Camille Schindler, L.Ac.
Honeycomb Acupuncture
3654 Grand Ave, Oakland CA 94610

tel: (707) 318-0423
email: camille@honeycombacupuncture.com

TODAY'S DATE: _____

Personal Information (Please print clearly)

Name: _____ Date of Birth: _____ Gender ID:_____

Address: _____

Preferred Phone #: _____ Is it ok to send texts & leave voicemails? ❑Yes ❑No

Email: _____ Is it ok to send emails? ❑Yes ❑No

Referred by: _____

Emergency Contact & Phone Numbers: _____

Employer: _____ Occupation: _____ Height: _____ Weight: _____

Primary Treating Physician: _____ Physician's Phone #: _____

Date of Last Visit to Physician: _____ Reason for Visit: _____

Health History Questionnaire (Please take the time to fill this out thoroughly)

Chief Concern

What health issues are you looking to have treated? _____

_____

_____

When did the problem begin? _____

_____

Please describe your symptoms _____

_____

_____

What sort of therapies are you currently using? _____

_____

What worsens or improves your condition? _____

Have you been given a diagnosis for your current health issue(s)? If so, what? _____

_____

Have you received acupuncture before? When and for what reason? _____

Are you using any medications, herbs, or supplements? If so, give names and reason for taking? _____

_____

_____

_____

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Medical History

Do you have any other health concerns, diagnoses, or conditions? If so, please explain: _____

_____

_____

_____

Do you have any of the following? ❑ Implant ❑ Joint Replacement ❑ Heart Pacemaker

Do you exercise regularly? ❑ Yes ❑ No If yes, what kinds? _____

_____

Are you pregnant? ❑ Yes ❑ No If no, when was last period? _____

List any diseases, injuries, traumas, or hospitalizations and when they happened: _____

_____

Do you think you have or might have any addictions? ❑ Yes ❑ No If yes, please describe:

_____

_____

Medical History continued

Do you have or have you had any of these conditions?

❑ Catch cold easily	❑ Headaches	❑ Breathing difficulty	❑ Fainting	❑ Frequent urination
❑ Night or day sweats	❑ Dizziness/vertigo	❑ Phlegm production	❑ Poor digestion	❑ Incontinence
❑ Fatigue/Low energy	❑ Ringing in ears	❑ Chronic cough	❑ Acid reflux/GERD	❑ Wake to urinate
❑ Difficulty falling or staying asleep	❑ Eye pain or itching	❑ Asthma/wheezing	❑ Constipation	❑ Urinary tract infection
❑ Wake too early	❑ Vision problems	❑ Pneumonia	❑ Diarrhea	❑ Yeast infections
❑ Sleep Apnea	❑ Facial pain	❑ High blood pressure	❑ Gas/flatulence	❑ Kidney stones
❑ Dry skin/scalp/hair	❑ Nosebleeds	❑ Low blood pressure	❑ Painful bowel movement	❑ Painful menstruation
❑ Eczema or psoriasis	❑ TMJ	❑ Heart palpitations	❑ Abdominal pain	❑ Irregular menses
❑ Acne	❑ Teeth/gum problems	❑ Cold hands or feet	❑ Pain urinating	❑ Changes in sex drive

_____

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Family Medical History

List significant illnesses that affect(ed) members of your family such as easy bleeding, diabetes, cancer, alcoholism, obesity, heart disease, allergy, epilepsy, high blood pressure, mental illness, stroke, etc:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Grandparents: _____

Disclosure of Information - Please Read the Following Carefully

How to Prepare for Your First Visit: Plan on showing up a few minutes early to your appointment and please wear, or bring with you loose comfortable clothing so that I may access just above the knees if needed. Allow for time to find parking and try to have a light meal before your treatment if you are hungry.

Your Privacy: Your right to privacy in this medical practice is paramount and I will never disclose any of your personal information without your express consent, unless required to do so by law.

After Your Visit: Plan ahead to allow some time for rest. Keep rigorous exercise and alcohol use to a minimum during the few hours after your treatment.

Financial Policies

Health Insurance: Camille Schindler does not accept insurance at this time.

Cancellation Policy: If you need to reschedule or cancel your appointment, please give me at least 24 hours notice, otherwise I reserve the right to charge a fee for the full cost of the missed appointments.

Payment Methods: Credit cards, cash, check, and PayPal are all acceptable forms of payment. If you pay with a PayPal, know that you may only receive an electronic receipt via email that you may print at a later time. If you pay with credit card there is a 4% service charge added to the appointment fee.

Discounts: There is a 20% discount offered to patients who give referrals (20% off per session with each referral).

Returned Checks: If your check is returned by the bank, Camille Schindler will notify and bill you for non-payment. You must pay in cash or PayPal the original fees plus a $30 dishonored check fee.

I understand that I am responsible for the cost of all care provided to me, and I accept full responsibility for these charges if my insurance company denies coverage.

Signature: *X*_____ Date: _____

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Informed Consent to Treatment *(please initial and sign at the end)*

By signing below, I (the Patient) do hereby voluntarily consent to be treated with the procedures mentioned below by Camille Schindler, Licensed Acupuncturist and Herbalist. I understand that receiving regular primary care by a licensed physician is an important choice that is strongly recommended by Camille Schindler. I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

_____ I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained. I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

_____ I understand that I may stop treatment at any time and that, while this document describes major risks of treatment, other side effects and risks may occur.

_____ **Acupuncture:** I understand that acupuncture is performed by the insertion of small, sterile, stainless steel needles at specific points in the body, causing a positive response in order to correct various ailments. The location, depth, and application of the needles is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection. Other adverse side effects may be the possible aggravation of symptoms existing prior to acupuncture treatment. I understand there are no guarantees concerning its use and effects and I am free to stop acupuncture treatment at any time. Camille Schindler L.Ac. has informed me that this clinic uses sterile disposable needles and maintains a clean and safe environment.

_____ **Moxibustion:** I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or group of points. Moxibustion is performed in an attempt to treat bodily dysfunction or diseases, to modify pain perception, and to normalize the body's physiological functions. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.

_____ **Cupping:** I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. I understand that the use of cupping commonly produces *temporary* bruising or redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury. I understand that I may refuse this therapy if it is recommended to me.

_____ **Chinese Herbs**: I understand that herbal substances may be prescribed to me to treat bodily dysfunction or disease, to modify pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with

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medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. *Should I experience any problems, which I associate with these substances, I should suspend taking them and contact Camille Schindler L.Ac. as soon as possible.*

_____ **Tui-Na Massage/Acupressure:** I understand that I may also be offered tui-na massage/acupressure as part of my treatment to modify pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment at any time if I choose to do so.

_____ **Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment and will notify Camille Schindler if I have or receive an electronic device implantation such as a pacemaker while under her care.

I hereby release Camille Schindler from all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I will notify Camille Schindler should I become pregnant or if I am in the process of trying to get pregnant while under her care so she may avoid acupuncture points and herbal formulas that could induce miscarriage. Otherwise, Camille Schindler has informed me that Chinese Medicine can be very beneficial in the pregnancy and birthing process. I have carefully read, or had read to me, all of the above information and am fully aware of what I am signing. I have had the opportunity to ask for a more detailed explanation and don't expect Camille Schindler to anticipate and explain all possible risks and complications of treatment. I fully understand that there is no implied or stated guarantee of success for the above-mentioned treatments. I give my permission and consent to treatment for my present condition and for any future condition(s) for which I seek treatment. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

You are always welcome to ask for more details if you wish. Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

Signature: *X*_____ Date: _____

Printed Name: _____

**If not signed by patient, please indicate relationship*
___ Parent or guardian of minor patient
___Personal representative of person with disabilities

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HIPAA NOTICE OF PRIVACY PRACTICES

Your right to privacy in this medical practice is paramount and I will never disclose any of your personal information without your express consent, unless required to do so by law.

This notice describes my office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. Please read it carefully.

Camille Schindler, L.Ac will acquire private information about his patients. This is confidential and will not be discussed outside the office, except that Camille Schindler may discuss patients with other health care professionals in terms that do not allow identification of the individual.

Your protected 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.

Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts, or contact by alternative means.

Additionally, we may be required to disclose your health information in the following circumstances: In the event of an emergency; if required by law; if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care; if ordered by the courts, government authorities, public health, law enforcement, coroners, or funeral directors; in the event of organ donations, research, military activity, or for national security.

Patients have the right to receive an accounting of any such disclosures made by my office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

If you would like copies of records, you must submit a written request for copies of medical records at least 5 business days in advance. The charge for copying records is 30 cents per page, with a $15.00 minimum charge.

Any complaints about these policies or requests for further information may be directed to
Camille Schindler at (707) 318-0423.

Signature: *X*_____ **Date:** _____

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PATIENT EMAIL CONSENT FORM

Honeycomb Acupuncture offer patients the opportunity to communicate by email for non-urgent matters. This form provides information about the risks of email and guidelines for email communication.

RISKS

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.

You should not communicate with Honeycomb Acupuncture via email if any of the above risks concern you.

GUIDELINES FOR EMAIL COMMUNICATION

- The content of the email should only be used for non-sensitive and non-urgent issues.
- The email message should not be time sensitive. Honeycomb Acupuncture endeavour to read and respond within 72 hours to any e-mail. However, we cannot guarantee that any email will be responded to within any particular time.
- Always use camille@honeycombacupuncture.com for the most secure correspondence.

I acknowledge that I have read and fully understand this consent form. I understand and agree to give my consent for email communications to and from Honeycomb Acupuncture.

Signature: *X*_____ **Date:** _____