Three Mountains Wellness, LLC

10524 E. Grand River, Suite 107F, Brighton, MI 48116

(734) 719-1229 Fax: (734) 272-4235

New Patient Intake Form

Welcome to Three Mountains Wellness. Please fill out the following questions as completely as possible. Oriental Medicine has its own way of looking at the body, mind and spirit and uses different groupings of symptoms to make a diagnosis than Western medicine. As a result, little things that you may not think would be related to your primary health challenge, may actually be very important. If you don't know or are confused by a question, please answer with a question mark. *All responses will remain completely confidential.*

Today's Date: _____

General Information

Name: _____ Age: _____ Date of Birth: _____/_____/_____
(*mm/dd/yyyy*)

Address: _____ Sex: M F

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Which phone would you like as your primary number? ☐ Cell ☐ Work ☐ Home

Would you like to receive appointment reminders as text messages to your cell phone? ☐ Yes ☐ No

Would you like to receive voicemail messages on your primary number? ☐ Yes ☐ No

Email: _____

Highest Educational Level Completed: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

How would you describe the quality of your significant relationship? _____

Children / Ages:

_____ _____

_____ _____

_____ _____

Physician Information

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Date of last medical examination: _____

What was your diagnosis? _____

Please list any other health care providers that you see:

Name	Specialty	Phone

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell : _____ Work Phone: _____

General Physical Health & Nutrition Status

Height: _____ Present Weight: _____ Weight One Year Ago: _____ Ideal Weight: _____

Maximum Weight and When: _____ Minimum Weight (adult) and When: _____

Are you generally in good health or do you frequently feel ill? _____

What illnesses are you prone to (frequent colds, gastro-intestinal problems)? _____

Do you have any problems with your energy level? _____ If yes, please briefly describe: _____

Do you have any problems with sleep? _____ If yes, please briefly describe: _____

Which of the following are a part of your lifestyle?

X	Substance	Frequency
	Alcohol	
	Artificial Sweeteners	
	Coffee	
	Energy Drinks	
	Excessive Sugar or Salt	
	Laxatives	

X	Substance	Frequency
	Occupational Hazards	
	Painkillers	
	Recreational Drug Use	
	Soft Drinks (soda)	
	Steroids	
	Tobacco/Nicotine	

How often do you exercise and what type of exercise do you do? _____

_____

Do you have any difficulties with exercise? _____

How many meals do you eat in a day? _____ How many snacks? _____

Do you follow any particular diet? _____

How many 8 oz. glasses of water do you drink in a day? _____

On average, how many servings a day do you have of: Meats _____ Dairy and Eggs _____ Grains _____

Fruits_____ Vegetables _____ Fats _____

Do you believe that your diet has any impact on your complaints? ☐ Yes ☐ No

Are you concerned about your weight or appetite (too much or too little)? ☐ Yes ☐ No

Please record your intake of food and drink for the past three days. Indicate the date for each day of recall.

	Date 1:	**Date 2:**	**Date 3:**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

If applicable, briefly describe any problems you think you have with your eating habits and appetite.

_____

_____

_____

Medication, Vitamins and Herbal Supplements

Please list all medications (prescription and over-the-counter), vitamins, herbs and supplements that you are taking.

Medication/Herb/Vitamin/Supplement	Dose	Frequency	How long taking this?

Please list any allergies and/or side effects you have experienced with any medications/herbs/supplements:

_____

_____

_____

Overall, in the past month, have you taken your prescription medications:

☐ Almost never ☐ Less than 50% of the time ☐ 50% of the time ☐ Routinely

Medical History

Please list all and note the year when they occurred or were first diagnosed.

X	Condition	Year		X	Condition	Year
	AIDS/HIV				Injuries	
	Alcoholism/ Substance abuse				Insomnia	
	Allergies				Intestinal Parasites	
	Anemia				Irritable Bowel Syndrome	
	Appendicitis				Joint Replacement	
	Arteriosclerosis				Kidney Stones and/or Kidney Disease	
	Asthma				Lupus	
	Bell's Palsy				Lyme Disease	
	Bipolar Disorder				Mood Disorder	
	Bleeding Disorder				Multiple Sclerosis	
	Blood Pressure (Low)				Osteoarthritis	
	Blood Pressure (High)				Osteoporosis	
	Cancer				Pacemaker	
	Chicken Pox/Shingles				Parkinson's Disease	
	COPD				Polio	
	Crohn's Disease/Colitis				Psoriasis	
	Chronic Fatigue Syndrome				PTSD (Post Traumatic Stress Disorder)	
	Depression				Reflux Esophagitis (GERD)	
	Diabetes				Rheumatoid Arthritis	
	Digestive Disorders				Schizophrenia	
	Eczema				Seizures and/or Epilepsy	
	Endometriosis				Sleep Disorder	
	Emphysema				Stroke	
	Epilepsy				Surgery (Please list all below)	
	Fatigue				Thyroid Disorder	
	Fibroids				Trauma (falls, accidents)	
	Fibromyalgia				Trigeminal Neuralgia	
	Gallstones				Tuberculosis	
	Gout				Ulcers	
	Heart Disease				Vascular Disease	
	Hepatitis Type:				Weight loss	
	Hernia				Weight gain	
	Hypoglycemia				Other	
	Infertility					

Please list all Major Traumas (mental, emotional and physical), Surgeries and Illnesses, the year when they occurred and any long-term effects.

Do or have any of your family members (mother, father, siblings, maternal grandparent, paternal grandparents) suffer from:

X	Condition	Relationship
	Alcoholism	
	Allergies	
	Arteriosclerosis	
	Asthma	
	Arthritis	
	Auto-immune disease	
	Bleeding Disorder	
	Cancer	
	Diabetes	
	Eating Disorder	
	Enlarged Prostate	

X	Condition	Relationship
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Liver Disease	
	Mental Illness	
	Overweight/Obesity	
	Seizures / Epilepsy	
	Stroke	
	Substance Abuse	
	Other:	

General Emotional Health

Do you experience any of the following? Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the Severity is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Anxious/Nervous	O	F	C	L	M	S
Binge Eating	O	F	C	L	M	S
Depression	O	F	C	L	M	S
Disorientation	O	F	C	L	M	S
Euphoria/ Too Much Energy	O	F	C	L	M	S
Extreme Lack of Emotion	O	F	C	L	M	S
Fatigue	O	F	C	L	M	S
Fearful	O	F	C	L	M	S
Feeling Manic	O	F	C	L	M	S
Feeling Overwhelmed	O	F	C	L	M	S
Feelings of Panic	O	F	C	L	M	S
Forgetfulness	O	F	C	L	M	S
Grief	O	F	C	L	M	S

Symptom	Frequency			Severity		
Impulsiveness	O	F	C	L	M	S
Insomnia	O	F	C	L	M	S
Irritability / Anger	O	F	C	L	M	S
Mood Swings	O	F	C	L	M	S
Nightmares	O	F	C	L	M	S
Poor Concentration	O	F	C	L	M	S
PTSD	O	F	C	L	M	S
Recurrent Thoughts / Pensive	O	F	C	L	M	S
Sadness	O	F	C	L	M	S
Worried	O	F	C	L	M	S
Other:	O	F	C	L	M	S
	O	F	C	L	M	S
	O	F	C	L	M	S

What is your most pressing emotional concern? _____

Do you believe your emotions interfere with the activities of daily living or that they are an obstacle to your achieving your goals? If so, how? _____

_____

Have you found that certain things (food sensitivities, light, noise, etc.) are emotional triggers? Please describe them:_____

_____

What is your current level of stress? _____

Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, how does stress affect you (headaches, gastrointestinal problems, edgy, etc.)? _____

_____

Describe Your Current Health Challenges

Please describe the reason for your visit today (Primary Complaint): _____

_____

_____

When did this start? _____ Was the onset: ☐ Sudden ☐ Gradual

What triggered this condition? _____

What other options have you tried to correct this problem? _____

_____

Did these/are these helping? _____

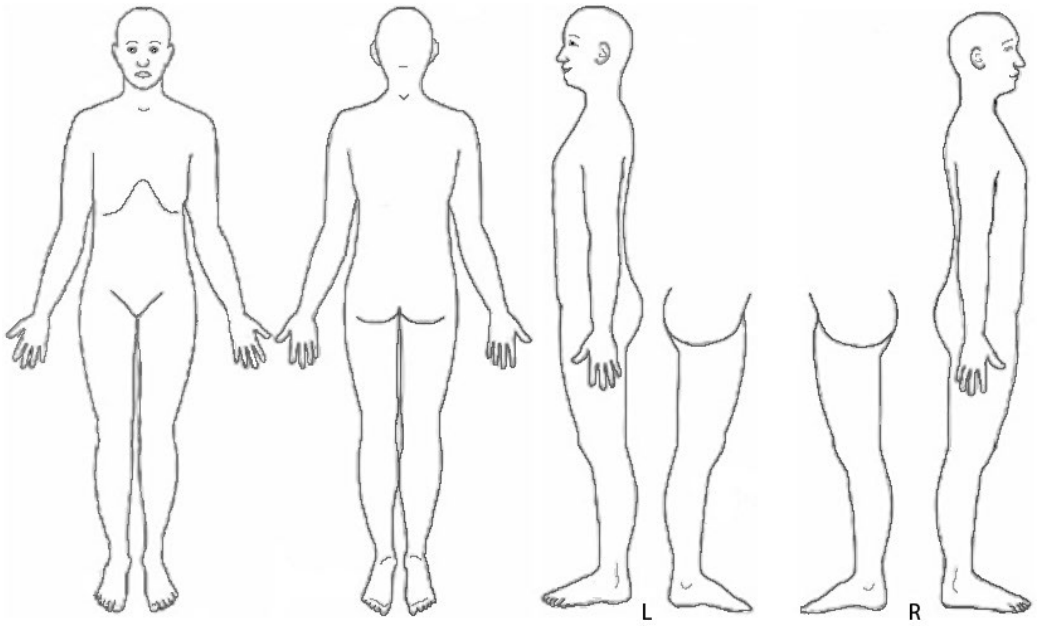
_____

Overall, is your condition: ☐ Getting Better ☐ Getting Worse ☐ Staying the same

Are there any other health concerns that you would like to address? _____

_____

Please shade in the areas on the diagram where you are experiencing symptoms.



Current Symptoms

Please fill this out carefully and list all symptoms, even if they don't seem to be connected to your primary health challenge. Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the Severity is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Head and Face						
Dizziness	O	F	C	L	M	S
Headache	O	F	C	L	M	S
Head Injury	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Eyes						
Changes in Vision	O	F	C	L	M	S
Eyelid Twiitching	O	F	C	L	M	S
Floaters	O	F	C	L	M	S
Pain	O	F	C	L	M	S
Redness/Dryness	O	F	C	L	M	S
Tearing/Discharge	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Ears:						
Ear Pain / Infections	O	F	C	L	M	S
Loss of Hearing	O	F	C	L	M	S
Tinnitus	O	F	C	L	M	S
Vertigo	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Nose						
Impaired sense of smell	O	F	C	L	M	S
Sinus Trouble	O	F	C	L	M	S
Bleeding	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Mouth						
Dental Problems	O	F	C	L	M	S
Gum Problems	O	F	C	L	M	S
Teeth Grinding / TMJ	O	F	C	L	M	S
Unusual Tastes	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Throat						
Sore Throat	O	F	C	L	M	S
Hoarseness	O	F	C	L	M	S
Difficulty Swallowing	O	F	C	L	M	S
Dryness	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Symptom	Frequency			Severity		
Respiration						
Difficulty Inhaling	O	F	C	L	M	S
Difficulty Exhaling	O	F	C	L	M	S
Pain or Tightness	O	F	C	L	M	S
Cough	O	F	C	L	M	S
Congestion	O	F	C	L	M	S
Shortness of Breath	O	F	C	L	M	S
Sputum	O	F	C	L	M	S
Voice Changes	O	F	C	L	M	S
Other	O	F	C	L	M	S
Heart and Chest						
High Blood Pressure	O	F	C	L	M	S
Palpitations	O	F	C	L	M	S
Chest Pain/Pressure	O	F	C	L	M	S
Edema	O	F	C	L	M	S
Difficulty Lying Down	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Circulation						
Easy Bruising	O	F	C	L	M	S
Easy Bleeding	O	F	C	L	M	S
Cold Limbs – Hands	O	F	C	L	M	S
Cold Limbs - Feet	O	F	C	L	M	S
Reynaud's Syndrome	O	F	C	L	M	S
Other	O	F	C	L	M	S
Gastrointestinal						
Always Thirsty	O	F	C	L	M	S
Never Thirsty	O	F	C	L	M	S
Low Appetite	O	F	C	L	M	S
Cravings	O	F	C	L	M	S
Gluten intolerance	O	F	C	L	M	S
Gas/Bloating	O	F	C	L	M	S
Abdominal pain	O	F	C	L	M	S
Nausea	O	F	C	L	M	S
Diarrhea/Loose Stool	O	F	C	L	M	S
Constipation	O	F	C	L	M	S
Rectal Bleeding	O	F	C	L	M	S
Colon Problems	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Symptom	Frequency			Severity		
Urination						
Frequent	O	F	C	L	M	S
Difficult	O	F	C	L	M	S
Painful	O	F	C	L	M	S
Nocturnal	O	F	C	L	M	S
Bleeding	O	F	C	L	M	S
Other	O	F	C	L	M	S
Neurological						
Changes in Consciousness	O	F	C	L	M	S
Confusion	O	F	C	L	M	S
Difficulty Concentrating	O	F	C	L	M	S
Nervousness/Anxiety	O	F	C	L	M	S
Tremors	O	F	C	L	M	S
Numbness or Tingling	O	F	C	L	M	S
Lack of Coordination	O	F	C	L	M	S
Nerve Pain	O	F	C	L	M	S
Attention	O	F	C	L	M	S
Neurofatigue	O	F	C	L	M	S
Memory Loss	O	F	C	L	M	S
Gait disturbance	O	F	C	L	M	S
Paralysis	O	F	C	L	M	S
Forgetfulness	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Symptom	Frequency			Severity		
Skin						
Acne	O	F	C	L	M	S
Dryness	O	F	C	L	M	S
Moles that Change	O	F	C	L	M	S
Lumps	O	F	C	L	M	S
Excessive Sweating	O	F	C	L	M	S
Night Sweats	O	F	C	L	M	S
Rarely Sweat	O	F	C	L	M	S
Changes in hair	O	F	C	L	M	S
Rash and/or skin lesion	O	F	C	L	M	S
Wounds that won't heal	O	F	C	L	M	S
Changes in nails	O	F	C	L	M	S
Itching	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Sleep						
Insomnia	O	F	C	L	M	S
Drowsiness	O	F	C	L	M	S
Excessive Dreaming	O	F	C	L	M	S
Waking Early	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Musculoskeletal:						
Limited Movement	O	F	C	L	M	S
Stiffness	O	F	C	L	M	S
Weakness	O	F	C	L	M	S
Joint Clicking	O	F	C	L	M	S
Spasms or Cramps	O	F	C	L	M	S
Swelling	O	F	C	L	M	S
Pain	O	F	C	L	M	S
Other:	O	F	C	L	M	S

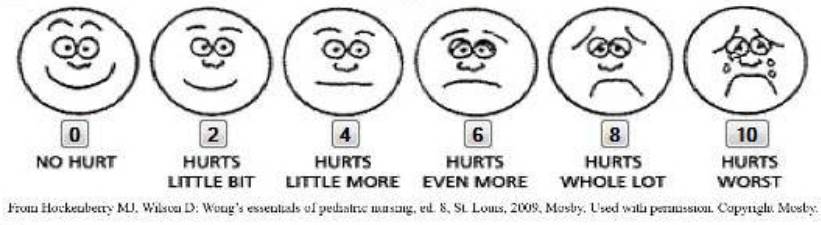
Other symptoms: _____

_____

For Patients with Pain:

Please make sure that you have shaded in the areas where you are experiencing pain in the diagram on page 9.

Which face describes your level of pain?



How long have you had this pain? _____

When did your pain first begin, was it gradual? If not what triggered it? _____

Is your pain: ☐ Continuous ☐ Intermittent

If your pain is Intermittent, how often does it occur? ☐ Several times a day ☐ Once per day

☐ Several times a week ☐ Once per week ☐ Less than once per week ☐ Other:_____

How long does your pain last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks

Is the pain worse at certain times of day? ☐ Yes ☐ No If so, when?_____

Below are a list of words that describe various types of pain, rate each words by placing an X in the column that best describes the intensity of each type of pain.

Type of pain	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				

Type of Pain	None	Mild	Moderate	Severe
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

What makes your pain feel better? Please be specific. _____

What makes your pain feel worse? Please be specific. _____

How does your pain interfere with your normal activities or mood?_____

Do you have chest pain? ☐ Yes ☐ No Chest pressure? ☐ Yes ☐ No Heartburn? ☐ Yes ☐ No

Pain that radiates to other areas of the body (left arm, jaw, back, legs, etc.)? ☐ Yes ☐ No

For Women:

Are you currently sexually active? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No ☐ Sometimes

What form of birth control do you use? _____ Since: _____

Are you or could you be pregnant? _____ If yes, how far along are you? _____

Are you trying to become pregnant? _____ If yes, how long have you been trying? _____

Number of pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Age of first menses? _____ Date of last menstrual period: _____

Do you have problems with vaginal discharge? If yes, please describe: _____

Age at menopause, if applicable? _____ Are you using hormones? ☐ Yes ☐ No

How long between periods? ☐ Less than 28 days ☐ More than 28 days ☐ Varied ☐ Regular

How many days do your periods last? _____ Do you bleed between periods? ? ☐ Yes ☐ No

Are your periods uncomfortable: ☐ physically ☐ emotionally

Describe the flow of your menses: ☐ Heavy ☐ Light ☐ Very little

Do you have clots? _____ Early in the cycle? _____ Throughout? _____

What color is your menstrual blood? ☐ Bright Red ☐ Red ☐ Purple ☐ Brownish ☐ Pale

Do you experience any of the following pre-menstrual symptoms? ☐ Irritability ☐ Depression ☐ Crying

☐ Rage ☐ Nausea ☐ Breast Tenderness ☐ Weight gain ☐ Bloating ☐ Other: _____

☐ Cravings If yes, for what types of foods? _____

Do you have any difficulty with libido? ☐ Too low ☐ Too high

Are you having difficulty with: ☐ Changes in hair distribution ☐ Hot flashes ☐ Dryness

Have you ever had any gynecological surgeries or any abnormal findings on any tests? _____

Do you have a current or past history of herpes, venereal warts, gonorrhea, syphilis, Chlamydia, HIV/AIDS or other STD?

☐ Yes ☐ No If so, which ones? _____

Do you have any sexual/gynecological/obstetrical concerns or complaints? _____

_____

For Men:

Do you experience any of the following? Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the **Severity** is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Urinary Frequency	O	F	C	L	M	S
Urging w/o passing urine	O	F	C	L	M	S
Waking during the night to urinate	O	F	C	L	M	S
Pain/burning	O	F	C	L	M	S
Trouble starting urine	O	F	C	L	M	S
Difficulty urinating completely	O	F	C	L	M	S
Cloudy urine	O	F	C	L	M	S
Red-tinged/blood in the urine	O	F	C	L	M	S
Foul smelling urine	O	F	C	L	M	S
Discharge	O	F	C	L	M	S
Pain or sores on penis	O	F	C	L	M	S
Hernias	O	F	C	L	M	S

Symptom	Frequency			Severity		
Testicular swelling	O	F	C	L	M	S
Testicular pain	O	F	C	L	M	S
Lumps on testicles, scrotum or penis	O	F	C	L	M	S
Fertility concerns	O	F	C	L	M	S
Inability to achieve or maintain an erection	O	F	C	L	M	S
Impotence	O	F	C	L	M	S
Premature ejaculation	O	F	C	L	M	S
Reduced libido	O	F	C	L	M	S
Excess libido	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Please list all and note the year when they occurred or were first diagnosed.

X	Condition	Year
	BPH	
	Testicular Cancer	
	Penile Cancer	
	Surgery of Prostate or Genitals	
	Vasectomy	

X	Condition	Year
	Sexually Transmitted Diseases (herpes, vanereal warts, gonorrhea, syphilis, Chlamydia, chancre, HIV/AIDS	
	Other:	

Are you currently sexually active? ☐ Yes ☐ No Do you use contraception? ☐ Yes ☐ No ☐ Sometimes

Do you have any sexual problems or concerns? ☐ Yes ☐ No _____

Do you have regular prostate exams? ☐ Yes ☐ No Have any been abnormal? ☐ Yes ☐ No

Any other health concerns? _____

Oriental Medicine Experience

Have you ever received acupuncture before? ☐ Yes ☐ No

If yes, for what conditions and what was the outcome? _____

_____

_____

Did you work with an Oriental Medicine practitioner? ☐ Yes ☐ No

Please describe your goals, hopes and expectations for your treatment: _____

_____

How committed are you to making important changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

What potential obstacles do you foresee in addressing any lifestyle factors that are undermining your health or in adhering to therapeutic protocols? _____

_____

How did you hear about Three Mountains Wellness, LLC?

☐ Physician Referral ☐ Other Healthcare Provider Referral

☐ Family Member ☐ Friend ☐ Internet Search Engine: _____

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's signature Date

THREE MOUNTAINS WELLNESS, LLC
10524 E. Grand River, Suite 107F, Brighton, MI 48116
(734) 719-1229 Fax: (734) 272-4235

Cancellation Policy

In order to provide quality care to our patients and to minimize wait lists for appointments, our office has implemented a policy with regard to missed appointments. Please read the policy carefully, as it will be enforced.

- **Late Cancellation**: Any appointment cancelled less than twenty-four business hours prior to my scheduled time is considered a late cancellation.

- **No-Show**: A missed appointment of any kind without calling or texting the office to cancel is considered a no-show.

PROCEDURE FOR LATE CANCELLATIONS AND MISSED APPOINTMENTS:

- If you are ill, please call and reschedule your appointment. Late cancellations due to illness or other unforeseen circumstances may be rescheduled within 10 business days at the discretion of the provider with no fee. Repeated late cancellations take appointment space away from other patients who need to be seen and each late cancellation may be charged a fee of $45, not covered by insurance, at the discretion of the provider.

- If **one** appointment is missed due to a no-show, I will receive a letter of notification and incur a fee of $65, not covered by insurance, which must be paid within thirty days of the missed appointment.

- If **two** appointments are missed due to a no-show, a certified letter will be mailed to the address on file stating that two appointments have been missed and I will be terminated as a patient. I will be provided with thirty days of urgent care while securing a new provider. Effective thirty days from the date of the letter, I will not be considered an active patient of Three Mountains Wellness, LLC or Three Mountains Oriental Medicine, PLLC. No further treatment (appointments, telephone calls, herbal refills, etc.) will be provided.

NOTE: Parents and/or legal guardians will be held responsible for the appointments of minor children.

My signature below acknowledges that I have read and understand the cancellation policy and furthermore, I agree to comply with the conditions of this policy.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient (or parent or legal guardian) Signature Today's Date

THREE MOUNTAINS WELLNESS, LLC
10524 E. Grand River, Suite 107F, Brighton, MI 48116
(734) 719-1229 Fax: (734) 272-4235

Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of 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 (Chinese massage), Chinese 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 have 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 (pheumothorax). 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy and that herbs may not have been researched for their interactions with all prescription medication combinations. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately 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 that 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.

Elizabeth Billings, MSOM, L.Ac.
Three Mountains Oriental Medicine, PLLC
Three Mountains Wellness, LLC

_____
Patient Name (Printed)

_____ _____
Patient Signature (or authorized representative) Date

THREE MOUNTAINS WELLNESS, LLC
10524 E. Grand River, Suite 107F, Brighton, MI 48116
(734) 719-1229 Fax: (734) 272-4235

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES
Health Insurance Portability and Accountability Act (HIPAA)

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.

We understand that medical information about you and your health is personal. Protecting your privacy and healthcare information is fundamental to our relationship. In administering your health care, we gather and maintain information that may include non-public personal information:

- From your patient record, including diagnostic information, as well as the care and services you receive.
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- About your financial transactions with us (billing transactions).

Disclosure of Information

In order to maintain the level of service that you expect from our office, we may need to share limited information for treatment, payment and healthcare operations. For example:

- **Treatment:** We may disclose medical information about you to other health care practitioners who are involved in your care. We may also share medical information about you in order to coordinate different types of treatment or to assist you and your physician or other health care providers in providing appropriate care for you.
- **Payment:** A receipt or bill may be sent to you or a third party payer that includes information that identifies you, as well as your diagnosis, medical information, procedures, herbs prescribed and supplies used.
- **Health Care Operations:** We are allowed to disclose your medical information if that is necessary for our office to function efficiently, safely, and in accordance with the law.
- Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your medical information, you may cancel that permission in writing, at any time. Once we receive written notice that you are canceling permission we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Patient Rights

Your health record is the physical property of Three Mountains Wellness, LLC, however you have the right to:

- Inspect and request a copy of your health record.
- Request communications of your health information by alternative means or to alternative locations. We will accommodate reasonable requests.
- Request a restriction on certain uses and disclosures of your information. However, we are not required by law to agree to a requested restriction.
- Request that we amend your health record as provided by law.
- Obtain an accounting of certain disclosures of your health information as provided by law.
- Obtain a paper copy of this notice of information practices upon request.

You may exercise your rights by providing us with a written request.

Privacy Safeguards

We will not use or disclose your health information without your written authorization, except as described in this notice or as permitted by law. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change.

For More Information or to Report a Problem

We value our relationship and respect your right to privacy. If you have questions regarding your privacy guidelines or would like additional information, please contact: Three Mountains Wellness, LLC at 517-763-1497 or 734-272-4235. If you believe your privacy rights have been violated, you may file a written complaint with Three Mountains Wellness, LLC or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and consent to the "**Notice of Privacy Practices**" of Three Mountains Wellness, LLC. I understand that I may receive a copy of the above "Notice of Privacy Practices" and may ask any questions about the notice prior to signing this document.

Patient Name (print): _____ Date: _____

Patient Signature: _____