Heather Biery Acupuncture, Massage & Natural Medicine

Patient Intake: Please Complete

CONTACT INFORMATION			Today's Date:	
Name:			Date of Birth:	
Mailing Address:			WC Claim No if applicable	
			Email :	
			Home Phone:	
City:	State:	Zip:	Cell Phone:	
			Work Phone:	

Occupation: Employer/School:

Are you Married/ Rela?onship/ Single/ Divorced? (circle one)

Emergency Contact Name: Phone: Relationship:

Do You Have Health Insurance? With which company?

How did you hear about us?

Have you ever had acupuncture before? When? Did it help you?

WOMEN: Is there any chance you could be pregnant? If so, how far along are you?

REASON FOR VISIT

Briefly describe your main concern that brings you to this office today:

When did this condition begin?

What makes it better?

What makes it worse?

Have you been given a diagnosis for this condition? What was the diagnosis?

MEDICAL HISTORY

Check all that apply

- ☐ Allergies
- ☐ Headaches /
- ☐ Migraines Arthritis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Blood Clot Disorder
- ☐ Hyper---Thyroid
- ☐ Hypo---Thyroid
- ☐ Epilepsy
- ☐ Cancer
- ☐ Diabetes
- ☐ Autoimmune Disease
- ☐ Venereal Disease
- ☐ HIV
- ☐ AIDS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Chemical addiction
- ☐ Depression /Bi-polar

Fill in the following information

Medications/Vitamins/Supplements/Herbs
Please indicate dosages

Major surgeries or hospitalizations
List date and reason for surgery

Falls, broken bones, auto accidents --------- List dates

FAMILY HEALTH HISTORY

Please check if any of your family members have or have had any of the following

- ___**Cancer** Relationship_____
- ___**Diabetes** Relationship_____
- ___**High Blood Pressure** Relationship_____
- ___**Low Blood Pressure** Relationship_____
- ___**Heart Disease** Relationship_____
- ___**Seizures Depression** Relationship_____
- ___**Hyper-----Thyroid** Relationship_____
- ___**Hypo-----Thyroid** Relationship_____

Notes:

Please list your daily intake or usage of any of the following items:

Tobacco: **Coffee:** **Alcohol:** **Sugar:** **Water:**

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Please describe your experiences or concerns with the following areas of health.

Digestion

Diet/Nutrition

Elimination

Bowel movements

Urination

Ears, Eyes, Nose and Throat, Head

Sleep

Reproductive System

Lifestyle / Exercise

Energy level

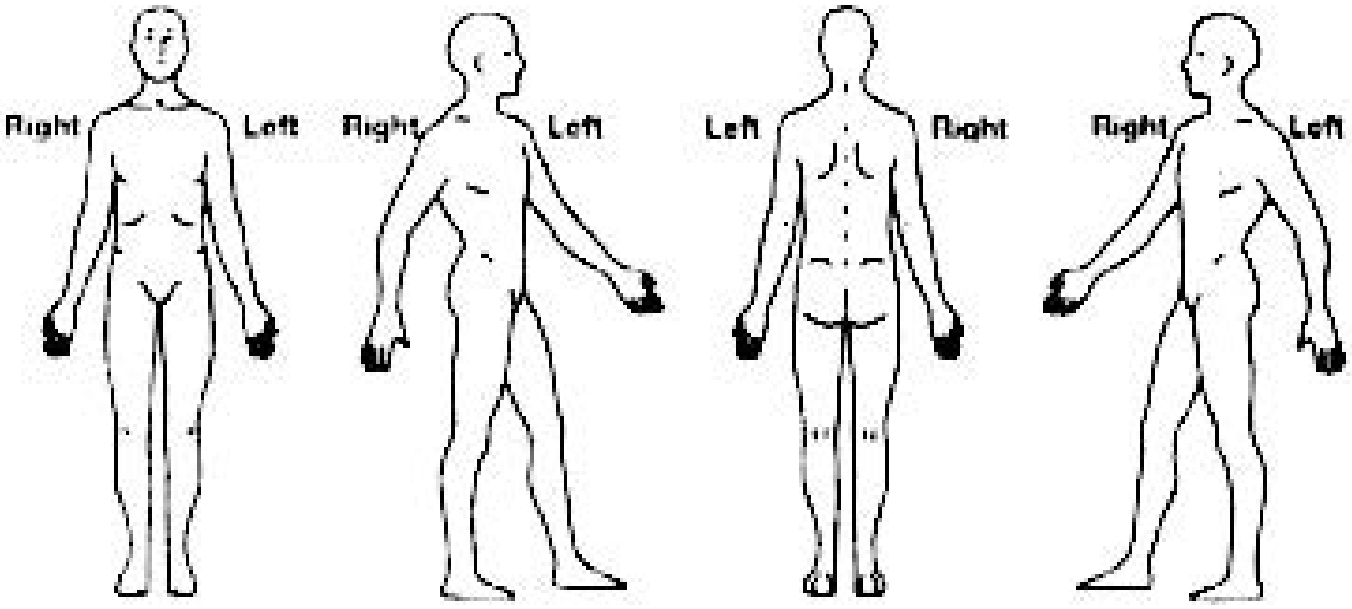
Emotions

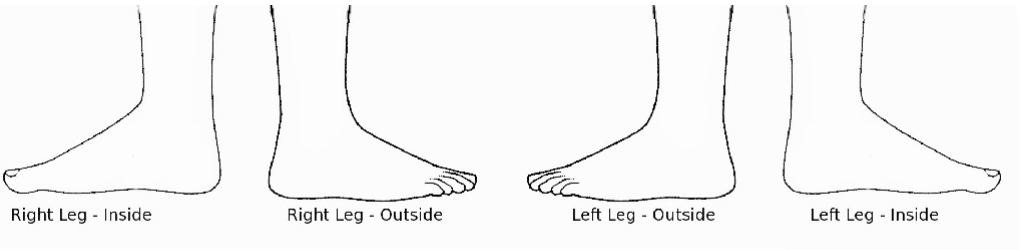
Body Temp. and Sweating

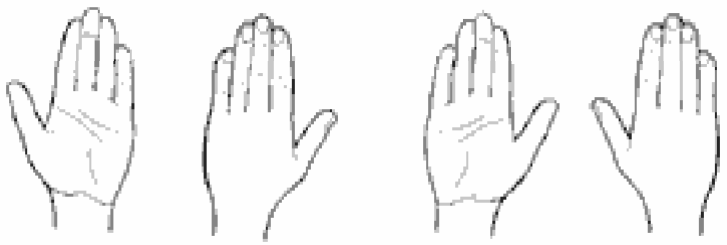
Notes:

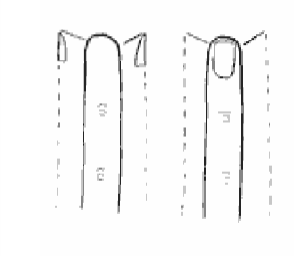
Please Mark

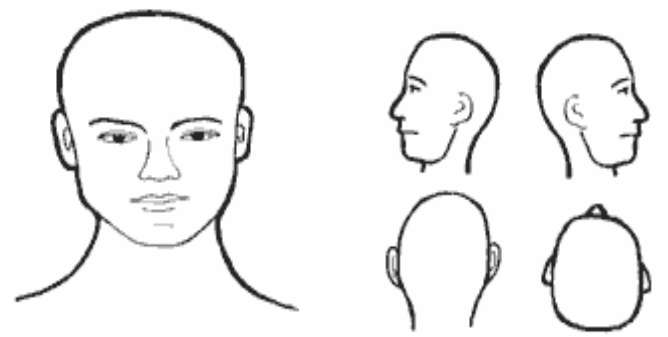
PAIN PICTURE











Please mark your area(s) of pain/discomfort in the appropriate picture(s).

Use the 1-10 pain scale to mark each area of pain Use the following key to indicate the quality of the pain or the type of discomfort.

Key:

XXX = Sharp pain
AAA = Aching
NNN = Numbness/ tingling
>>> = Radiating pain
BBB = Burning
//// = Tension

Patient Name: **Date:**

Privacy Practices Summary and Patient Acknowledgement of Receipt

Please refer to our complete **Notice Of Privacy Practices** for the details of the information summarized below at any time.

Summary:

Heather Biery Acupuncture, Massage & Natural Medicine may use and share Protected Health Information (PHI) about you: as necessary to provide you with appropriate medical treatment and health services, to collect payment for services rendered to you and for our internal health care operations management and compliance monitoring.

Heather Biery Acupuncture may disclose PHI without your written permission: as required by state, federal or local law; in the case of suspected child abuse or neglect; when the public health is at risk; in response to a court order or warrant; to coroners, medical examiners and funeral directors; to organ donor facilities if you are an organ donor; when the information is in no way personally identifiable as yours.

All other uses of your PHI not covered by our Notice of Privacy Practices or the laws that apply to us will be made only with your written consent.

You have the following rights relating to the health data we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

Other Policies

Please initial in the space next to each of the following to acknowledge that you have read and agree to the policies and conditions relevant to receiving treatment from Dr. Heather Biery Wellner DAOM, of Heather Biery Acupuncture, Massage & Natural Medicine.

_____ I acknowledge that I have received the SUMMARY and NOTICE OF PRIVACY PRACTICES of this practice.

_____I understand that Acupuncture and Chinese Herbal Medicine are not meant to replace medical diagnosis or treatment. If symptoms are severe or persistent I should consult my physician as well.

_____I understand that I am personally responsible for payment. I agree that if Dr. Biery Wellner is billing a third party claim on my behalf, that I will pay her in full when the claim is settled.

_____I understand that there will be interest charges at the rate of 20% annually on any unpaid balance on my account that remain past due for 30 days or more.

_____I understand that there will be a $25.00 Returned Check Fee on all returned checks.

_____I understand that it is my responsibility to provide Dr. Biery Wellner with a minimum of 24 hours notice if I have to cancel or reschedule an appointment and that I will be charged in full for any appointments cancelled with less than 24 hours notice.

_____I agree to keep my Doctor of Acupuncture & Oriental Medicine informed of any and all changes in my health.

Release of Information --- *Please complete the section below to indicate your Release of Information if applicable.*

I,_____(patient) authorize Dr. Heather Biery Wellner DAOM, LAc, to release therapeutic and medical information to the following individuals or insurance companies:

The purpose of sharing this information with the above individuals or entities is to enhance my treatment as well as for assistance in the reimbursement of funds.

This consent is authorized for the following period of time: _____

Signature of patient or representative Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office 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, electrical stimulation, Tuina (Chinese massage), Shiatsu (Japanese Massage), Seitai (Japanese Structural Balancing), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or 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 effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept 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, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend 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.

PRINT PATIENT'S NAME:

PATIENT SIGNATURE: **X** (Date)

(Or Patient Representative) Indicate relationship if signing for patient _____

OFFICE SIGNATURE: **X** (Date)

Dr. Heather Biery Wellner DAOM LAc

Heather Biery Acupuncture, Massage & Natural Medicine

Colorado Mandatory Disclosure

Education & Experience:

B.A. Stanford University 1998, Stanford, CA.

M.S. American College of Traditional Chinese Medicine (ACTCM) 2006, San Francisco, CA.

D.A.O.M. American College of Traditional Chinese Medicine (ACTCM) 2013, San Francisco

Dr. Wellner's background includes a 3 year Doctoral Fellowship at American College of Traditional Chinese Medicine (ACTCM) in San Francisco (specializing in women's gynecology & fertility and sports medicine recovery), a four-year graduate degree from ACTCM, and a bachelors degree with honors from Stanford University. The degree of Doctorate in Acupuncture and Oriental Medicine is a newly accredited, advanced degree for licensed acupuncturists requiring an additional 3 years of study, a capstone study, and internships with master practitioners of 20 years. Dr. Wellner is one of very few Doctors of Acupuncture in the United States.

Dr. Wellner has advanced training in orthopedics with George Stretch ND, an orthopedic specialist, and Whitfield Reeves, L.Ac., 30 year practitioner and author of The Acupuncture Handbook of Sports Injuries and Pain, as well as Master Yu-Tai Fu, award-winning Qigong Master and traditional "bone-setting" healer from Beijing. She has also trained with Dr. Sadhna Singh, fertility specialist, and Claudia Citkovitz L.Ac., Director of the Acupuncture Program at Lutheran Medical Center in Brooklyn, where she is a labor and delivery specialist, as well as Raven Lang L.Ac. midwife and acupuncturist, author of the Birth Book and "The Art and Science of Obstetrics". As a practitioner, Dr. Wellner has worked and trained in a variety of hospital and clinical settings, including internships with talented gentle Japanese style clinician Dr. Cameron Bishop and 30+ year practitioner of Japanese Koshi (Structural) Balancing Jeffrey Dann, L.Ac. Dr. Wellner has also received special training in pediatric shonishin with Japanese Masters Masanori Tanioka Sensei, Takahiro Funamizu Sensei and Shoji Kobayashi Sensei.

Dr. Wellner's training includes advanced therapies such as meridian therapy, moxibustion, tuina, shiatsu, seitai Koshi Balancing, acupressure, cupping, auriculotherapy, electric stimulation, and dietary and lifestyle counseling. She is a licensed acupuncturist in Colorado and in California. None of these licenses, certificates, or registrations have ever been suspended or revoked. This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper disposal of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

New Patient 75 minute Treatment	$195
New Patient Pediatric 1 hour	$135
90 Minute Treatment	$195
75 Minute Treatment	$165
1 hour Treatment	$135
45 minute Treatment	$105
30 minute Treatment	$75
15 minute single modality	$45
Injection per ampule	$55
Herbal Consult 20 min	$75
Microneedling treatment	$310
Microneedling 3 pack ($80 Savings)	$850
Microneedling 16 pack ($960 Savings)	$4000

Cancellation Policy

Please give at least 24 hours notice if you cannot make your appointment. Appointments cancelled with less than 24 hours notice will be charged the **full amount**.

·Patient's Rights

·The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

·The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7851.

I have read and understand this document

PRINT PATIENT'S NAME: _____ DATE: _____

PATIENT SIGNATURE: X _____ _____DATE: _____

PATIENT'S REPRESENTATIVE: X_____RELATIONSHIP_____ DATE: _____

Dr. Heather Biery Wellner DAOM LAc