Colorado Mandatory Disclosure Statement

TCM Whole Health, Inc.
Acupuncture Associates of Castle Rock
720-445-6292
www.AcupunctureofCastleRock.com

107 5th St. suite B
Castle Rock, CO 80104

Education and Experience

Rebecca Baker earned her Master of Science Degree in Traditional Chinese Medicine from Colorado School of Traditional Chinese Medicine in August 2012. This intensive 3 year program consists of 2,850 hours total including 795 hours of clinical experience. Rebecca is certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine in fall of 2012. This includes certification in Clean Needle Technique. She is licensed to practice acupuncture in the state of Colorado. Her license number is: 1855. Rebecca also received a Bachelor of Arts degree from Fort Lewis College in 1995.Rebecca is a licensed acupuncturist in the state of Colorado and has always been in good standing.

Rebecca's training includes adjunctive therapies such as Chinese herbs, moxibustion, tui na, gua sha, cupping, auriculotherapy and dietary and lifestyle recommendations.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the use of single-use, disposable, sterilized needles and the sanitation of acupuncture offices.

Fee Schedule:

Initial Consultation and Treatment	$150	+ cost of herbs
Follow-up Treatment	$115	+ cost of herbs
Late Cancelation (24-hour notice required)	$50	
Tibetan Herbal Foot Soaks	$30	
Heart Sound Recording Assessment (HSR)	$100	
Acugraph Energy Assessment	$75	
Both HSR & Acugraph Assessment	$150	

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

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 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) 894-7800

I have read and understand this document related to acupuncture and other services to be provided by the employees of TCM Whole Health Inc.

Patient or Guardian's Signature Date

Consent to Receive Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medical by a licensed acupuncturist representing TCM Whole Health, Inc. DBA Acupuncture Associates of Castle Rock. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medical may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call TCM Whole Health, Inc. as soon as possible.*

Acupressure/Cupping/Gua Sha/Tui-Na Massage: I understand that I may also be given adjunctive treatments as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Email: _____ **Would you like to receive our Newsletter: Y / N**

How did you hear about us?

a) Another Client: _____
b) Google: _____
c) Yelp: _____
d) Doctor: _____
e) Facebook: _____
f) Other: _____

TCM Whole Health, Inc. DBA Acupuncture Associates of Castle Rock

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____

I understand that as part of my healthcare, TCM Whole Health, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:
X_____ _____ _____
Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:
☐ Accepted _____ _____ _____
☐ Denied Signature Title Date

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Emergency Contact Name: _____ Phone #: _____ Email: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Who is your primary care physician? _____

2. Would you recommend them? _____

3. Other healthcare practitioners on your "team" (massage, chiro, specialists):

_____

4. Please identify the health concerns that have brought you to TCM Whole Health in order of importance below:

a. **Condition** **Past Treatment**

b. _____ _____

i. How does this condition affect you?

_____

5. _____

___

a. _____ _____

i. How does this condition affect you?

_____

6. _____

____

a. _____ _____

i. How does this condition affect you?

_____

7. How committed are you to improving your health? (circle one)

a) I'm thinking about it
b) I've started to make changes
c) I have a new routine
d) This is my last resort

8. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

a. _____

b. _____

9. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

a. _____
b. _____
c. _____

10. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

11. Do you have any infectious diseases? Y N
    a. If yes, please identify: _____

12. **Height:** _____ **Weight:** Currently: _____ **Blood Pressure:** _____/_____ When was this reading taken?

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

14. **X-ray, MRI, CAT SCAN**

Reason	When	Reason	When
_____		_____	
_____		_____	

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):
    a. Mood Swings Anxiety Stress Depression

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

    a. Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):
    a. Impaired Vision b) Eye Pain/Strain c) Glaucoma Glasses/Contacts Tearing/Dryness
    b. Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
    c.Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

a. Pneumonia Frequent Common Colds Difficulty Breathing
Emphysema
b. Persistent Cough Pleurisy Asthma Tuberculosis
c. Shortness of Breath Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

a. Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

a. Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
b. Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

a. Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
b. Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

a. Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow
b. Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

a. 1. Age of First Menses: _____ 24. 25. 4. Birth Control Type: _____ 26. 7. Age of Menopause: _____
a. 2. # of Days of Menses: _____ 27. 28. 5. # of Miscarriages: _____ 29.
a. 3. Length of Cycle: _____ 30. 31. 6. # of Live Births: _____ 32.

33. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

a. Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

34. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

a. Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain Low Back Pain Leg Pain Joint Pain (if so, where?):

_____

35. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

a. Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

36. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

a.Hypothyroid Hypoglycemia Hyperthyroid Diabetes Night Sweats Feeling Hot or Cold

37. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

a. Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet
b. Is there anything else we should know?
_____
c. _____
38. .**Lifestyle:**
39.

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

g. Do you enjoy work? Y/N Why/Why not?

_____ g. Nicotine/Alcohol/Caffeine Use:

_____

h. h. Have you experienced any major traumas? Y N Explain: _____
i. _____

___ i. How many ounces of water do you drink per day? _____

j. Television habits: _____ Reading habits:
_____

k. Interests and hobbies:
_____