Rhiannon Herpolsheimer LAc • Mandala Acupuncture
Heart Spring Health Center 心泉中醫 • 3483 Golden Gate Way Suite 206, Lafayette CA 94549 • 925.255.5390
Kane Sports and Therapeutic Massage • 1317 Court St Redding CA 96001 • 530.276.8406

Patient's Full Name _____ Today's Date ____/____/_____

Date of Birth _____/_____/_____ Age _____ [ ] Male [ ] Female Marital Status _____

Phone (Home) (_____)_____-_____ Phone (Cell) (_____)_____-_____

Address _____ City _____

State _____ Zip _____ E-mail _____

Employer _____ Occupation _____

Spouse/ Partner/ Legal Guardian Name _____

Family Physician _____ Phone (_____)_____-_____

Referred by _____ Phone (_____)_____-_____

Health Insurance Information (fill out only if permission to contact)

Company _____ Policy # _____ Group # _____

Primary Name & Birth Date _____ Provider Contact #_____

Emergency Information

Name _____ Phone (Home) (_____)_____-_____

Relationship _____ Phone (Cell) (_____)_____-_____

Chief Complaint(s) *Please indicate how long you've had the condition(s).*

_____

_____

_____

_____

_____

List Medications/Supplements being taken (with dose if known)

_____ _____

_____ _____

_____ _____

_____ _____

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Rhiannon Herpolsheimer and staff to keep confidential all medical records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally. Under no circumstances will your private medical information be disclosed to a third party outside of our office without your **written** consent **except** when mandated by federal or state laws.

I, the undersigned, hereby request Rhiannon Herpolsheimer to communicate my personal health information electronically. I understand that this form of communication is less secure.

_____ ____ Email _____ ____ Text _____ ____ Phone/Voicemail
Date Initial Date Initial Date Initial

Consent Form

I, the undersigned, hereby authorize Rhiannon Herpolsheimer L.Ac. to perform the following procedures:

Date	Initial		
_____	____	Acupuncture:	Insertion of sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
_____	____	Massage/Tuina/ Cupping/Gua Sha:	Manipulation of all superficial body structures with or without oils, creams, and liniments/Chinese therapeutic manipulation/Cups attached to the skin with a vacuum created by heat or a hand-held vacuum pump/Rubbing an area of the body with a blunt, round instrument.
_____	____	Herbs:	Pills, powders, tinctures, pastes, plasters or raw herbs to be cooked. Herbal formulas may include shell, mineral, plant and animal materials.

I recognize the potential risks and benefits of these procedures as described below:

- Risks: discomfort, pain, bleeding, bruising, infection and blistering at the site of procedure, needle sickness, broken needle, temporary discoloration of the skin and even aggravation of symptoms existing prior to the acupuncture treatment. Patients with severe bleeding disorders or pace-makers should inform practitioners prior to treatment.

- Benefits: relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem, and strengthening the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Rhiannon Herpolsheimer and affiliates regarding cure or improvement of my condition. I hereby release Rhiannon Herpolsheimer and affiliates from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of patient (or legal guardian) Date