Cynergy Chiropractic Center
Dr. Alison M. Milbauer, D.C.
Dr. Peter Eisenhauer, D.C.
Julie Johnson, L.Ac.

Welcome to Cynergy – ACUPUNCTURE INTAKE

Patient Information

Thank you for choosing our practice.

Name:____ Date:____________
First MI Last

Address: ______________________________________ City_____________ State______ Zip ________

Gender: Female Male Trans Non-Binary Pronouns: She/Her He/Him They/Them

Birth date: __________________E-Mail :____

Main Phone #:___________________________ Other Phone #: ______________________________

Are you: Minor Single Married Partner Divorced

Your Employer: ______________________________________ Occupation: ____________________

Business Address_________________________ City ________________ State________ Zip_________

Whom may we thank for referring you to us? ___________________________________

Person to contact in case of emergency _____________________________

Phone #______________________________

Responsible Party:

Name of person responsible for this account ____
Relationship to patient ________________________________ Phone #_______________________
Address _________________________________ City ______________ State _________ Zip_________
Name of employer:__________________________ Work Phone #:___________________________

Insurance Information:

If you have any insurance information please provide the staff with your insurance card and/or necessary forms. Thank you.

Symptoms:

1. What is your number one problem or the one area of greatest pain? ______________________
2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**
3. When did this problem/pain start? [ ] Gradual [ ] Sudden [ ] Progressive

4. What do you think caused this problem? ____

5. How often do you experience the pain?
___ 1-2 hours per day ___ About half of the day ___ Most of the day ___ The pain never goes away

6. How does the pain affect your daily activities?
___ It does not affect my daily activities ___ I have had to change how I do things
___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities

7. What increases your pain? ____

8. What decreases your pain? ____

9. Have you ever experienced this problem before? [ ] Y [ ] N When? ____________________

10. List any other complaints currently bothering you and rate your pain level for each.
a. __________________ **0 1 2 3 4 5 6 7 8 9 10**
b. __________________ **0 1 2 3 4 5 6 7 8 9 10**
c. __________________ **0 1 2 3 4 5 6 7 8 9 10**
d. __________________ **0 1 2 3 4 5 6 7 8 9 10**

11. Have you ever been involved in an automobile accident? [ ] Y [ ] N When? ______________
Were you injured? [ ] Y [ ] N Explain: ____

12. Have you ever been injured at work? [ ] Y [ ] N When? ________________________________
Explain: ____

13. List all medications you are currently taking (prescribed and over the counter):
____

14. List all surgeries you have had: ____

Patient History: If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (Check all that apply.)

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficult urination	___ bloody stools	___ diverticulosis	___ difficult bowel movements
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ ulcers	___ dizziness	___ loss of memory	___ menstrual cramping
___ shortness of breath	___ constipation	___ diarrhea	___ general fatigue
___ sudden weight loss	___ nausea	___ headache	___ migraine
___ muscle cramping	___ soreness in joints	___ loss of hearing	___ ears ringing
___ epilepsy	___ gout	___ tuberculosis	___ syphilis
___ HIV	___ broken bones	___ chest pain	

Family History: If any of your family members have experienced any of the following conditions listed, please also mark the condition with an "F" on the line provided (Check all that apply.)

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficult urination	___ bloody stools	___ diverticulosis	___ difficult bowel movements
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ ulcers	___ dizziness	___ loss of memory	___ menstrual cramping
___ shortness of breath	___ constipation	___ diarrhea	___ general fatigue
___ sudden weight loss	___ nausea	___ headache	___ migraine
___ muscle cramping	___ soreness in joints	___ loss of hearing	___ ears ringing
___ epilepsy	___ gout	___ tuberculosis	___ syphilis
___ HIV	___ broken bones	___ chest pain	

General Activities: (Check all that apply.)

___ read in bed ___ fall asleep in recliner/on couch
___ sewing ___ sleep on stomach ___ use two or more pillows to sleep
___ lift weights/wt. mach. ___ exercise ______x/wk ___ jog ______x/wk
___ swim ___ use health rider ___watch television (_______ hrs per day)
___ computer use (________ hrs per day) ___ play video games (________ hrs per day)

Neurodivergences: (Check all that apply)

___ ADHD ___Autism Spectrum Disorder ___ Intellectual Disability ___ OCD
___ Sensitivities: ____
___ Other: (please list how we can support) ____
____
____

Please add anything else you would like the doctor to know: ___________________________
____
____
____

Financial Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child, during the period of such chiropractic care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature_______________________________________ Date_________________

(Signature of parent if the patient is a minor)

Doctor's Comments: ____
____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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. Some possible side effects 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME: JULIE C. JOHNSON, L.Ac.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

AAC-FE
A2004

Julie Johnson, L.Ac.
Cynergy Chiropractic Center
980 N. Grant St. #100
Denver, CO 80203
303-832-3668
www.cynergychiropractic.com

Whenever a needle is introduced through the skin, inherent risks are present. Although the risks are small, the expected benefit from the procedure must outweigh the possible risks. Make sure that you have a thorough understanding of the expected benefit from the injection. The risks of injection depend on where the injection is made and what is being injected. If the injection is made in a large muscle, the risk of hitting vital structures is very small. Injections in the area of neuromuscular bundles (where nerves, veins, and arteries travel together) have a higher risk of injury, and injections in the area of the lung organs have higher risk of injuring them.

The risks of injection are:

1. **Injection: With current standard procedure of sterile needles and antiseptic technique, this risk is very small, but it still exists. Redness and swelling are the early signs of injection. Any redness or swelling should be reported immediately to avoid the more serious complications of sepsis (bacteria in the blood stream) or osteomyelitis (infection of the bone).**

2. **Puncture of nerves, arteries, or veins: This risk varies greatly on the area of injection. When acupuncture point injections are made in the body of larger muscles, this risk is very small. In other areas where these structures are larger and running together, the risk is increased. A nerve may be permanently damaged, or bleeding may occur with puncture of a vein or artery.**

3. **Puncture of a lung or vital organ: Injections in the area of the chest could puncture a lung in which the serious complication of a tension pneumothorax could occur. In this condition the lung leaks air into the lung cavity progressively compressing the heart and lung. The person becomes short of breath, which can advance to death if untreated. Puncture of other vital organs is extremely unlikely and depends on the site of injection.**

4. **Allergic reaction to injected substance: Allergic reactions to homeopathic substances have not been reported, and in fact, they are used to treat allergic conditions. However, the possibility still exists. An allergic reaction is usually hives, but a lung reaction could occur with sever shortness of breath, or the most serious reaction is anaphylaxis. In anaphylaxis there is the acute onset of shock, and this is a serious, life-threatening emergency that could result in death.**

INFORMED CONSENT AND AGREEMENT

I, ____, hereby request and consent to injection therapy on my body, in order to enhance the effect of stimulating an acupuncture point. I understand that I ill only be injected with substances that fall within the scope of practice of Licensed Acupuncturists in Colorado. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. By signing this form, I agree to accept all risks and release all liabilities from Julie Johnson, L.Ac.

Patient's Signature____________________________________

Relationship________________ Date_____________________

Disclosure Statement

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to by this clinic, including proper cleaning and sterilization equipment and office.

The practice of acupuncture is regulated by the Department of Regulatory agencies. Any complaints should be directed to: Director of the Division of Registrations in the Department of Regulatory Agencies: 1560 Broadway, Suite 1350, Denver, CO 80202, phone (303) 894-7800.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Clinic Fee Schedule

Initial Consultation	$140.00
Follow-up visit	$ 89.00
Herbal Consult	$ 40.00
Injection w/ACU visit	$ 50.00
Injection w/o ACU visit	$ 75.00

Certification and Experience

BGS from Indiana University (1995). Certificate of Completion in Therapeutic Massage from Indiana College of Bodywork Modalities (1999, 750-hour program). Masters of Science in Oriental Medicine from Southwest Acupuncture College (2004, including the recommendation and application of adjunctive therapies and herbs.) NCCAOM Diplomate of Acupuncture 2004. NCCAOM Diplomate of Oriental Medicine 2005.

Patient Signature ____

Date ______________________________

Cancellation/Reschedule & Missed Appointment Policy for Massage & Acupuncture

Cancellation/Reschedule/Missed Appointment Policy:

Please be aware that we require 24 hours notice when cancelling, rescheduling or missing a Massage Therapy or Acupuncture appointment. For cancellations or rescheduling with less than the required 24 hour notice, regardless of the reason behind the need to move your appointment, an $89 full hour fee will be charged. We have implemented this policy as a courtesy to our acupuncturist and massage therapists. In the event that less than 24 hours notice was given, and we are able to fill the acupuncture or massage slot, the $89 fee will be waived; however, if we are *unable* to fill your vacated appointment time, we will charge the $89 fee for the cancelled appointment.

We will be retaining a Credit Card number stored in our secure system which will be used to charge the same day as the missed appointment. If you prefer to use a different card, please let our Front Desk know.

By signing below, I state that I understand and agree to the cancellation, reschedule / missed appointment policy upheld by Cynergy Chiropractic Center, Inc. for Massage and Acupuncture services.

____
Print Name

____
Signature

____
Date
____

Credit Card # ____EXP____________

HIPAA: Consent for Purposes of Treatment, Payment, and Health Care Operations

I, ______________________________, hereby consent to the use or disclosure of my protected health information by Cynergy Chiropractic Center, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Cynergy Chiropractic Center, Inc.

I understand that diagnosis or treatment of me by Cynergy Chiropractic Center, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Cynergy Chiropractic Center, Inc. is not required to agree to the restrictions that I may request. However, if Cynergy Chiropractic Center, Inc. agrees to a restriction that I request, the restriction is binding on Cynergy Chiropractic Center, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent Cynergy Chiropractic Center, Inc. has taken action in reliance on this consent.

My “Protected Health Information” means health information, including my demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cynergy Chiropractic Center, Inc.’s Notice of Privacy Practices prior to signing this document.

Cynergy Chiropractic Center, Inc.’s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Cynergy Chiropractic Center, Inc.

The Notice of Privacy Practices also describes my rights and the duties of Cynergy Chiropractic Center, Inc. with respect to my protected health information.

Cynergy Chiropractic Center, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative’s Authority