Palmer Complete Health
Julie Palmer, AP
12443 San Jose Blvd Suite #304
Jacksonville, FL 32223
(904) 661-8299

Personal Information

Name_____ Sex: M □ F □ DOB: _____ Age_____
Address_____ City_____ State_____ Zip _____
Home Phone (____) _____ Cell (____) _____
Email_____ Occupation_____
Sign up to receive the Newsletter? Y □ N □ How did you hear about us? _____
Emergency Contact: Name_____ Phone _____
Relationship_____
Healthcare Providers: Primary Care Physician_____
Previous experience with acupuncture ? Y □ N □

Health History

Please list your major health concerns in order of importance to you: (reason you are here)
1)_____
2)_____
3)_____

Are you being treated for the listed condition by another health care provider? Y □ N □
What kinds of treatments have you tried for this condition?
_____

Please indicate what this condition has limited or stopped you from being able to do:
_____
_____

List any serious diseases, injuries, **surgeries**, or hospitalizations you have had and the year they occurred:
_____
_____
_____

Family History (List any family physical or mental illnesses and age of death)
Mother_____
Father_____
Siblings_____

What do you enjoy doing for fun?
_____

Check any conditions that you have had in the past or are currently experiencing:

□ Epstein Barr Virus (EBV) / Mono / Lyme	□ gynecological disorder
□ cold sores	□ congenital abnormalities
□ genital herpes	□ skin diseases
□ osteoporosis/osteopenia	□ cholesterol
□ rheumatic fever	□ heart disease
□ high blood pressure/low blood pressure	□ cardiac pacemaker
□ stroke	□ surgical implants
□ kidney disease	□ change in bowel or bladder habits
□ urinary bladder problems / infections	□ sores that will not heal
□ diabetes	□ unusual bleeding or discharge
□ cancer	□ indigestion / acid reflux
□ pneumonia	□ crohn's disease
□ emphysema / asthma	□ irritable bowel disease
□ bronchitis / sinus infections	□ difficulty swallowing
□ ulcer	□ dementia / alzheimer's
□ anemia or other blood disorder	□ Parkinson's
□ bleeding disorder	□ epilepsy or convulsions
□ fibromyalgia / chronic fatigue	□ history of smoking # per day
□ osteoarthritis	□ history of smokeless tobacco use
□ rheumatoid arthritis	□ history of drinking alcohol
□ mental disorder	□ history of recreational drug use
□ gout	□ history of sexually transmitted disease
□ hepatitis	□ HIV
□ liver cirrhosis	□ Auto Immune Disease
□ gallstones	□ Pregnant
□ jaundice	□ Yeast Infections (candida)
□ hernia	□ joint replacement
□ thyroid disorder	□ Other:

Prescription Medications, Herbs, and Supplements (List those that you are currently taking)

Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____
Name_____ Reason_____ How long_____

(If you bring a copy of medication no need to write them down)

Allergies to any medication or foods?

_____

Describe your typical daily diet: (ONLY FOR WEIGHT LOSS or MIGRAINES)
Breakfast: _____Time: _____
Lunch:_____ Time:_____
Dinner:_____ Time:_____
Snacks:_____Time:_____

CURRENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

□ Depression/Stress
□ Headaches/Migraines
□ Visual problems/Blurred Vision/Floaters
□ Dizziness
□ Muscle Cramping/Twitching
□ Neck/Shoulder Pain/Tightness
□ Seizures/Tremors
□ PMS/Menstrual problems
□ Tend to be irritable/Angry
□ Constipation
□ Colitis

□ Heart Palpitations
□ Rapid or Irregular Heartbeat
□ Chest Pain
□ Insomnia/Sleep Problems

□ Body Heaviness
□ Energy Level: 1-10 (low to high) _____
□ Edema (□ Hands □ Feet)
□ Gas/Belching
□ Hemorrhoids
□ Chronic Loose Stools

□ Cough
□ Post Nasal Drip
□ Snoring
□ Shortness of Breath
□ Sinus Infection/Congestion
□ Catch Colds Easily
□ Dry Mouth/Nose/Throat
□ Skin Rashes/Hives

□ Get up more than once a night to urinate
□ Bladder Infection
□ Incontinence
□ Weakness/Pain in Low Back
□ Osteoporosis/Osteopenia
□ Low or Excess Sex Drive (circle which)
□ Hot Flashes/Night Sweats
□ Impotence

Women Only:

1. Are you pregnant now? □ Yes □ No
2. Number of pregnancies: _____
3. Age of first period: _____

Patient Signature: _____ **Date:_____**

Reviewed with Patient _____ Julie Palmer, AP Date :_____

Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures with the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated 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, Tui-Na (Chinese massage), 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 taste or smell. 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 sites that may last a few days, and dizziness or fainting. Burns and/or scarring are the potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 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 substances) 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 pregnant or become pregnant.

While I do expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 faces 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.

Patient Signature X_____Date: _____
(Or Patient Representative)
Acupuncturist Signature: _____ Julie Palmer, AP

NOTICE OF PRIVACY POLICIES

The following is the privacy policy of Oriental Medical Center as described in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires Oriental Medical Center by law to maintain the privacy of your personal information and to provide you with notice of Oriental Medical Center's legal duties and privacy policies with respect to your Personal Health Information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information
We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information. This office may send birthday cards, newsletters and appointment reminders (telephone, text, email, letters, etc.)

Use or Disclosures of Your Personal Health Information
Generally, we may not use or disclose your personal health information without your permission. The following are the circumstances under which we are permitted by law to use or disclose your Personal Health Information:

***As Required By Law*.** We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Your rights With Respect to Your Personal Health Information
Under HIPAA, you have certain rights with respect to your Personal Health Information. It is your right to request the following regarding your Personal Health Information:

- Right to request restrictions of use or disclosure of your Protected Health Information.
- Right to receive confidential communications.
- Right to inspect and copy your Personal Health Information.
- Right to request amendment of your Personal Health Information.
- Right to receive and Accounting of Disclosures of your Personal Health Information.

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Complaints files with the Secretary of DHHS must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred.
U.S. Department of Health and Human Services
DHHS (Office of Civil Rights)
200 Independence Ave. SW Room 509 Building F
Washington, DC 20201
If you have questions or want more information regarding HIPAA, please contact:
Julie Palmer, AP, at telephone: (904) 661-8299.

_____ _____
Patient Signature Date

INFORMED CONSENT FOR LOW LEVEL LASER THERAPY

I understand that the RJ Cluster Probe and the RJ Light Needle Laser 300 and 600 are low wattage lasers which have been given a 501 clearance by the US Food and Drug Administration.

I understand that there is a potential risk of eye injury if I were to stare into the beam. I understand that if I have any condition, which makes me extra sensitive to light, I should discuss it with my physician prior to consenting to low level laser therapy. It has been explained to me that there may potentially be a short term increase in pain after low level laser treatment, but that this has not been associated with any harm.

Accordingly, before giving my agreement and informed consent by signing this form, I have been advised to my personal satisfaction that this treatment entails the use of visible red and/or infrared laser light at low intensity, of the possible beneficial effects to be derived, of the methods, means and duration of the treatments, of the inconveniences, of the nature of the risks associated with the treatment, and of the alternatives to this form of treatment. I have been informed that I am to immediately notify the individual treating me or contact the clinic if any problems are encountered during my treatment.

I understand that I may withdraw consent to continue low intensity laser therapy at any time and that there are not consequences to this withdrawal. This consent will serve as permission for continued treatments with laser as long as I am under the care of Julie Palmer, AP.

I have been provided with an opportunity to ask any pertinent questions.

BioPhoton and Laser Therapy

BioPhoton therapy utilizes packets of light called Photons to stimulate blood circulation to the treatment area. This results in relief of pain and reduction of symptoms associated with soft tissue injury, such as swelling. It also decreases the healing time associated with superficial injuries, such as burns, cuts, and contusions. Adverse effects from BioPhoton therapy are normally rare and temporary. These effects may include from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, excessive pressure from the treatment unit, and over-stimulation. BioPhoton therapy can cause serious damage to the eye, therefore it is veryimportant to wear protective glasses that will be provided at all times during treatment. Although rare, the most common adverse effects to BioPhoton therapy are:

1) Temporary increase in pain during BioPhoton application.
2) Temporary increase in pain in the day or days following BioPhoton therapy.
3) Mild bruising from stimulation of blood circulation or direct pressure of treatment unit.
4) Temporary dizziness.
5) Reactions when photosensitizing drugs are used with BioPhoton therapy.

I have read and understand the risks of BioPhoton therapy. I agree to wear the protective glasses provided to me at all times during my treatment.

_____ _____

Patient Signature Date

_____

Print Name (Patient)

_____ _____

Witness Signature Date

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____ DOB:_____

From time to time it may be necessary for a representative of Palmer Complete Health to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize Palmer Complete Health and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below.

I authorize Palmer Complete Health to leave detailed, personal health information by the following
means:
Check and complete all that apply:

	Method	Number with Area Code
□	Home Telephone/Voice Message	
□	Cell Phone/Voice Message	
□	Work Telephone/Voice Message	
□	Text Message	
□	Email	

AUTHORIZATION TO SHARE PERSONAL
HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number with Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Palmer Complete Health in writing should I wish to change any of information noted above and to notify Palmer Complete Health if my contact information changes.

_____

Patient or Legally Authorized Representative's Signature Date

Financial Policy & Patient Responsibility

We request payment at the time service is provided. We are able to accept payment in the form of cash, American Express, Visa, Discover and Master Card.

Philosophy
Palmer Complete Health is Your Solution to Wellness. We make the highest effort to serve our patients as quickly as possible. Usual visits are one visit per week for 4 weeks then a re-evaluation. Some conditions take one month and then you are put on maintenance visits which are one visit every three months other chronic problems require several months of treatment. Your treatment plan will be customized based on your needs.

Insurance
We do not accept insurance. However, we are happy to provide a fee sheet for services provided where you can submit it to your insurance carrier. We do accept HSA or FSA cards. It is ultimately your responsibility to ensure what your HSA or FSA covers regarding treatment or herbs and supplements.

Cancellation Policy:
Palmer Complete Health's cancellation policy requires patients to give a **24-hour** cancellation notice if they need to reschedule or cancel their appointment. As time and space are limited someone else may be able to take your spot if advance notice is given. If you are not sure you will make your scheduled appointment, please do not schedule it. We ask that you please value our time and understand the reason for our cancellation policy.

The fee for missed appointments or cancellations is $95. Patients will not be able to see the provider until the cancellation fee is paid. By signing below, you are agreeing to the fees outlined above.

Signature: _____ Date: _____

Print Name: _____