Rhiannon Herpolsheimer LAc • Mandala Acupuncture • CA Lic 14393
North State Healing Arts Collective • 1539 Chestnut St Redding CA 96001 • 530.276.8406

Patient's Full Name _____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ [ ] Male [ ] Female Marital Status _____

Phone (Home) (_____) _____-_____ Phone (Cell) (_____) _____-_____

Address _____ City _____

State _____ Zip _____ E-mail _____

Employer _____ Occupation _____

Spouse/ Partner/ Legal Guardian Name _____

Family Physician _____ Phone (_____)_____-_____

Referred by _____ Phone (_____)_____-_____

Health Insurance Information (fill out only if permission to contact):

Company _____ Member # _____ Group # _____

Primary Name & Birth Date _____ Provider Contact #_____

Emergency Contact Information:

Name _____ Phone (Home) (_____) _____-_____

Relationship _____ Phone (Cell) (_____) _____-_____

Chief Complaint(s) Please indicate how long you've had the condition(s)

_____

_____

_____

_____

_____

List Medications/Supplements being taken (with dose if known)

_____

_____

_____

_____

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Rhiannon Herpolsheimer and staff to keep confidential all medical records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally. Under no circumstances will your private medical information be disclosed to a third party outside of our office without your written consent except when mandated by federal or state laws.

I, the undersigned, hereby request Rhiannon Herpolsheimer LAc to communicate my personal health information electronically (choose preferred method(s) below). I understand that this form of communication is less secure.

Email _____ _____ Text _____ _____ Phone/Voicemail _____ _____
Date Initial Date Initial Date Initial

Consent

I, the undersigned, hereby authorize Rhiannon Herpolsheimer L.Ac. to perform the following procedures:

Date Initial

_____ _____Acupuncture: Insertion of sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.

_____ _____ Massage/Tuina/ Cupping/Gua Sha: Manipulation of all superficial body structures with or without oils, creams, and liniments/Chinese therapeutic manipulation/Cups attached to the skin with vacuum created by heat or a hand-held vacuum pump/Rubbing an area of the body with a blunt, round instrument.

_____ _____ Herbs: Pills, powders, tinctures, pastes, plasters or raw herbs to be cooked. Herbal formulas may include shell, mineral, plant and animal materials.

I recognize the potential risks and benefits of these procedures as described below:
Risks: discomfort, pain, bleeding, bruising, infection and blistering at the site of procedure, needle sickness, broken needle, temporary discoloration of the skin and aggravation of symptoms existing prior to the acupuncture treatment. Patients with pregnancy, severe bleeding disorders or pace-makers should inform practitioners prior to treatment.
Benefits: relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem, and strengthening the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Rhiannon Herpolsheimer and affiliates regarding cure or improvement of my condition. I hereby release Rhiannon Herpolsheimer and affiliates from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I recognize my responsibility in paying for my treatments when insurance doesn't fully cover the fee (if applicable):
Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office.

_____ _____
Signature of patient (or legal guardian) Date