NEW PATIENT INFORMATION

Welcome to the Neighborhood Acupuncture Project. We are a sliding scale clinic that provides Oriental Medicine; which includes, acupuncture, herbology and Asian bodywork. Other Oriental Medicine techniques that fall in the scope of our practice also include, gua sha, cupping, moxa and Chinese dietary counseling and may occasionally be recommended based on your condition.

NAP APPOINTMENTS

Because NAP is dedicated to making acupuncture accessible to as many people possible through low cost treatments and high volume, we strive to keep our clinic fully booked. Treatments, therefore, are by appointment only**. If you find that you need to cancel an appointment, it is important that you provide 24 hr notice,** this will enable us to fill the time slot. We reserve the right to charge a **$25 fee** for appointments canceled with less than a 24 hr notice or for "no show" appointments.

Because of the tight schedule and the nature of our clinic, **we ask that you arrive to your appointments early or on time**. Should you arrive late, our staff will try to accommodate you, but you may be asked to reschedule for a later date.

PAYMENT FOR SERVICES RENDERED

Payment is due at the time of service and must be paid in cash or with a check. You decide where you fall on the sliding scale and pay accordingly, no questions asked.

1st treatment: **$40 - $60**
Follow up treatments: **$25 - $50**

INSURANCE

In order to keep clinic prices affordable, we do not file insurance claims of any kind. Upon request, we will provide you with a printed receipt.

Please sign & date on the line below. Thank you for allowing us to provide you with quality, low cost alternative medicine.

______________________________ __________________

Patient's Signature **Date**

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient name), ____
am notifying Neighborhood Acupuncture Project of the following:

Yes___ No___ I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

Or

Yes___ No___ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _______________, and the most recent date of chiropractic 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 to follow this advice.

____
Patient signature (required) Date

A NAP practitioner has advised me to see a physician for the condition in which I am seeking treatment. It is my responsibility and choice to follow his/her advice.

____
Patient signature (required) Date

____
Acupuncturist's Signature Date

Neighborhood Acupuncture Project, LLC is not responsible for untrue statements made by patients.

NAP 1909 E 38 ½ Ste. A Austin TX 78722 Tel: 512-473-8884 www.napaustin.org

Appointment reminders and Health Care Information Authorization

Staff members of NAP may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with whoever answers the phone. Thank You cards, appointment reminders, or holiday cards may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which our heath care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

______________________________ __________________

Patient Name Printed Date

____

Patient Signature

____

Personal Representative Printed Signature

____

Description of personal representative’s authority to act for the patient

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE AT NAP

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____
Patient's name (please print)

____
Patient's signature

____
Date signed

____
Witness

____
Print name of patient's representative (if applicable)

____
Relationship or authority of patient's representative

____
Signature of patient's representative (if applicable)

____
Date Signed

Office Signature:______________________________