KNOLL Acupuncture
PROVEN HEALTHCARE SOLUTIONS FOR ACTIVE LIVES©

Health History Questionnaire
(Information For Your Acupuncturist)

Important: Please complete this document as thoroughly as possible. All information is strictly confidential.

Patient Information:

Date: ___/____/____

Name: _____

Address:_____City: _____Zip_____

Best Phone to reach you : _____ Cell___Work___ Home___

Email Address: _____

Age: _____ Date of Birth: ___/___/___ Place of Birth:_____

Guardian (if under 18): _____

Gender: ☐M ☐F Height: ____' ____" Weight: _____lbs.

Occupation: _____Employer: _____

Emergency Contact: Name_____ Relationship_____ Phone:_____

How did you hear about our office?_____

Other physicians/therapists seen for this condition? _____

_____

Medications: (if any)_____

Supplements: (if any vitamins, herbs, minerals, etc.):_____

_____

Major Complaint(s) in order of significance to you:	Severe	Moderate	Slight
1.			
2.			
3.			
4.			
5.			

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INFORMED CONSENT TO ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT AND CARE

I _____ hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxibustion, cupping, electro acupuncture, herbology, various modes of physiotherapy by the acupuncturist at Knoll Acupuncture.

I have had an opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electro-acupuncture, herbology, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but limited to, slight burning, tingling near the needling sites that that last a few days, nausea, infection and blisters. There have been instances of fainting, infection and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

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

_____ _____

Signature of Patient or Representative | Print Name of Patient's Representative

_____ _____

Witness to Patient's Signature | Relationship to Representative

_____ _____

Translated By | Date

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Consent to the Use or Disclosure of my Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Knoll Acupuncture for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care operations of Knoll Acupuncture, LLC.

I understand that diagnosis or treatment of me by Knoll Acupuncture, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Knoll Acupuncture, LLC is not required to agree to the restrictions that I may request. However, if Knoll Acupuncture, LLC agrees to a restriction that I request, the restriction is binding on Knoll Acupuncture, LLC.

I have the right to revoke this consent in writing, at any time, except to the extent that Knoll Acupuncture, LLC has taken action in reliance of this consent.

My 'protected health information' means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Knoll Acupuncture's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Knoll Acupuncture, LLC.

The Notice of Privacy Practices for Knoll Acupuncture, LLC is also posted in the lobby.

The Notice of Privacy Practices also describes my rights and the duties of Knoll Acupuncture, LLC with respect to my protected health information.

Knoll Acupuncture reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by asking for it at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

PLEASE PRINT NAME OF PATIENT REPRESENTATIVE

Date _____

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TELEPHONE CONSUMER PROTECTION ACT (TCPA) OPT IN CONSENT FORM

Due to recent changes to the Telephone Consumer Protection Act (TCPA), clients are now required to "opt in" to receive automated communications on their mobile device.

Knoll Acupuncture uses the PRACTICE FUSION notification system to quickly and efficiently notify clients of upcoming appointments. This means clients must provide express consent to receive general messages through automated calls and SMS text messages on their mobile device(s). Please note that you can revoke consent to receive these messages at any time.
Please take a moment to fill out this consent form indicating your desire to receive these important messages in the future.

- ☐ CONSENT: I, (_____PRINTED name) give KNOLL ACUPUNCTURE permission to contact me via my cellular device for automated phone calls and SMS text messages for general messages. I understand that emergency notifications are excluded from this permission and will be sent as normal. By signing, I certify that I am the owner of this cellular device and its user contract. I understand that consent is not required to make a purchase. Message and Data rates may apply.

SIGNATURE:_____
MOBILE NUMBER:_____
DATE:_____