Into the Light
Acupuncture and Holistic Medicine
Lauren Pitasch LA.c MSOM

INDICATIONS: HERBAL AND OTHER SUPPLEMENTS

Patient Name ______________________________ Date ____________________

Are you presently taking any of the following medication?

Yes No Analgesics Dosage____________ Frequency__________
(Aspirin, Ibuprofen, and Naproxen Sodium)

Yes No Cardiovascular Agents Dosage____________ Frequency__________
(Digoxin, Lanoxin, and Captopril)

Yes No Laxatives Dosage____________ Frequency__________

Yes No Antacids Dosage____________ Frequency__________
(Bicarbonate of Soda and Calcium Carbonate)

Yes No Sedative, Anti-Anxiety, Anti-Psychotic Medications Dosage____________ Frequency__________
(Lithium, Thioridazine, Chlorpromazine, and Prozac)

Yes No Anti-Inflammatory Agents Dosage____________ Frequency__________
(Prednisone, other corticosteroids, and NSAID's)

Yes No Respiratory Agents Dosage____________ Frequency__________
(Theophylline)

Yes No Diuretics Dosage____________ Frequency__________
(Lasix)

Yes No Antibiotics Dosage____________ Frequency__________

Yes No Elixirs Containing Sorbitol Dosage____________ Frequency__________
(Theophylline and Acetaminophen)

Yes No Insulin or Diabetic Oral Medications Dosage____________ Frequency__________

Yes No Sleep-Aids Dosage____________ Frequency__________

Yes No Thyroid Medications Dosage____________ Frequency__________

Yes No Blood -Thinners Dosage____________ Frequency__________

Yes No Anti-Seizure Medications Dosage____________ Frequency__________

Yes No Weight Reducing Medications Dosage____________ Frequency__________

Yes No Birth Control Pills Dosage____________ Frequency__________

Yes No Hormones Dosage____________ Frequency__________

Yes No Blood Pressure Medications Dosage____________ Frequency__________

List any others (including over-the-counter medications) Herbal or natural supplements you currently take/use: ____________________

____

Are you allergic to any medications, natural supplements, or over-the-counter medications? Please name and describe reaction:

____

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60004

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Acupuncture Individual Care Plan

Patient's Name ___________________________________ Date ______________________

Daily

____
____
____
____

Weekly

____
____
____
____

Ongoing

____
____
____
____

Diet/Nutrition

____
____
____
____

Herbs/Supplements

Herbal Supplements	AM	Noon	PM	Before Bed	As Needed

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PATIENT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient we may use or disclose personal and health related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

- You health care records as well as your billing records may be disclosed to another party, such as an
- Insurance carrier, an HMO, PPO or your employer, if they are or may be responsible for the payment
- of your services.

Your name, address, phone number and health care records may be used to contact you regarding appointment reminders or other healthcare information that may be of interest to you.

Under federal law, we are also permitted or required to use or disclose your health information without consent or authorization in these following circumstances:

If we are providing health care services to you based on the orders of another health care provider.

If we provide health care services to you in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do if there are substantial barriers to communicating with you, but in our professional judgment we believe that you Intend for us to provide care. if we are ordered by the courts or another appropriate agency.

You have the right to: Revoke any authorization and/or consent, in writing, at any time.

Inspect and/or copy your health care information for seven years from the date that the record was created or as long as the information remains in our files.

Request an amendment to your health information. Requests to inspect, copy or amend your health Related information should be made in writing.

Office Rights and Requirements – This Office:

- Is required by law to maintain the privacy of protected health information and provide individuals with notice
- of its legal duties and privacy practices with respect to protected information.
- Is required to abide by the terms of this notice.
- Reserves the right to change the terms of this notice and to make the notice provisions effective for all
- protective information that it maintains. We will notify you in writing of any changes made to our privacy notice.

Will not retaliate against you for filing a complaint. If you have any complaints regarding our privacy notice, our privacy practices or any aspect of our privacy activities, please submit in writing to this office.

This notice is effective as of ____

____.

By signing below, I certify that I have received and reviewed this notice.

____

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Consent For Treatment Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the sc
practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupu
named below and/or other licensed acupuncturists who now or in the future treat me while employed by, workin
associated with or serving as back-up for the acupuncturist named below, including those working at the clinic o
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, e
stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that t
may need to be prepared and the teas consumed according to the instructions provided orally and in writing. Th
may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated
unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side
including bruising, numbness or tingling near the needling sites that may last a few days, dizziness, drowsiness
fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscar
nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, a
the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring a
potential risk of moxibustion and cupping. I understand that while this document describes the major risks of tre
other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and
sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, alt
some may be toxic in large doses.
I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herb
nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify
staff member who is caring for me if I am or become pregnant. I understand that results are not guaranteed. I u
the clinical and administrative staff may review my patient records, including lab reports, but all my records will
confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, h
told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask ques
intend this consent form to cover the entire course of treatment for my present condition and for any future cond
for which I seek treatment.

Patient Signature________________________________Date______________________

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