Confidential Patient Information

NAME_____ DoB_____

ADDRESS_____CITY_____ST_____

ZIP_____ PHONE#_____

May I text you appointment reminders? Yes No

E-MAIL ADDRESS_____

May I add you to my e-mail newsletter list? Yes No

YOUR EMPLOYER_____

TYPE OF WORK PERFORMED_____

Ins ID#_____Group#_____

Insurance by Spouse/Partner: his/her/their name_____

Birthdate: _____and Company:_____

EMERGENCY CONTACT PERSON OR RELATIVE NOT LIVING WITH YOU:

NAME_____PHONE_____RELATIONSHIP_____

FINANCIAL POLICY

BILLING: Patients are expected to make payments at the time of service unless other arrangements have been approved in advance. Pharmacy items, such as herbs and supplements must be paid for upon receipt. (please initial_____)

APPOINTMENTS

If you are unable to keep an appointment, 24 hours notice is required. If you fail to keep your appointment or cancel without sufficient notice, one-half of an office visit cost will be charged ($55.00). (please initial_____)

I have read all the above terms and agree to these conditions.

_____

Patient Signature Date

Patricia (Atty) Zschau, L.Ac.
1611 NE 16th Avenue
Portland, OR 97232

CONSENT FORM

I do hereby voluntarily consent to be treated with acupuncture and Oriental Medicine. Acupuncture is defined as an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. Acupuncture includes the treatment method of moxibustion as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians to induce acupuncture anesthesia or analgesia, to treat bodily dysfunctions or diseases, and to make normal the body's physiological functions.

The practice of acupuncture also includes traditional and modern techniques of diagnosis and evaluation; Oriental massage, exercise, and related therapeutic methods; and the use of the Oriental Materia Medica (Chinese herbs), vitamins, minerals and dietary advice.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary 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 discontinue acupuncture treatments at any time.

I understand substances from the Oriental Materia Medica may be recommended to me and that I am not required to take these substances; however, if I decide to take them, I must follow the directions for the administration and dosage. I have been made aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort and possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any of these symptoms associated with these substances, I should suspend taking them and call the practitioner.

I have carefully read and understand all of the foregoing and consent to treatment as mentioned above.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Printed Name

Patricia (Atty) Zschau, L.Ac.
1611 NE 16th Ave, Portland, OR 97232

Consent to Use or Disclose Clinical Information

I authorize Patricia E. (Atty) Zschau, L.Ac. to use and disclose the health and clinical information of (your name)_____for the purpose of Treatment, Payment and Health Care Operations.*

*Treatment includes activities performed by a practitioner, facility, program, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation with and between other health care providers. This consent includes treatment provided by any practitioner who covers my practice in person or by telephone as the on-call provider.

*Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for clinical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations is the necessary administrative and business functions of my office.

You may review Patricia E. Zschau, L.Ac.'s Notice of Privacy Practices (long form) for additional information about the uses and disclosures of information described in this consent prior to signing this consent.

Because I have reserved the right to change my privacy practices in accordance with the law, the terms contained in the Notice may also change. A summary of the Notice will be posted in my office indicating the effective date of the Notice in the lower left of the then current Notice. I will also provide you with a copy of the Notice upon request.

As more fully explained in the Notice, you have the right to request restrictions on how I use and disclose your protected health information for treatment, payment, and health care operations purposes. I am not required to agree to your request. If I do agree, I am required to comply with your request unless the information is needed to provide you with emergency treatment. Other practitioners/providers who provide call coverage for my office are required to use and disclose your protected health information consistent with this Notice.

Please verify that you have received a copy of my Notice of Privacy Practices short form, available at my website or in my office, by placing your initials here:_____.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Patricia E. Zschau, L.Ac. has already used or disclosed the information in reliance on this CONSENT. Signature of

Patient_____Date_____ or

Signature of Person Authorized by Law_____Date_____