camille musso acupuncture

Aloe Skin + Body
2425 A Exposition Boulevard
Austin, TX 78703
Phone: 512.344.9394
Email: info@aloeskinandbody.com
Web: www.aloeskinandbody.com

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Camille Musso Acupuncture is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 2055.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (patient's name) ____
am notifying Camille Musso Acupuncture of the following:

___ Yes ___ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is __________, and the most recent date of treatment prior to acupuncture treatment is __________. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic Pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

Patient's Name (please print): ____

Patient's Signature: ____ **Date signed:** _______________

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow her advice.

Patient's Signature: ____ **Date signed:** _______________

Acupuncturist's Signature: _______________________________________ **Date signed:** _______________

Aloe Skin + Body
2425 A Exposition Boulevard
Austin, TX 78703
Phone: 512.344.9394
Email: info@aloeskinandbody.com
Web: www.aloeskinandbody.com

Notice of Privacy Practices

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 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 or from other health care practitioners.
- From health care providers (*e.g*. requests for medical records, claim payment).

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 512-344-9394.

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

Aloe Skin + Body
2425 A Exposition Boulevard
Austin, TX 78703
Phone: 512.344.9394
Email: info@aloeskinandbody.com
Web: www.aloeskinandbody.com

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Camille Musso Acupuncture "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that the staff at Camille Musso Acupuncture and/or Aloe Skin and Body may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that Camille Musso Acupuncture may use my clinical information for research purposes. All information that can identify me personally will be removed.

By signing this form, I am giving Camille Musso Acupuncture authorization to contact me and am giving my informed consent to utilize my information for research purposes. I acknowledge that all information discussed during the assessment and treatment at Camille Musso Acupuncture will be held confidential except in the instance where my safety or the safety of others may be at risk.

Patient's Name (please print): ____

Patient's Signature: ______________________________ **Date signed:** ______________

Acupuncturist's Signature: ______________________________ **Date signed:** ______________

Authorization for Release of Health Information (Optional)

I, (patient's name) ______________________________, hereby authorize Camille Musso Acupuncture the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Patient's Signature: ______________________________ **Date signed:** ______________

Aloe Skin + Body
2425 A Exposition Boulevard
Austin, TX 78703
Phone: 512.344.9394
Email: info@aloeskinandbody.com
Web: www.aloeskinandbody.com

Informed Consent to Oriental Medical Health Care

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 Camille Musso Acupuncture. I understand that acupuncturists practicing in the state of Texas 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

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 Camille Musso Acupuncture as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage 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.

Patient's Name (please print): ____

Patient's Signature: ________________________________ **Date signed:** ______________

Name of Patient's Representative (if applicable): ______________________________

Signature of Patient's Representative: ______________________ **Date signed:** ______________

Relationship or Authority of Patient's Representative: ___________________________

Aloe Skin + Body
2425 A Exposition Boulevard

www.birdsnestacupuncture.com
512.761.6719

birds nest
acupuncture & herbs

4101 Medical Parkway Suite 204
Austin, Texas 78756

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name ______________________ Sex ☐ F ☐ M Date ______________________

Date of birth ______________________ Age __________ Occupation ______________________

Address ______________________ City ______________ State __________ ZIP ______________

Main phone number ______________________ Other phone number ______________________

E-mail address ______________________ Allow email contact ☐ Yes ☐ No

Relationship status ____________ Children ______ Family physician ______________ Chiropractor ______________

Do you have health insurance? ☐ Yes ☐ No If yes, name insurance company ______________________

Does your health insurance cover acupuncture? ☐ Yes ☐ No Who is your employer? ______________________

Emergency contact name ______________________ Phone number ______________________

How did you find out about us? ☐ Friends/relatives (Name) ______________________

☐ Direct mail ☐ Location ☐ Website ☐ Yellow pages ☐ Periodicals ☐ Other ______________

Main problem(s)

What is/are your main problem(s)? ______________________

What diagnosis, if any, have you received for this problem? ______________________

When did this problem begin? ______________ What are the causes of this problem? ______________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ______________________

What kind of treatment have you tried? ______________________

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

Is there anybody in your family with the same/similar problems? ______________________

Remarks and additional information: ______________________

Medical History (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: ______________________ Hospitalization: ______________________

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

Allergies: (drugs, chemicals, foods, environmental): ______________________

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

____

Occupation: ______________________________ Do you usually work ☐ indoors ☐ outdoors?

Occupational stress (chemical, physical, psychological, etc): ______________________________

Personal Data

Height __________ Weight now __________ Weight one year ago _________ Weight maximum _________ @Year _________

Do you smoke? ☐ Yes ☐ No What? _________________ How many per day? _____ Since when? _________________

Please describe any use of drugs for non-medical purposes: ______________________________

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program: ______________________________

How many hours do you sleep in general? ______________ What time do you usually go to bed? ____________________

Diet

How much coffee do you drink? _____ cups/day Colas? _____ number/day Tea? _____ cups/day Water? ____ glasses/day

What kind of alcoholic beverages do you drink, if any? ______________________ Average number of drinks/week? _______

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict Do you eat a lot of spicy food? ☐ Yes ☐ No

Remarks and additional information (e.g. diet) ______________________________

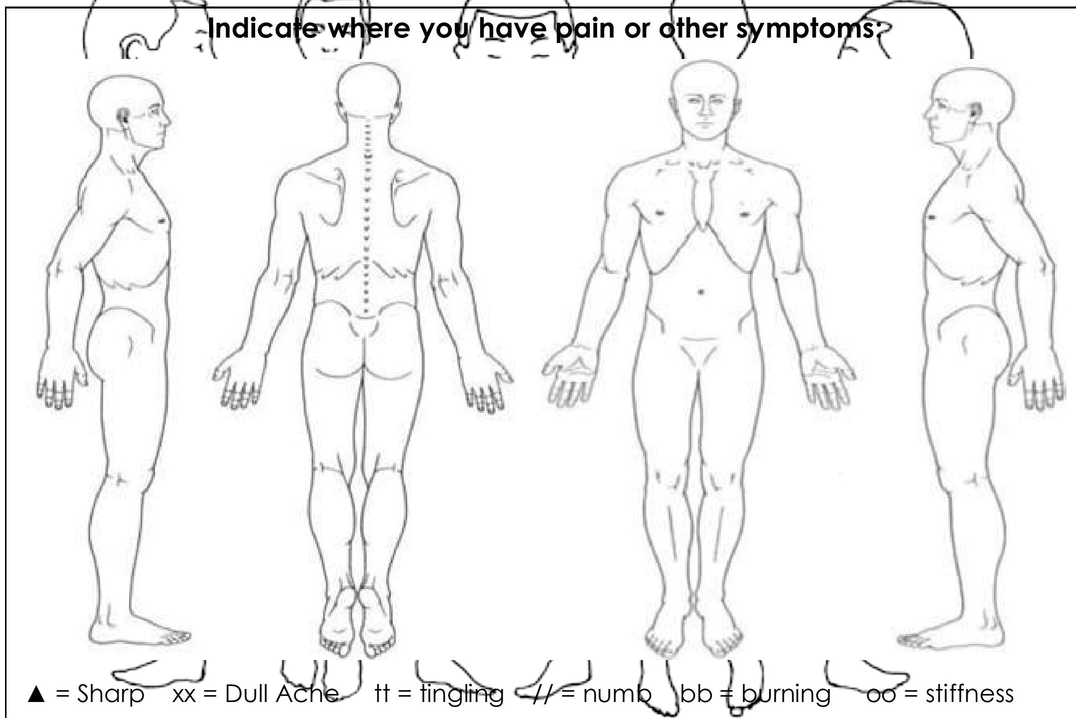
Please describe your average daily diet (Please be as specific as possible):

Morning ______________________________

Afternoon ______________________________

Evening ______________________________

Snacks ______________________________



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Change in appetite ☐ Cravings

☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (What time of day) _______________ Favorite time of year ____________ Worst time of year _____________

Skin & hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema

☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles

☐ Loss of hair ☐ Purpura ☐ Change in hair or skin texture ☐ Other _________

Musculoskeletal

☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in muscles ☐ Tremors

☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Back pain

☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness

☐ Neck pain ☐ Shoulder pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain

☐ Joint sprain ☐ Other _______________

Head, eyes, ears, nose, and throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens ☐ Eye strain

☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sore throat

☐ Spots in front of eyes ☐ Sinus problems ☐ Nose bleeding ☐ Grinding teeth ☐ Teeth problems

☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other _________

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting

☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other _________

Respiratory

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing ☐ Bronchitis

☐ Pneumonia ☐ Chest pain ☐ Production of phlegm (what color) _______________

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath

☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites

☐ Chronic laxative use

Bowel movements: Frequency ______________ Color __________________ Odor __________________ Texture _________

Neuro-psychological

☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Depression ☐ Anxiety

☐ Stress ☐ Bad temper ☐ Bi-polar

Genital-urinary

☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Kidney stones

☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other ________

Female

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Fibroids

☐ Vaginal/genital discharge ☐ Ovarian cysts ☐ Irregular periods ☐ Clots

☐ Pain/cramps prior to/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Hot flashes

☐ Moodiness related to periods ☐ Fertility problems

____ Number of pregnancies ____ Number of births ____ Miscarriages ____ Abortions

____ Premature births ____ C-sections ____ Difficult delivery

First date of last period __________ Age of first period ___________ Duration of periods _________ days, cycle __________ days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? ____

If you're on birth control pills, what are you taking and for how long? ____

Male

☐ Prostate problems ☐ Fertility problems ☐ Erectile dysfunction ☐ Ejaculation problems ☐ Discharge

☐ Frequent seminal emission ☐ Painful/swollen testicles ☐ Other ________

I have completed this form correctly to the best of my knowledge.

Signature: ____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?

Signature Date