# INFORMED CONSENT

Name ____________________________________ Phone(H)_________________(W)_______________

Street____________________________________ City___________________ Zip Code ___________

Sex _____ Age ______ Height _______Weight_______ Date of Birth: ________/_______/__________

Employer's Name ______________________________________________________________________

Email Address_____________________________________ Marital Status _________________

Number of Children _______ In an emergency contact _________________________________

Phone (_______)______________ Relation: _______________________

Personal Physician______________________________________ Date of Last Physical_____/____/____

Whom may we thank for referring you? ____________________________________________________

I, the undersigned, an adult over the age of 18, hereby consent to receive acupuncture treatment from Tawnya M. Salas, Diplomat in Acupuncture and Chinese Herbology.

I am fully aware the acupuncture needles are sterile and disposable and every needle used, has never been used on another person.

I fully understand there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand minor complications may result from acupuncture treatments. I understand acupuncture and Chinese medicine is not a substitute for standard Western medical advice and treatment at any time either in lieu of or concurrently with acupuncture treatment.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Responsible Party's Signature:_____________________________________________ Date __________

## Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above 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.

Signature _____________________________________________ Date ___________________________

# Appointment reminders

- [ ] Text message 24hrs prior to appointment
- [ ] Phone call
- [ ] Email 2 days before appointment

**Notifications:**

- [ ] Email notifications for new, canceled, and rescheduled appointments
- [ ] OK to send marketing emails (This would be an email a couple of times a year at most, updating you on changes, special offers, and news about the company)
- [ ] Rating's Emails periodically so you can let us know how we are doing and if we can make improvements to give you the best quality care

**Signature:** ______________________________________ **Date:** _______________

# Informed Consent for Acu-point Injections and/or B12 Injections

______________________________________________________________

Understand that whenever a needle is introduced through the skin, inherent risks are present. Although the risks are small, the expected benefit from the procedure must outweigh the possible risks. Make sure that you have a thorough understanding of the expected benefit from the injection. The risks of an injection depend on where the injection is made and what is being injected. If the injection is made in a large muscle, the risk of hitting vital structure is very small. Injections in an area of neurovascular bundles (where nerves, veins, and arteries travel together) and in the area of the lungs have a higher risk of injury.

The risks of injection are:

1. Infection- With current standard procedure of sterile needles and antiseptic technique, this risk is very small, but it still exists. Redness and swelling are the early signs of infection. Any redness or swelling should be reported immediately to your doctor to avoid the more serious complications of sepsis or osteomyelitis.
2. Puncture of nerves, arteries, or veins- This risk varies greatly on the area of injection. When acupuncture point injections are made in the body of large muscles, this risk is very small. In other areas where these structures are larger and running together, the risk is increased. A nerve may be permanently damaged or bleeding may occur with puncture of a vein or artery.
3. Puncture of lung or vital organ- Injections in the area of the chest could puncture a lung in which the serious complication of a tension pneumothorax could occur. In this condition the lung leaks air into the lung cavity progressively compressing the heart and lung. The person becomes short of breath, which can advance to death if untreated. Puncture of other vital organs is extremely unlikely and depends on the site of injection.
4. Allergic reaction to injected substance- Allergic reactions to homeopathic substances have not been reported, and, in fact, they are used to treat allergic conditions. However, the possibility still exists. An allergic reaction is usually hives, but a lung reaction could occur with shortness of breath, or the most serious reaction of anaphylaxis which can be life-threatening.

## Consent and Agreement

I, the undersigned, hereby request and consent to injection therapy on my body, in order to enhance the effect of stimulating an acupuncture point. I understand that I will only be injected with substances that fall within the scope of practice of Licensed Acupuncturists in Colorado. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. By signing this form, I agree to accept all risks and release all liabilities from Acupuncture by Tawnya Salas.

Responsible Party's Signature:__________________________________________ Date:___________________

# *COLORADO MANDATORY DISCLOSURE STATEMENT*

Acupuncture by Tawnya Salas
Tawnya M. Salas, L.Ac., M.S.O.M.
Tel: (719) 545 6189
301 Colorado Ave
Pueblo, Colorado 81004

<u>Education:</u>

| | |
|---|---|
| Southwest Acupuncture College, Boulder, Colorado<br>Masters Degree of Science in Oriental Medicine | 4 years |
| Colorado State University, Ft. Collins, Colorado<br>Bachelor of Science in Food Science and Human Nutrition | 3 years |
| University of Southern Colorado, Pueblo, Colorado | 2 years |

Advanced studies in Acupuncture and Herbal Medicine
Beijing International Acupuncture Training Center
Beijing, China – 2002

<u>Professional Organizations:</u>

Acupuncture Association of Colorado

<u>Certification, Licenses, and Registrations*:</u>

Council of Acupuncture and Oriental Medicine
*Clean Needle Technique Certificate, 2000*
National Commission for the Certification of Acupuncture and Oriental Medicine
*Diplomate in Acupuncture, 2001*
National Commission for Certification of Chinese Herbal Medicine
*Diplomate in Chinese Herbs, 2002*
*No certification, license or registration ever revoked or suspended

<u>Training and Experience:</u>

| | |
|---|---|
| Acupuncture | Acupressure |
| Chinese Herbal Medicine | Moxibustion |
| Cupping | Electric Stimulation |
| Nutritional Counseling | Oriental Physical Therapy |

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to by including proper cleaning and sterilization of equipment and office.

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of the Division of Registration in the Department of Regulatory Agencies, 1560 Broadway, Suite 1545, Denver, Colorado 80202, phone (303) 894-2464.

Patients may seek a second opinion and may terminate therapy at any time. In a Professional relationship, sexual intimacy is never appropriate and should be reported to the Director of Registration in the Department of Regulator Agencies.

Fee Schedule (subject to review each January and July):

Initial treatment with consultation……………………………………….$115.00
Follow-up treatment…………………………………………….....……$85.00
Missed appointments (less than 24 hour notice)………………....……$85.00

Payment is expected at time of treatment; cash or credit card accepted. There is a **$5 weekly** charge on unpaid balances. All returned checks are subject to a **$45 service fee**. Herbal prescriptions, patents, or other herbal products are priced separately. I ask you make every effort to notify me as far in advance as possible if you are unable to keep an appointment. I require 24 hour notice for cancellation or above fee is implemented. Fee schedule is available upon request.

*I have carefully read and understand the above, and agree to the terms of this Client Disclosure Form and will be responsible for all charges. I understand that I will be liable for any reasonable attorney's fees and collection/court fees if applicable.*

*Signature*___________________________________*Date*______________________________

301 Colorado Healing Center
Pueblo, Colorado 81004
Phone: (719) 545 6189, Fax: (719) 545 2807

**NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT**

Each time you receive a treatment program at our clinic, a record is made. Typically, this record contains your symptoms, examination observations, test results, diagnosis, treatment, and future care/treatment plans. Understanding your health information and how it is used helps to ensure that it is accurate, used and disclosed appropriately, and that you make informed decisions when authorizing disclosures to others.

Our Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information.

(This information will be provided to you upon your request)

**By my signature below, I acknowledge:**

☐ I have been notified of the availability of this information to me but decline a copy.

☐ I have received a full copy of the Privacy Practices.

_______________________________________________________________

Patient Signature                                                    Date

Notation, if any, by staff:

_______________________________________________________________
_______________________________________________________________
________________________________

________________________________________    ____________________

Staff Member                                                    Date

# CREDIT CARD PAYMENT AUTHORIZATION
(Non VA only)

Whether you choose to pay by cash or credit card, I require one active Visa, MasterCard, or Discover number from you that may be used in the event that you are unable to bring cash or check with you to an appointment.
I, _____________________________ hereby authorize Acupuncture by Tawnya Salas, L.Ac to charge the credit card listed below at the rate of $115 for an initial appointment or $85 for a follow-up appointment, in the event that payment is not made at the beginning of the treatment. I also authorize Acupuncture by Tawnya Salas to charge the credit card listed below at the rate of $85 if I cancel an appointment or initiate a schedule change less than 24 hours in advance of my originally scheduled appointment time, or if I do not attend a scheduled appointment. I understand that the amount charged, the date of the charge and Acupuncture by Tawnya Salas will appear on my credit card statement, producing a record of services visible to my credit card company. I also understand that no specific content of my treatment will be disclosed to billing or credit card agencies without my signed consent. I understand that my credit card information will be stored in a locked file cabinet during the duration of my treatment and for 7 years after treatment termination, at which point all card information will be shredded. I also understand that up-to-date encryption programs will be used in all online credit card billing procedures.

Please note, if you choose to not give your card information, in the event that you no-show or have a cancelation less than 24 hours before your scheduled time, an invoice will be mailed to you. We will not be able to schedule you again until the invoice has been paid. Thank you for your understanding.

Visa, MasterCard, or Discover number:
_________-_________-_________-_________
Card Expiration Date:____________________
Three-Digit Authorization Code from the Back of the Card:________
Name on the Card:_____________________________________________________
Billing Zip Code:___________

Client Signature: ______________________________________Date:_____________

*Signature Required

## Activities of Daily Living Questionnaire

When you experience difficulties from a painful or restrictive condition, you may find it difficult to perform some of the activities you would normally do. In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. You will be given this questionnaire periodically throughout your treatment to determine the effectiveness of acupuncture on your condition.

For each item below, please rate how well you can do the following activities with the following:

0= NO ISSUES 1=MILD 2=MODERATE 3= SEVERE

________Bending ________Climbing Stairs ________Lifting

________Sitting ________Standing ________Walking 20+minutes

________Lying Down ________Rising out of chair ________Turning over in bed

________Housework ________Driving/riding ________Dressing

________Sleeping ________Exercise ________Yardwork

________Golf ________Cycling ________Family activities

________Work activities ________Sleep Disturbances (less than 4 hours without interruption)

________Other (please list)________________________________________________________________

Age:__________ Height__________ Weight__________

Name:__________________________________________________
Date:________________________

Health History

Name:________________________________ Age:______ Date:__________________

O = Occasional F = Frequent C = Constant Never = leave blank

| O F C | O F C | O F C |
|---|---|---|
| **Head** | **Respiratory** | **Skin** |
| ☐ ☐ ☐ Headache | ☐ ☐ ☐ Chronic cough | ☐ ☐ ☐ Bruise easily |
| ☐ ☐ ☐ Migraine | ☐ ☐ ☐ Difficulty breathing | ☐ ☐ ☐ Dryness |
| ☐ ☐ ☐ Dizziness | ☐ ☐ ☐ Spitting up blood | ☐ ☐ ☐ Hives and allergy |
| ☐ ☐ ☐ Loss of consciousness | ☐ ☐ ☐ Spitting up phlegm | ☐ ☐ ☐ Skin eruptions/rash |
| ☐ ☐ ☐ Fainting | ☐ ☐ ☐ Tightness in chest | **Psychiatric** |
| ☐ ☐ ☐ Poor memory | ☐ ☐ ☐ Varicose veins | ☐ ☐ ☐ Depression |
| ☐ ☐ ☐ Unable to concentrate | ☐ ☐ ☐ Wheezing | ☐ ☐ ☐ Anxiety |
| **Eyes, Ears, Nose &Throat** | **Cardio-Vascular** | ☐ ☐ ☐ Stress |
| ☐ ☐ ☐ Floaters in vision | ☐ ☐ ☐ Chest pain | **General** |
| ☐ ☐ ☐ Red or itchy eyes | ☐ ☐ ☐ Cold hands and feet | ☐ ☐ ☐ Allergies |
| ☐ ☐ ☐ Failing vision | ☐ ☐ ☐ High blood pressure | ☐ ☐ ☐ Chills |
| ☐ ☐ ☐ Ringing in ears | ☐ ☐ ☐ Low blood pressure | ☐ ☐ ☐ Congenital deformity |
| ☐ ☐ ☐ Loss of hearing | ☐ ☐ ☐ Poor circulation | ☐ ☐ ☐ Convulsions |
| ☐ ☐ ☐ Nasal discharge | ☐ ☐ ☐ Rapid heart beat | ☐ ☐ ☐ Fatigue |
| ☐ ☐ ☐ Nose bleeds | ☐ ☐ ☐ Slow heart beat | ☐ ☐ ☐ Fever |
| ☐ ☐ ☐ Poor sense of smell | ☐Yes ☐No Are you taking prescribed blood thinners? | ☐ ☐ ☐ Loss of sleep |
| ☐ ☐ ☐ Dry throat | | ☐ ☐ ☐ Nervousness |
| ☐ ☐ ☐ Plum pit sensation in throat | ☐Yes ☐No Are you wearing a pacemaker? | ☐ ☐ ☐ Sweats ☐Day ☐Night |
| | | ☐ ☐ ☐ Hernia |
| ☐ ☐ ☐ Poor sense of taste | **Gastro-Intestinal** | ☐ ☐ ☐ Low energy |
| **Muscle and Joint** | ☐ ☐ ☐ Belching or gas | ☐ ☐ ☐ Tiredness after meals |
| ☐ ☐ ☐ Arthritis | ☐ ☐ ☐ Blood in stool | ☐Yes ☐ No Frequently thirsty |
| ☐ ☐ ☐ Bursitis | ☐ ☐ ☐ Mucus in stool | **For Women Only** |
| ☐ ☐ ☐ General fatigue | ☐ ☐ ☐ Constipation | ☐ ☐ ☐ Tenderness in breasts |
| ☐ ☐ ☐ Generalized pain | ☐ ☐ ☐ Distention of abdomen | ☐ ☐ ☐ Irregular cycle |
| ☐ ☐ ☐ Decreased flexibility | ☐ ☐ ☐ Excessive hunger | ☐ ☐ ☐ Menstrual problems |
| ☐ ☐ ☐ Swollen joints | ☐ ☐ ☐ Eating disorders | ☐Yes ☐No Are you pregnant? |
| ☐ ☐ ☐ Tremors | ☐ ☐ ☐ Loose stools | |
| Pain or Numbness in: | ☐ ☐ ☐ Nausea | ➔ |
| ☐ ☐ ☐ Arms ☐R ☐L | ☐ ☐ ☐ Abdominal pain | |
| ☐ ☐ ☐ Buttocks ☐R ☐L | ☐ ☐ ☐ Poor Appetite | |
| ☐ ☐ ☐ Elbows ☐R ☐L | ☐ ☐ ☐ Vomiting | |
| ☐ ☐ ☐ Feet ☐R ☐L | **Genito-Urinary** | |
| ☐ ☐ ☐ Hands ☐R ☐L | ☐ ☐ ☐ Bed-wetting | |
| ☐ ☐ ☐ Head | ☐ ☐ ☐ Blood in urine | |
| ☐ ☐ ☐ Hips ☐R ☐L | ☐ ☐ ☐ Frequent urination | |
| ☐ ☐ ☐ Knees ☐R ☐L | ☐ ☐ ☐ Incontinence | |
| ☐ ☐ ☐ Low back | ☐ ☐ ☐ Infertility | |
| ☐ ☐ ☐ Mid-back | ☐ ☐ ☐ Erectile Dysfunction | |
| ☐ ☐ ☐ Upper back | ☐ ☐ ☐ Low libido | |
| ☐ ☐ ☐ Shoulders ☐R ☐L | ☐ ☐ ☐ Painful intercourse | |
| ☐ ☐ ☐ Neck | ☐ ☐ ☐ Painful urination | |
| ☐ ☐ ☐ Other ______________ | ☐ ☐ ☐ Cloudy urine | |
| ☐Yes ☐ No Are you taking | ☐ ☐ ☐ Urine retention | |

| prescribed painkillers? | ☐ ☐ ☐ Late night urination | |
|---|---|---|

1. What is your primary complaint?______________________________________________
2. Other health concerns:_____________________________________________________
3. How long have you had this condition?_________________________________________
4. What was happening in your life at the time of onset?___________________________
5. What aggravates your condition?_____________________________________________
6. Is this condition getting worse? ____Yes _____No ______Constant ________Comes and goes.
7. List previous diagnoses and treatments you have received for present conditions:______________
_________________________________________________________________________
8. List additional surgical operations and dates:__________________________________
9. List all pharmaceutical drugs you are currently taking:___________________________
_________________________________________________________________________
10. List other supplements you are taking:_______________________________________
_________________________________________________________________________
11. Habits: ___Alcohol ___Coffee ____Tobacco ______Recreational Drugs ______Regular Exercise

_________________________________________________________________________
Additional comments regarding your condition:__________________________________
_________________________________________________________________________
_________________________________________________________________________
______________________________________________

THANK YOU FOR THOROUGHLY COMPLETING THIS FORM