Welcome!

Please take the time to read this letter in its entirety as well as all information and instructions on the New Patient Forms. It should help you prepare for your appointments with our office and answer any questions.

Please feel free to contact any member of our Staff for information or assistance via phone or text (804) 501-8060- email is also an option but is not checked as often.

Preparing for your Acupuncture Treatments

A few tips for making your first and follow-up acupuncture treatments as comfortable and relaxing as possible:

- Wear loose fitting clothes that can be easily rolled up above your elbows and knees. Also, you may need to expose your abdomen from your rib cage to the top of your hips, so separates are more practical than dresses.

- Be sure you have eaten prior to arriving. It gives extra energy to fuel the healing response elicited by the acupuncture.

- Drink plenty of water and stay hydrated after your appointment

- For best results, avoid strenuous activity immediately following a treatment. Do your workouts hours before acupuncture treatments; but light walking after treatment is fine.

- During the intake, you will be asked many questions, some related specifically to your complaint and others seemingly unrelated. Oriental Medicine requires all aspects of your health to be taken into consideration. One of the strengths of Oriental Medicine is treating the symptoms from their root cause in order to discourage their recurrence instead of simply masking symptoms.

Thank you for choosing Empress Acupuncture and Healing Arts, we look forward to being part of your healthcare team. Observers and referrals are welcome if you have any friends or family that may be interested in acupuncture and Oriental Medicine.

Empress Acupuncture & Healing Arts

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at this clinic of Chinese Medicine. I understand that acupuncturists practicing in the state of Virginia 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/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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 Medica 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 the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na: I understand that I may also be given acupressure/tui-na 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: 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:** _____

***ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION SIGN BELOW**

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X_____ Date____/____/___ X_____ Date____/____/___

Patient's Signature Explained by me and signed in my presence

Recommendation for Examination by a Physician

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).

_____ _____/_____/_____

Acupuncturist Signature Date

I, _Remee Gemo, L.Ac._, recommend to you _____that you be examined by a

(licensed acupuncturist) (patient name print)

physician regarding the condition for which you are seeking acupuncture treatment. I understand this recommendation.

_____ _____/_____/_____

Patient Signature Date

Empress Acupuncture & Healing Arts

New Patient Forms

Name	Sex M F	Date / /
Date of Birth / /	Age	Name of Family Physician:
If applicable, name of reproductive specialist:		Name of doula/midwife:
Address:		
City	State	Zip
Cell Phone #	Home Phone #	
Email:		
Marital Status S M D W	How many children do you have?	
In Emergency notify:	Emergency contact #	

Have you ever had acupuncture before? **Yes** **No** If yes, by whom and how long ago? _____

How did you hear about us? Friends/Relatives/Referred by_____

Website Ad Yelp/Google Walk-by Other (please specify) _____

Reason for coming in: _____

What diagnosis have your received for this problem?

When did this problem begin? What are the precipitating factors?

What makes this problem worse? What makes this problem better?

What kind of treatments have you tried?

Additional details:

Past Medical History:

	Tuberculosis		Diabetes		Hemophilia		Emotional Imbalance
	Hepatitis		Cancer		Anemia		Venereal Disease
	HIV/AIDS		Hypertension		Arthritis		Digestive Disorders
	Seizures		Fibromyalgia		Heart Disease		Breathing Problems

Month /Year when diagnosis was established:

Other significant illnesses:

Surgeries/Hospitalization:

Significant trauma (auto accidents, sports injuries, etc.):

Allergies (drugs, chemicals, foods, plants/flowers):

Do any of the allergens cause anaphylaxis? **Yes** **No** If so do you carry an epi-pen? **Yes** **No**

Family Medical History: (please specify family member)

Cancer	Diabetes	Hepatitis	Hypertension	Stroke
Asthma	Alcoholism	Miscarriage	Heart Disease	Fibromyalgia
Other:				

Medications: including vitamins, over the counter medications, and herbals

Occupation: What is your occupation? _____ Do you usually work indoors __ or outdoors__?

Is work related stress high? **Yes** **No** **Occasionally**

Personal: Height _____Ft _____in Weight _____ lbs. One year ago _____lbs.

Maximum weight _____lbs. @ year _____

Habits: Do you smoke? **Yes** **No** How much? _____ For how long? _____ Describe any recreational drug use: _____

Do you exercise regularly? **Yes** **No** What type of exercise and how often?

_____

How many hours do you usually sleep? _____ Do you sleep soundly? **Yes** **No**

Diet: How much coffee/tea do you drink? _____ cups/day Colas? _____number/day

How many alcoholic beverages do you consume in a week? _____ How much water do you drink in a day? ____

Are you: vegetarian/vegan___ gluten-free ___ Dairy-free___ Other _____ ?

Please describe your average daily diet and any dietary restrictions:

Morning _____

Afternoon _____

Evening _____

Snacks _____

Are you interested in: Chinese herbal formulations ___ Eastern food therapy ____ Acupuncture during Pregnancy ____

Detoxification ____ Facial rejuvenation ____ Chinese Facial analysis ___ Tea/Medicinal Tea_____

Do you have any history of seizures or epilepsy? **Yes** **No**

Do you have any bleeding disorders (hemophelia etc.)? **Yes** (specify) _____ **No**

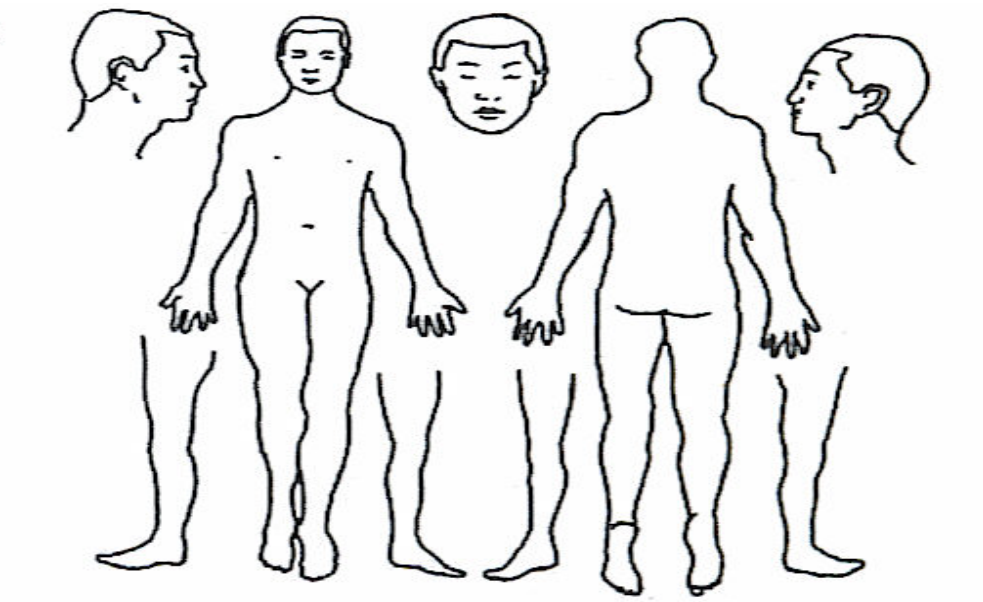
Are you taking any blood thinners (coumadin etc.)? **Yes** (specify) _____ **No**

Have you had botox, a facelift, fillers, injectables or other cosmetic procedures/surgeries?

Yes (specify what type and when)_____ **No**

Please indicate painful or distressed areas with:

N=Numbness **P**=Pins and Needles **S**= Stabbing Pain **A**= Achey **T**= Tightness



Women's Health: *check/answer if applicable*

	Hysterectomy		Endometriosis		Mood Swings		Frequent Vaginal/Pelvic Infection
	Ovarian Cysts		Irregular Periods		Clotting		Vaginal Discharge
	Fertility Problems		Vaginal pain		Fibroids		Prolapse
	Hot Flashes		PMS		Hormonal Imbalances		Pain/Cramps at Period
	Post-partum Depression		Breastfeeding		Fibrocystic Breast		Breast Tenderness
Other:							Lack of sex drive

Number of pregnancies ____ Number of births ____ Abortions ____ Premature births ____ Cesareans ____ Breech ____

Difficult Delivery ___ Age of first menses ____ First date of last period _____/_____/_____ Duration of periods ___days, cycle ___days

Do you track ovulation? **Yes No** If yes, What cycle day do you typically ovulate?_____ What cycle day are you on today?_____

By what means do you track ovulation (bbt, ovulation kit etc) **NA** _____ Do you practice birth control? **Yes No**

What type and for how long? _____ Are you pregnant? **Yes No** Are you trying to conceive? **Yes No Not at this time**

If trying to conceive what methods are you using? **Natural IVF / IUI Medicated Other**_____

If medicated, specify medications(clomid etc.)_____

If using IVF/IUI, when will you be doing the IVF/IUI? _____ **yet to be determined**

Have you done IVF/IUI in the past? **Yes No** If yes, how many time? IUI_____ IVF_____ Will you do egg retrieval this cycle? **No Yes**

Number of miscarriages: _____ at how many weeks? _____ when did they occur? _____

Additional information: _____

Please check if you have had any of the following diseases or conditions in the past 3 months.

General

	Poor Appetite		Night Sweats		Poor Balance		Easily Bleed/Bruise
	Poor Sleep		Sweats Easily		Weight Loss/Gain		Desire Hot/Cold Foods
	Fatigue		Tremors		Peculiar Tastes		Sudden Energy Drop
	Fevers/Chills		Excessively Hungry		Strong Thirst		Dizziness

Musculoskeletal

	Joint Disorders		Cold Hands/Feet		Paralysis		Swelling of Hands/Feet
	Knee/Hip Pain		Back Pain		Shoulder Pain		Difficulty Walking
	Hand/Wrist Pain		Spinal Curvature		Cramping		Neck Tightness/Pain
	Numbness		Hernia		Muscle Weakness		Whole Body Soreness

Other: _____

Skin/Hair

	Rash		Itching		Dandruff		Loss of Hair
	Ulcerations		Eczema		Dry Skin		Purpura
	Hives		Pimples		Recent Moles		Other _____

Head/Eyes/Ear/Nose/Throat

	Concussion		Eye Strain/Pain		Cataracts		Blurry Vision
	Migraine		Night Blindness		Poor Vision		Difficulty Swallowing
	Ringing In Ears		Poor Hearing		Sinus Problems		Spots in front of Eyes
	Nosebleeds		Sore Throat		Grinding Teeth		Teeth Problems
	Facial Pain		Jaw Clicking		Earaches		Sores on lips/tongue

Other: _____

Cardiovascular

	Chest Pain		Palpitations		Fainting		High/Low Blood Pressure
	Phlebitis		Irregular Heartbeat		Varicose Veins		Slow/Fast Heartbeat

Other: _____

Respiratory

	Cough		Bronchitis		Wheezing		Difficulty Breathing
	Coughing Blood		Pneumonia		Chest Pain		Production of Phlegm
Other: _____							Color of Phlegm _____

Gastrointestinal

	Nausea		Vomiting		Diarrhea		Constipation
	Gas/Bloating		Belching		Acid Reflux		Blood in Stool
	Indigestion		Bad Breath		Rectal Pain		Gallbladder Problems
	Hemorrhoids		Chronic Laxative use		Ulcers		Abdominal Pain/Cramps
Bowel Movements: Frequency: _____times per day							Other: _____

Neuro-psychological

	Concussion		Depression		Anxiety		Loss of Balance
	Stress		Bad Temper		Bipolar		Lack of Coordination
	ADD/ADHD		Schizophrenia		Addiction		Obsessive/Compulsive

Other: _____

Genito-urinary

	Pain on Urination		Blood in Urine		Urgent Urination		Frequent Urination
	Kidney Stones		Dark Urine		Dribbling		Pause of Flow
	Incontinence		Frequent UTI		Genital Pain		Genital Itching

Other: _____

Male

	Prostate Problems		Discharge		Impotence		Frequent Seminal Emissions
	Painful SwollenTesticles		Lack of sex drive		Genital Pain		Ejaculation Problems

If being treated for fertility issues, what were the results of sperm analysis?

Other: _____

Are there any other issues you would like to discuss? _____

I understand the above information and guarantee this form is completed to the best of my knowledge.

Date ____/____/____Signature: _____ Adult Patient Spouse Parent/Guardian

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

NAME _____

BIRTHDATE _____/_____/_____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization 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: _____ ___/__/___ _____

Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

Î Accepted _____ _____ _____

Î Denied Signature Title Date

Our Clinic Protects Your Health Information and Privacy / HIPPA

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.
Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use: In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to/from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).
We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (804)501-8060.
-***The Acupuncturists of Empress Acupuncture & Healing Arts***

Empress Acupuncture & Healing Arts Office Procedures

Appointments

As a patient of the Empress Acupuncture & Healing Arts and/or Remee Gemo, L.Ac., it will be your responsibility to keep scheduled appointments. The clinic will require notification of ***cancellation at least 24 hours prior*** to the appointment or earlier if possible. This can be done by calling or texting our clinic at 804-501-8060**. Failure to cancel your appointment will result in being assessed an appointment fee of $95**. This fee is due when billed, or at your next appointment whichever comes first. In cases of extraordinary circumstances which do not allow you to give one-day advanced notice you still need to call as soon as you are able and inform Empress Acupuncture that you will be missing your appointment.

Late Arrivals:

If you arrive late to your appointment, you may be asked to reschedule or will still be required to pay the **full session fee** regardless of how much time is left of your scheduled appointment.

Payment

We accept checks, cash or credit cards. Payment is due at time of service. We have a $75 bounced Check fee.

Insurance

The Empress Acupuncture does not file insurance/health savings account/flex-spending account claims, if you plan on using one of those methods for reimbursement you will need to file the claims on your own. Empress Acupuncture will provide you with a receipt of services that can be used to complete the paperwork to submit to your insurance company.

Outstanding debts/delinquent accounts

Patients with outstanding account balances are denied services until all debts are paid in full.

Late penalty

Late fees are assessed at the time of billing for accounts that are 30 or more days past due. **At 30 days past due, a late penalty of 10% of the outstanding balance is assessed**. The late penalty indicates that your account is past due. Unless you resolve the debt, Empress Acupuncture will advance the matter to the next step in the collection process, and you risk tarnishing your credit rating.

Collection Activities

Once an account is **90 days past due and forwarded to collections**, repayment arrangements must be made directly with the collection agency, and the account holder bears the costs associated with the collection efforts. The costs associated with collection efforts are 33.33% of the outstanding balance, which is the standard and customary amount for the collection industry. I have read and understand the above document; by signing below I agree to adhere to the policies and procedures of Empress Acupuncture/Energy Medicine Center LLC.

Signature: _____ Date: ____/_____/____

Printed Name: _____Date of Birth: ____/____/_____

********** IF YOU ARE HAVING ACUPUNCTURE FACE LIFTING/ L.I.F.T. TREATMENTS PLEASE SIGN BELOW **********

INFORMED CONSENT TO ORIENTAL MEDICINE FOR FACE LIFTING

I hereby request and consent to the performance of the following on myself (or the patient named below for whom I am legally responsible) by __Remee Gemo, L. Ac._.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped people for face lifting, I understand that no guarantee of effectiveness or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand these risks include, but are not limited to: bleeding, bruising, puncture of other organs, pain or strong sensation, nerve pain, burns due to acupuncture; cupping marks; sensitive reactions due to external application of Chinese herbs, including itching, skin rashes, scars, burns; nausea, vomiting, diarrhea, abdominal pain due to internally taking of Chinese herbs. 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 such judgment, during the course of my treatment, as the acupuncturist feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. 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 my present condition and for and my future conditions(s) for which I seek treatment at the Acupuncture Center of Richmond /Empress Acupuncture/ Energy Medicine Center LLC.

_____ _____

Patient's Name (PRINTED) Patient's/Representative's Signature

_____/_____/_____ _____

Date Signed

Witness