# Consent for Treatment

*Brynn Graham, L.Ac. 925 NW Davis Street, Portland, OR 97209*

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Oriental medicine, and/or Chinese herbal medicine provided by Brynn Graham, L.Ac.

I understand that acupuncturists practicing in the state of Oregon are not primary care providers. I understand that this clinic requests that all patients have a primary care provider and that all patients provide medical records from their primary care provider upon request.

I understand that acupuncture is performed by the insertion of needles through the skin. Additionally, application of heat, electroacupuncture stimulation, tuina massage, cupping, and other Oriental medicine therapies as well as MPS/ Acu-current therapy may be applied in the treatment protocol, but will be discussed with me prior to their usage.

I understand that Brynn Graham, LAc. performs acupuncture treatment for chronic pelvic pain which may require the placement of acupuncture needles to the external groin and pelvic area. Strict adherence to my comfort will be prioritized at all times. I understand that I am free to bring a chaperone of my choice to accompany me during these treatments, if so desired.

I understand that only disposable needles will be used during each treatment. I have been made aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning the use and effectiveness of acupuncture are given to me and that I am free to stop acupuncture treatments at any time.

I understand that Brynn Graham, LAc. may recommend herbal formulas and therapies from the Oriental pharmacopoeia to treat dysfunction or disease, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow directions for their administration and dosage if I do decide to take them. I have been made aware that, although rare, certain adverse side effects may result from taking these substances which could include, but are not limited to: changes in bowel movements, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any adverse side effects which I associate with these substances, I should suspend taking them and contact Brynn Graham, LAc. as soon as possible.

**I have carefully read and understand all of the above information, and I give my consent to be treated.**

Signature: _____ Date: _____

_____ Date: _____

*Parent/guardian signature (if applicable)*

# Financial Policies

*Brynn Graham, L.Ac., 925 NW Davis Street, Portland, OR 97209*

Please read this sheet carefully, then acknowledge your understanding with your signature at the bottom. If you need clarification or have any questions, please ask.

I am pleased to offer my services to you! My goal is to remove the cause of illness as well as to treat the symptoms. After your initial evaluation, I will discuss a course of treatment that generally includes a series of acupuncture treatments and herbal therapy (if warranted) with specific goals.

Fee schedule:
Initial Consultation and Treatment (90 minutes) - $120
Acupuncture Treatment (60-75 minutes) - $90
MPS/Acu-current Therapy - (60-75 minutes) - $90
Acupuncture/MPS Therapy Combination Treatment (60-75 minutes) - $90
Missed Appointment Fee - $75

Payment: payment for your treatment is due at the time of service. Payment can be made by cash, check, or credit card (Visa, MasterCard, Discover, or American Express). I also accept payment with Health Savings Account (HSA) cards. I do NOT bill health insurance. However, I can generate an invoice for you which you can submit directly to your health insurance company for reimbursement - please check with your health insurance company to verify that you have acupuncture coverage. I DO bill car insurance for motor vehicle accidents. Please have copies of your car insurance and accident claim information ready and available at your first appointment.

I understand that if my car insurance company will be billed for services related to a motor vehicle accident, I hereby give consent to Brynn Graham, LAc. to bill my car insurance company for acupuncture and associated services provided to me. _____ (initial here)

If you foresee any financial challenges, be sure to address them with me directly so that we can negotiate a payment plan. I will consider senior and student discounts on an individual basis.

Appointment Changes: unforeseen circumstances do happen for all of us, but if you should need to cancel or reschedule an appointment, I ask that you do so at least 24 hours prior to your scheduled appointment time. I reserve the right to charge for missed appointments as well as any appointments canceled or changed with less than 24 hours notice. I will make every effort to contact you in a timely manner in case of any appointment cancelation on my part or in the event of extreme weather.

Appointment Scheduling: appointments can be scheduled with me directly or through the front desk at Yoga Pearl.

**I have read, understand, and agree to the above statement regarding responsibility for my appointment and payment policy.**

Signature:_____ Date:_____

# Patient Privacy Notice

## Health Insurance Portability and Accountability Act (HIPAA)

*Brynn Graham, LAc. 925 NW Davis Street, Portland, OR 97209*

Brynn Graham, L.Ac. is dedicated to preserving your personal health information. We are required by law to protect your health information and to provide you with a Notice describing how your medical information may be used and disclosed and how you can access this information.

This Patient Privacy Notice describes your rights and our clinic's duties with respect to your protected health information. Brynn Graham, L.Ac. may use or disclose your personal health information for the purpose of diagnosing or providing treatment, obtaining payment for health care bills, or to conduct health care operations. We may be required by law to use and disclose your medial information for other purposes without your consent or authorization.

Your personal health information means health information, including your demographic information collected by us, other health care providers, a health care clearinghouse, or an employer. This protected health information relates to your past, present, or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed long form Notice of Privacy Practices which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current Notice in effect - please ask and you will be provided with a copy.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Brynn Graham, L.Ac. at 503-789-7576.

**My signature below indicates that I have received, read, and understand this Patient Privacy Notice**.

Signature: _____ Date:_____

# Patient Health History

Name:_____ Date: _____

Address:_____

Date of birth:_____ Age:_____ Marital status:_____ Gender: Male Female X

Occupation:_____ Social Security number:_____
(only needed if you need invoice for insurance reimbursement)

Referred by:_____

Contact information

Phone:_____ Email address:_____

If the need arises, how do you prefer that I contact you? _____

Emergency contact person:_____ Relationship:_____

Phone: _____

_____

What health concerns have brought you in today?

Have you seen a MD, ND, or chiropractor for this/these condition(s)?

Please list your health history (injuries/accidents, illnesses, surgeries, major emotional/physical traumas, etc.) for the following time periods:

Birth to age 12:

Age 13 to 20:

Age 21 to present:

Please list any medications or supplements you are currently taking:

Please list any allergies or hypersensitivities you may have (food, medications, environmental):

How would you rate the level of stress in your life? low medium high

What are the primary sources of stress in your life? (circle all that apply)
work family friends finances health other:_____

Please circle any emotions that are presently significant or recurring in your life:
excitement anger worry grief anxiety sadness depression frustration fear

What are your treatment goals with acupuncture and Oriental medicine?

## Lifestyle

Please indicate what you typically eat for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you eat meals at regular times each day?

How many meals do typically eat each day?

Do you feel that you eat a healthy diet?

Do you drink caffeine or alcohol? How much and how frequently?

Do you use tobacco products or recreational drugs?

What forms of physical/cardio exercise do you do, and how often?

What forms of breathing, meditative, or mindfulness exercise do you do, and how often?

How many hours of sleep do you typically get each night?

Do you feel there's anything that interferes with your ability to sleep well?

Do you have a family history of any of the following health conditions? (circle all that apply)
Diabetes Asthma Mental Illness Cancer Migraines High Blood Pressure Heart Disease Stroke

**Please circle any conditions you're experiencing now, and underline any experienced in the past:**

Slow wound healing Hypoglycemia Hypothyroid Hyperthyroid Hashimoto's Thyroiditis

Bruise easily Cold hands/feet Reynaud's Disease Unusual sweating Insomnia

Low energy/fatigue Sudden weight gain/loss Difficulty relaxing Frequent sighing

Frequent urination Nighttime urination Painful urination Urinary tract infection(s)

Psoriasis Eczema Acne Rosacea Skin sensitivities Rashes Other skin disorders

Cancer High blood pressure Low blood pressure Arrhythmias/irregular heart beats

Heart palpitations/flutterings Heart Disease Chest pain Anemia Heart murmur

Varicose veins Vertigo/dizziness Meniere's Disease Ear congestion/discomfort TMJ/jaw pain

Tinnitus Poor memory Difficulty focusing Anxiety Depression Unusual hair loss

Frequent headaches Migraine headaches Kidney disease Kidney stones PTSD

Asthma Bronchitis Pneumonia Peripheral neuropathies Numbness/tingling

Sinus infection(s) Seasonal allergies/hay fever Breathing difficulty Unable to get deep breath

Diabetes Liver disease Gall bladder disease Hepatitis type ____ Herpes Zoster/Shingles

Canker sores Cold sores Frequent colds/illness Slow wound healing HIV+

Osteoporosis Osteoarthritis Rheumatoid arthritis Autoimmune condition:_____

Bad breath Heartburn/indigestion Anorexia or Bulimia Constipation Stomach ulcers

Irritable Bowel Syndrome (IBS) Changes in appetite Frequent loose stools or diarrhea

Mucous or blood in stools Crohn's Disease Ulcerative Colitis Abdominal pain Stroke

Women:

Irregular menstrual cycles  Painful menstrual periods  Excessive menstrual bleeding  PMS symptoms

No menstrual periods  Frequent menstrual periods  Pain with sex/intercourse  Pelvic pain

Bleeding between menstrual periods  Inability to reach orgasm  Perimenopause symptoms

Menopausal symptoms  Night sweats  Day sweats  Vaginal yeast infection(s)  Vaginal discharge

Infertility  Low libido

Men:

Pelvic pain  Slow urine stream  BPH/Prostate issues  Testicular pain/swelling  Low libido

Painful ejaculations/pain with sex  Low sperm count/Infertility  Difficulty maintaining erections

Please list any other health concerns you feel I should be aware of: