Sophia Scheffel, L.Ac.
Acupuncture, Herbal Medicine, Medical Qigong

Patient Information:

Name: _____ Today's Date:_____

Address:_____

_____ ZIP _____

Home Phone # : _____Cell Phone #: _____Other #: _____

May we leave a message at these phone numbers? _____ Email Address: _____

Would you like to be added to the mailing list for occasional announcements, classes details, and promotions? Yes ☐ No ☐

Patient Status:

Birth Date:_____ Age: _____ Gender: M___ F___

Marital Status: _____

Employment Status:

Full Time ___ Part Time___ Retired ___ Unemployed ___ Student ___ Other: _____

Occupation: _____

Employer's Name: _____

Primary Health Care Source:

Physician's Name:_____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

What are you being treated for? _____

Date of Injury or Onset of Illness: _____

Are you under the care of any other practitioner(s)? Yes ☐ No ☐

Contact Name: _____ Contact #: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #: _____

Are you presently being treated for a medical condition(s)?

What health issue do you want treated? Please describe.

Date of injury or onset of illness:

What treatment have you been using for relief of this issue?

Please briefly describe any chronic pain:

Please list all medications, supplements and / or herbs you are currently taking:

Do you have a pacemaker?

Are you currently Pregnant?

Sophia Scheffel, L.Ac.
Acupuncture, Herbal Medicine, Medical Qigong

Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Sophia Scheffel, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture. cupping, electrical stimulation, Chinese herbal medicine, and nutritional & lifestyle counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have 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 needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effects 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. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy.** I will notify Sophia Scheffel, L.Ac. if I am or become pregnant.

I do not expect Sophia Scheffel, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment which the Clinic Medical Staff thinks at the lime, based upon the facts then known, is in my best interests.

I understand that 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, this 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.

Financial Agreement: I acknowledge that I am responsible for the payment of services at time of appointment. I acknowledge that if I do not give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Consent: Consent is to be completed by patient (or by patient's representative if the patient is a minor or is physically or legally incapacitated)

_____	_____	_____
Print Name of Patient	**Signature of Patient (or Representative)**	**Date Consent Completed**

Representative (if applicable):
Print name of representative: _____ Relationship to patient: _____

1030 Brown Avenue
Lafayette, CA 94549
925.268.0117

Sophia Scheffel, L.Ac.
Acupuncture, Herbal Medicine, Medical Qigong

Notice of Privacy Practices

Our Pledge Regarding Medical Information:
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information
We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

- For treatment
- For payment
- For healthcare operations
- When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls or mail.

Patient Rights

1. Upon written request, you have the right to access, review or receive copies of your health care records. There is a copy fee of $15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request that we amend your protected health information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact Sophia Scheffel, L.Ac.
Send written complaints to the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services in this office. This practice has attempted to provide each patient with a statement of Privacy Practices.

_____ _____
Patient Signature **Date Signed**

1030 Brown Avenue
Lafayette, CA 94549
925.268.0117