Striving FOR Health

New Patient Information

To receive the best possible results, it is important to read and understand the following information:

- Some cases may require treating preliminary items that are contained within a substance, such as a vitamin, mineral, phenolic and/or sugar. For example, sugar may need to be addressed before proceeding with alcohol, grains, or fruit.
- After addressing any preliminary items, patients may choose what order the remaining substances are treated.
- It is possible to treat numerous items in one session if they are all part of the same family. For example, al dairy products (milk, cheese, and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be addressed in the same session. The treatment will not be successful.
- We cannot guarantee how many sessions each substance will require to reduce the symptoms associated with that item.
- When addressing a condition, instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore, such conditions may require multiple sessions to relieve the symptoms or condition.

Please adhere to the following guidelines:

- As a courtesy to our other patients who may have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming into the clinic.
- Do not eat, drink, or chew gum during the session.

Office Policies

- There is a 24-hour cancelation policy for the AAT treatments. Late cancelations or no-shows will be charged $75.
- Please arrive on time for your appointment time. Late arrivals may need to be rescheduled.
- Payment is due at the time services are rendered.

Initial Assessment for :_____

	Amines		Glutamates		Cats		Acids
	Caffeine		Grain / Wheat		Cockroaches		Enzymes
	Calcium		**Iron**		Dogs		
	Chicken		**Minerals**		Dust / Dust Mites		
	Chocolate		Protein		Flowers		
	Coffee		Salicylates		Fungus		
	Corn		Salts / Chlorides		Grasses		
	Dairy/Milk		Soy		Molds / Mildews		
	Eggs		**Sugar**		Plant Phenolics		
	Flavor Enhancers		**Vitamin A**		Plants		
	Food Coloring		**Vitamin B**		Pollens		
	Food Phenolics		**Vitamin C**		Sinus Fungus		
	Food Preservatives		Yeast		Trees		
					Weeds		

Striving FOR Health

First Name: _____ Last Name_____Date:_____

Address:_____Zip_____

Home phone number:_____ Cell number:_____

Email address:_____

Occupation:_____ Age:_____ DOB:_____

Emergency Contact:_____ Phone:_____

Are you currently receiving health care? _____Which modality? MD | DC | L.Ac. | ND | DO

Condition being treated: _____ Is it helping? _____

Name of physician or practitioner: _____

What are your most common health concerns?

1) _____
2) _____
3) _____

Please list tested or suspected allergies or sensitivities and their related symptoms:

Foods:_____

Seasonal:_____

Drugs/other:_____

Current Medications and Supplements: (please list all prescription or OTC medications you are taking):

_____

Do you have a current medical condition? (ex: pregnancy, epilepsy)_____

How did you hear about the clinic? _____

Would you like to receive our e-newsletter containing health and treatment tips? _____

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the information listed on the New Patient Information form.

Signature_____ **Date**_____

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Authorization to Release Health Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patients.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of the office. In accordance with the Notice of Privacy Practices, this office via this authorization form, requests that the patients indicate below to authorize the release of his/her health information. This office doesn't accept insurance so the need to have any records released outside of the office is very rare.

I, the undersigned, understand that I have the right to:

- Refuse to sign this authorization
- Receive a copy of the authorization
- Restrict what is disclosed by this authorization
- Inspect or request an amendment of the health information to be disclosed
- Revoke this authorization, by written notice
- Be notified if any records are requested

I recognize that once disclosed, my health information is no longer under the control of this practitioner/clinic. While I understand that the practitioners/clinic will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document, it will not affect my treatment at this practice or the payments I incur. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Right for my state at: http://www.hhs.gov/ocr/regmail.html

I hereby authorize this office to disclose my health information as described in this document.

_____ _____

Name of Client Contact Number

_____ _____

Signature Date

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Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s):_____

_____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s)that we will be addressing in this office.

I have read and understand this information.

_____ _____

Signature Date

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