Greetings!

Welcome to Holy City Acupuncture. I thank you for your interest in this natural form of healthcare. I look forward to working with you towards achieving and maintaining your most optimal well-being in body, mind, and spirit. I will do all I can to make your experience a pleasant one.

Your first appointment will last approximately two hours. During this time, you will have the opportunity to speak at length about your health concerns, medical and social history, and I will perform a physical exam. We will further discuss your goals and reasons for seeking acupuncture treatment. A needling treatment will be included in the initial appointment.
Following appointments will last approximately one hour.

Please complete the enclosed health history questionnaire and fact sheet and bring them to your first appointment. This will help me with my diagnosis and treatment planning.

Ways to get the most out of treatment:
-Set aside enough time to arrive for treatment unhurried and in a timely manner.
-Avoid coming to treatment hungry or on an empty stomach.
-Avoid alcohol 24 hours after treatment and be cautious that treatment can make you more sensitive to the effects of alcohol.
-Drinking an adequate amount of water following treatment is advised.

If you require any further information or need to change an appointment please contact me a minimum of 48 hours prior to your scheduled appointment.

Contact Information
Phone:843.442.4566
Web: HolyCityAcupuncture.Com
Email: HolyCityAcupuncture@gmail.com

I look forward to seeing you on:

Date:_____________________________________Time:___________________

Warmest Regards,

Colby M. Christy, M.Ac.
Licensed Acupuncturist
NCCAOM Board Certified

Holy City Acupuncture
Information and Consent to Services

CONSENT TO SERVICES
I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service(s) to be performed have been explained to me. I have also received the Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information. I understand my health information will be used and disclosed consistent with the Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Further, I have felt free to ask my practitioner questions regarding the proposed services and other pertinent information, including questions about him or her, and have received satisfactory explanations. I understand that I am free to discontinue services(s) at any time.

Services to be Provided
I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

Risks/Possible Side Effects/Healing Response
I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

INFORMATION DISCLOSURES
No Guarantees
I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Infectious Disease Prevention
I understand infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my practitioner follows universally prescribed precautions and procedures (such as clean needle technique and hand washing) to prevent the spread of infectious disease.

Client Responsibilities
I understand that it is my responsibility as a client to inform my practitioner about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort or adverse side effects, it is my responsibility to immediately notify my practitioner. Additionally if I currently have any infectious disease (cold, flu, intestinal virus etc.) or rash that I am aware of, I am to notify the practice prior to my appointment.

Medical Treatment
I recognize that my acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time, I understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Fees

Initial Consultation	**$160.00**	**Home visit $225**
Acupuncture Treatment	**$85.00**	**Home visit $125**
Late Cancellation/Missed Appointment Charge	**$85.00**	(Late cancellation is less than 24 hours notice)

Payment of cash or check is due at the time of service

Insurance Policy
Because health insurance is an arrangement between you and your insurance company, you should contact your insurance company's representative to determine if coverage will be provided for your treatments. It is my policy that patients file for reimbursement with their insurance carriers. I can provide you with an appropriate Patient Receipt for filing. If you plan to seek reimbursement, please let me know so that a Diagnostic Code may be assigned.

___I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment at least 24 hours in advance, than I am liable for the fee.

______________________________ ______________________________

Signed **Date**

Holy City Acupuncture

Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information*, describe how health information about you may be used and disclosed and how you can get access to your health information . The* Notices *are posted and copies are given to all individuals receiving care. Please review this information carefully*.

Understanding your health record

A record is made each time you come for a treatment or consultation. Your symptoms, the practitioner's judgments, and a plan of services are recorded. This record forms the basis for planning your care and treatment / consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where and why others may be allowed access to your health information.

Understanding your health information rights

Your health record is the physical property of this practice, but the content is about you, and therefore belongs to you. You have the right to request restrictions, to authorize disclosure of the record to others and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibilities

We are required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. We reserve the right to change our practices and promise to make a good faith effort to notify you of any changes. Other that for the reasons described in the notice, we agree not to use or disclose your health information without your consent.

To report a problem

If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. secretary of Health and Human Services with no fear of retaliation by this office.

Holy City Acupuncture

Colby M. Christy, M.Ac., L.Ac.
1503 King Street, Suite 200, Charleston,SC 29405 phone: 843.442.4566

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue. S.W. Room 509F, HHH Building
Washington, D.C. 20201
OCR Hotlines-Voice: 1-800-368-1019

Holy City Acupuncture

Practices Regarding Disclosure Of Client Health Information

Your health information will be routinely used for treatment / consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment / Consultation**- Information obtained by your practitioner will be entered in your record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectations and those of others involved in our care may also be recorded.
- **Payment-** Your record will be used to receive payment for services rendered. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and / or practitioner's impressions, and procedure performed.
- **Quality Monitoring-** Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and Drug administration (FDA)-** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation-** This office will release information to the extent authorized by law in matter of worker's compensation.
- **Public Health-** This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity
- **Law Enforcement-** As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys (1) in response to a valid subpoena; (2) In the event that an employee of this office believes in good faith that one or more clients, workers, or the general public are
- endangered due to suspected unlawful conduct or a practitioner or violations of professional or clinical standards; (3) When a clients is a suspected victim of abuse, neglect or domestic violence.

It is our practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, we will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Business Associates**- Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- **Communication with Family**- Using best judgment, a family member, close personal friend identified by you, personal representative or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Read and understood by:

______________________	______________________	________
Print Name	Sign Name	Date

Healthcare Questionnaire and Fact Sheet

Please help me provide you with a complete evaluation by taking the time (about 15 minutes) to fill out this questionnaire carefully. All answers are confidential.

Name: ____ Date ___________

Address: ______________________________ City:____________________ State: _____ Zip:__________

Date of Birth: __________ Place of birth: ______________ Age: _______Height: _______ Weight:_________

Telephone: Home ( )________________ Work ( )_____________________ Cell ( ) _______________

Referred by:___________________________________ Do you wish to receive the Monthly E-newsletter? Yes/No

Email: ____

Single ______Married ______Divorced ______Widowed ______ Living with ______________________________

Education: _____________________________ Occupation: _______________________________________

Children Names & Ages:

____

____

____

Reason for visit today: ____

Other concerns: ____

How long have you had this condition?_______________________ Have you ever experienced this before?_______

What seemed to be the initial cause? ____

What seems to make it better? ____

What seems to make it worse? ____

Does it bother your: Sleep ____Work____ Other (what?) ____________________________________

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes

	Self	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Age of death						
Hepatitis						
Kidney disorders						
Thyroid disorders						

Muscular-skeletal disorder						
Blood transfusion (if before 1985)						
Parkinson's disease						
AIDS						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs)__________ Coffee/Tea (cups) _____________ Alcohol (drinks per week) ________________________

Marijuana ____

Other recreational drugs ____

Vitamins & herbs ____

Dietary restrictions ____

Food cravings ____

Diet: What might you eat on a typical day?

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Exercise _____________________________________ How often? ____________________________

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

____

____

MEDICINES:

Medications you are taking & for what condition? Herbs Vitamins

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

Year	Operation/Illness

Health Summary Sheet:

Please put a "**C**" if the condition is current or a "**P**" if you had it in the past

General
___Insomnia
___Dreams/ nightmares
___Irritability
___Depression
___Mood swings
___Lethargy / Inertia
___Poor memory
___Difficulty making decisions
___Anxious or worried
___Hopeless or negative
___Cry easily
___ Fearful / Fearless
___Loose temper easily
___Difficult to accept sympathy
___Difficult to express joy
___Easily startled
___Extremely organized
___Spiritual
___Ever considered suicide
___Recent weight loss/gain
___Cold hands or feet
___Tends to push when exhausted
___Inflexible
___Lyme Disease
___Broken bones
___Nails split/crack
___Swelling of hands/feet
___Tumors / growths
___ Night sweating
___ Excess sweating
___ Difficulty being still / relaxing
___ Water retention / bloating
___Easily overheats or over chills
___Needs to sleep a lot

Head & Neck
___Headaches
___Migraines
___Stiff neck
___Dizziness
___Fainting
___Swollen glands
___Hair loss / thinning

Ears
___Ringing
___Hearing loss /Hearing aids
___Infections / Earache
___Vertigo
___Motion, air or seasickness

Eyes
___Glasses/ contact lenses
___Blurred vision / double vision
___Poor night vision
___Spots or floaters
___Eye inflammation
___Glaucoma / Cataracts
___Pain or itching
___Watery or too dry
___Recent laser surgery

Nose, Throat & Mouth
___Sinus infection
___Hay fever / allergies
___Frequent sore throat
___Difficulty swallowing
___Mouth & tongue ulcers
___Frequent colds
___Nosebleed / Dry nose
___Nasal congestion
___Loss of voice
___Thirst
___Excessive phlegm
___TMJ
___Facial pain
___Gum problems
___Dry mouth
___Loss of taste or smell

Skin
___Hives / Rashes
___Eczema/ Psoriasis
___Dry skin
___Easy bruising
___Changes in moles, lumps
___Itching
___Dandruff
___Recent Dermabrasion
___Recent Botox

Respiratory
___Difficulty breathing
___Wheezing
___Asthma
___Chronic cough
___Wet cough
___Dry cough
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Tight chest
___Pneumonia

Cardiovascular
___High / low blood pressure
___Chest pain or tightness
___Palpitation
___Rapid heart beat
___Irregular heart beat
___Poor circulation
___Swollen ankles / Phlebitis
___Anemia
___History of heart attack
___Varicose Veins

Gastrointestinal
___Nausea / vomiting
___Indigestion / slow digestion
___Stomach pain
___Diarrhea
___Constipation
___Poor appetite
___Excessive/ deficient hunger
___Flatulence
___Burping / Hiccups
___Acid regurgitation
___Bloating
___Laxative use
___Bloody stool
___Mucus in stool
___Hemorrhoids
___Liver / Gall Bladder disorder
___Colitis / Diverticulitis
___Crones
___Ulcer

Musculoskeletal Joint pain/ disorder
___Sore muscles
___Weak muscles
___Difficulty walking
___Neck/shoulder pain
___Back pain
___Rib pain
___Limited range of motion
Other (describe)______________

Neurological
___Seizures
___Tremors
___Numbness or tingling
___Pain
___Paralysis
___Poor coordination
___Epilepsy or convulsions
___Fainting spells
Other (describe)______________

Genital-urinary
___ Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Unable to hold urine
___Incomplete urination
___Bedwetting
___Wake to urinate
___Increased libido
___Decreased libido
___Kidney stones
___Impotence
___Premature ejaculation
___Nocturnal emission
___Pain/itching of genitalia
___Lumps in testicles

Infection Screening
___Parasites
___HIV risks: self or partner
___TB: self or household
___Hepatitis risk: self or partner
___STD's: self or partner
___Herpes/Shingles