds a License of Acupuncture in the State of Washington (License number AC60040885).

**New Patient Intake Form**

**Today's Date** \_\_\_\_\_

Name: \_\_\_\_\_ Prefer to be called \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number:(cell/home/other) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Yes, I have been treated by Acupuncture before. Date of last treatment: \_\_\_\_\_

Yes, I am currently taking prescription drugs. Please list \_\_\_\_\_

I heard about this clinic by \_\_\_\_\_

**Personal Health History** (Please check if any of the following apply)

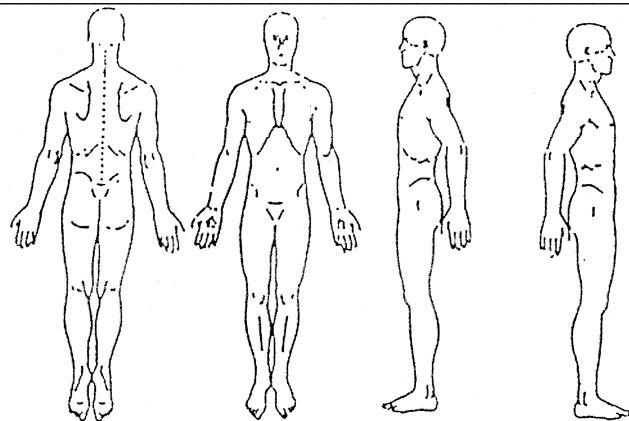
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Autoimmune Disease                                       | <input type="checkbox"/> Epilepsy/Seizure Disorder  | <input type="checkbox"/> Hernia                  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Endocrine Disorder         | <input type="checkbox"/> Multiple Sclerosis      |
| <input type="checkbox"/> Allergies _____  | <input type="checkbox"/> Cr. Fatigue/Fibromyalgia   | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Kidney Stones or Disease   | <input type="checkbox"/> Stroke/CVA/TIA          |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Major Surgeries (please list, with approx. dates): _____ |   |  |
| <input type="checkbox"/> Others: _____  |   |  |

Any trouble with your:  
Sleep?  
Digestion?  
Mood?  
Energy?  
Cycle?  
(females)

**Current Symptoms** (Please check if any of the following apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Poor Mobility/Flexibility | <input type="checkbox"/> Constipation/Diarrhea  |
| <input type="checkbox"/> Vision/Eye Problems       | <input type="checkbox"/> Muscular Pain _____       | <input type="checkbox"/> Indigestion/Heart Burn |
| <input type="checkbox"/> Jaw/Teeth Pain / Problems | <input type="checkbox"/> Joint Pain _____          | <input type="checkbox"/> Nausea/Vomiting        |
| <input type="checkbox"/> Ear Pain / Problems       | <input type="checkbox"/> Other Pain _____          | <input type="checkbox"/> Excess/Lack of Thirst  |
| <input type="checkbox"/> Sinus Pain/Problems       | <input type="checkbox"/> Depression / Anxiety      | <input type="checkbox"/> Skin Disorders         |
| <input type="checkbox"/> Throat Pain/Problems      | <input type="checkbox"/> Stress                    | <input type="checkbox"/> Hair Changes           |
| <input type="checkbox"/> Breathing Difficulties    | <input type="checkbox"/> Fatigue / Low Energy      | <input type="checkbox"/> Cough                  |
| <input type="checkbox"/> Chills or Fever           | <input type="checkbox"/> Gas / Bloating            | <input type="checkbox"/> Night Sweating         |
| <input type="checkbox"/> Dizziness/Vertigo         | <input type="checkbox"/> Weight Gain or Loss       | <input type="checkbox"/> Spontaneous Sweating   |
| <input type="checkbox"/> Insomnia/Restless sleep   | <input type="checkbox"/> Poor or Excess Appetite   | <input type="checkbox"/> Poor Immune Function   |
| <input type="checkbox"/> Chest Pain/Pressure       | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Urination Difficulties |
| <input type="checkbox"/> Others: _____             |  |   |

NOTES:



NOTES:

**\*\*Please indicate any areas of pain on the diagram**

*Thank you kindly for taking your time to fill out this form as accurately as possible.  
The information above will help the acupuncturist in their assessment and treatment plan.*