ELIXIR
LIFESTYLE MEDICINE

From pain relief to stress relief and enhancing your wellbeing with acupuncture, Traditional Chinese Medicine, nutritional counseling and bodywork, it is our pleasure to be your partner on your quest for greater health. To simplify your visit and ensure fair and prompt service, please note the following office policies:

* We have a 24-hour cancellation policy. This means you will be charged in full for not keeping your appointment, unless we have notice AT LEAST 24-hours in advance.

* Please be timely. If you are late, it shortens your treatment time. Other patients will not be delayed to accommodate your late arrival.

* If you are more than 20 minutes late, you will have missed your appointment and incur a missed appointment fee.

* If your insurance doesn't cover your treatment, you will be responsible for paying in full. This includes the New Patient Intake on your first appointment & any extra services that are not covered by your insurance. This means that you will personally need to pay for services. No exceptions.

* Once established with your insurance company, your co-pay is due at the time of service. We reserve the right to refuse care to patients who do not meet the co-pay requirement, or whose payments are in arrears.

* As a courtesy we will provide a printed superbill for out of network patients.

* Supplements must be paid in full at the time of pick up. Unopened supplements may be returned within 14 days. There will be a 15% restocking fee.

* Opened supplements and custom herbal formulas are non-refundable.

* We accept cash, checks, and credit cards.

* Outstanding balances over 30 days are subject to a 1.5% fee, and there will be a $25.00 fee on ALL bounced checks.

* If your account has a balance and is not paid within 60 days from the due date, your account will be turned over to collections and your credit will be negatively affected.

* Treatments provided are non-refundable after services are rendered.

Yours in Health, Elixir Lifestyle Medicine

Patient Signature: _____ Date: _____

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NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

Name _____Date _____

Birth Date _____ Height _____ Weight_____

Major Complaints _____

_____

_____

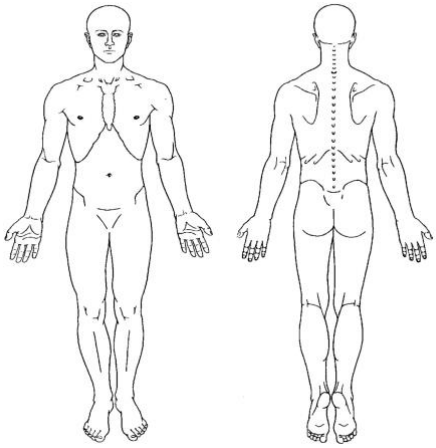
_____

_____

Other Complaints _____

_____

PLEASE MARK YOUR AREAS OF PAIN



Date of onset (when you first noticed your problem)? _____ Pain is: ☐ Minimal ☐ Slight ☐Moderate ☐ Severe

How long have you had this condition? _____ Have you had this in the past? ☐ Yes ☐ No When? _____

What makes it better? _____ What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes & Goes

Medications/Drugs/Herbs you are currently taking _____

_____

_____

List Surgeries/Operations you have had and dates _____

_____

_____

Date of your last physical examination _____ By whom? _____

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MEDICAL HISTORY: (Do you have or have you ever had?): ☐ Arthritis ☐ Asthma ☐ Anemia ☐ Heart Trouble ☐ Cancer

☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ High blood pressure

☐ Chronic Fatigue ☐ Hepatitis ☐ Jaundice ☐ Sudden weight loss ☐ Sudden weight gain

Other _____

FAMILY HISTORY: (Has any member of your family had any of the above?) ☐ Yes ☐ No If yes, which member and what did they have? _____

_____

ENERGY LEVEL: ☐ High (Time of day) _____ ☐ Low (Time of day) _____

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it? _____

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating _____

CIRCULATION: Feelings of ☐ Hot ☐ Cold What area? _____

☐ Bleed easily ☐ Cold limbs Other _____

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Changing moles or lumps (cysts/tumors) ☐ Boils ☐ Frequent skin rashes

☐ Acne ☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled ☐ Bruises easily (black and blue spots) ☐ Hives

Other _____

SCARS: (List ALL scars from accidents or surgeries) _____

_____

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Other _____ How many hours do you sleep a night? _____

HEAD: ☐ Headaches (what area?) _____ ☐ Dizziness ☐ Memory loss ☐ Loss of balance

Other _____

EYES: ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes Other _____

EARS: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears Other _____

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds Other _____

THROAT: ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems ☐ Teeth/gum problems ☐ Swollen tongue

Other _____

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing ☐ Trouble breathing at night

☐ Pain/pressure in chest ☐ Palpitations ☐ Persistent cough ☐ Coughing blood ☐ Coughing phlegm

Sputum color _____ Consistency _____

Other _____

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools ☐ Hemorrhoids ☐ Lower bowel gas

☐ Stools have foul odor ☐ Colon Problems Number of bowel movements a day _____ Other_____

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URINE: Color _____ Amount _____ Frequent urination ☐ Daytime ☐ At night

☐ Strong smelling urine ☐ Hard to urinate ☐ Pain or burning when urinating ☐ Blood in urine ☐ Frequent infections

☐ Water retention Other _____

MUSCULOSKELETAL: Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands ☐ Hips ☐ Knees ☐ Fingers

☐ Big toe ☐ Weakness in legs ☐ Weak ankles ☐ Stiff all over ☐ Tingling in feet ☐ Muscle spasm/cramps

☐ Loss of feeling in hands/feet ☐ Painful joints ☐ Bursitis Other _____

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequent crying ☐ Worry/Anxiety

☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors ☐ Numbness/tingling limbs

☐ Poor coordination ☐ Muscle weakness ☐ Feel weak & shaky ☐ Seizures ☐ Neuralgia (nerve pain) ☐ Shingles

Other _____

FEMALES: Pregnant? ☐ Yes ☐ No Last monthly period _____ Last PAP test_____

Form of birth control: ☐ None ☐ Pill Other _____

Age started menstrual cycle _____ Age stopped _____ ☐ Menstrual Pain ☐ Low backache ☐ Irregular ☐ Clotting

☐ Heavy bleeding ☐ Light scanty bleeding Color _____

☐ Water retention ☐ Mood changes ☐ Miss periods ☐ Low sexual drive ☐ Lack of sexual drive ☐ Pelvic pain

☐ Painful breasts ☐ Hot flashes ☐ Food cravings Other _____

Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid Other _____

# of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions _____ # of cesareans _____

Operations: ☐ Cervix ☐ Uterus ☐ Ovaries Other _____

MALES: ☐ Low sexual drive ☐ Lack of sexual desire ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges

☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostate Trouble Other_____

APPETITE: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed

☐ Excessive thirst ☐ Never thirsty Other _____

Specific food cravings? ☐ Yes ☐ No If yes, what? _____

DIGESTION: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning/belching ☐ Stomach pain ☐ Stomach cramps

☐ Nausea ☐ Vomiting ☐ Bad breath ☐ Sores in mouth ☐ Weight gain ☐ Weight loss ☐ Bitter/sour taste in mouth

☐ Abdominal bloating How long after eating? _____

Food allergies? ☐ Yes ☐ No If yes, to what? _____

_____

_____

NUTRITION: List some of your favorite foods _____

_____

_____

_____

_____

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ☐ Yes ☐ No How often _____

How many ounces of water do you drink a day? _____ ☐ Filtered ☐ Bottled

Do you use alcohol? ☐ Yes ☐ No Amount per week _____ Type _____

Do you use tobacco? ☐ Yes ☐ No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

Eat greens or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐ No

Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No

Eat the same foods almost every day? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐ No

Occasionally go on a "crash" diet? ☐ Yes ☐ No

Always add salt at the table? ☐ Yes ☐ No

Eat refined sugars? ☐ Yes ☐ No

Eat processed foods? ☐ Yes ☐ No

Patient Name _____

Patient's Signature _____

Date _____

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Informed Consent

I hereby request and consent to acupuncture treatments and other procedures within the scope of practice of Licensed Acupuncture for myself (or the patient named below, for whom I am legally responsible) by the acupuncturist named above.

I have been informed and understand that, as in the practice of medicine, the practice of Acupuncture entails some risks with treatment, including but not limited to slight bruising, tingling near the needling sites that may last a few days, nausea, a punctured lung or other internal organ, and infection. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications which may be possible, and I choose to rely on her expertise to exercise appropriate judgment during the course of the procedure which she deems appropriate at the time, and based upon the facts then known, in my best interest. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reaction(s) to herbs, I will promptly inform the acupuncturist.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the acupuncture procedure. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____ _____
Signature of Patient or Patient's Representative Date

X_____ _____
Print Name of Patient Print Name of Patient Representative

I acknowledge that a 1.5% fee will be added to any balance over 30 days past due.

X_____
Initials

I realize that I am responsible for a payment in full for a missed appointment charge if less than 24 hours notice is given for changing a scheduled appointment. A 1.5% fee will be added to any balance over 30 days past due. If your account is in arrears over 90 days it will be turned over to a collection agency.

X_____
Initials

I understand that if, for any reason, my insurance does not cover my acupuncture sessions, that payment is my personal responsibility, and that I will provide such payments.

X
Signature

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, HEREBY STATES that by signing below, I acknowledge and agree as follows:

The Practice's Privacy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operation. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, **in writing,** at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

X_____ **X**_____
Name of Individual (Print) Signature of Individual

X_____ _____
Signature of Legal Representative Relationship
(e.g. Attorney, Guardian, Parent if a minor)

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It is the office policy to keep your credit card on file in order to secure your appointments. As you know, our office is very busy and keeps a waiting list. If you miss your appointment, that is a time slot we could have offered another patient.

Your credit card information is kept in a secure, locked file and will only be used if you cancel with less than 24 hours-notice or don't keep the time we've allotted specifically for your care.

We hope you understand that this policy is in place so we can continue to put your healthcare first and serve you with the respect, focus and intention you deserve.

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Credit Card Authorization Form

PLEASE NOTE THIS AUTHORIZATION WILL ONLY BE USED FOR MISSED APPOINTMENT FEES AND UNPAID BALANCES.

Credit Card Details

Credit Card # _____

Expiration Date _____

CVC _____

Credit Card Holder Name _____

Billing Address

Street _____

City_____ State_____ Zip_____

Acknowledgement & Agreement

I hereby authorize my signature to be on file with Elixir Lifestyle Medicine for the purpose of client sessions that I schedule but fail to keep without providing 24 hours notice. I understand that all credit card transactions are subject to a 5% fee. I authorize the respective credit card company designated by my card on file to accept this form in lieu of my signature appearing on the individual credit card receipt for the services provided. By signing the authorization form, I acknowledge and agree to be financially responsible for any and all charges invoiced to me by Elixir Lifestyle Medicine. I confirm that I am the credit card holder responsible for the credit card number I have indicated. I agree to permit Elixir Lifestyle Medicine to submit unsigned credit card vouchers, stating that my signature is on file, or to amend, alter, complete or execute on my behalf, credit card vouchers in my name for payment of charges. I further agree that in the event my credit card becomes invalid, I personally guarantee payment and will provide Elixir Lifestyle Medicine with a new valid credit card number upon request, to be charged for the payment of any outstanding balances owed.

_____
Card Holder Signature

_____ _____
Print Name Date

Out of respect for our chemically sensitive patients

THIS IS A FRAGRANCE FREE OFFICE

Please refrain from wearing perfume, aftershave and scented body lotions on the day of your treatment

Thank you for Your Understanding