



Cindy Haxel Acupuncture

Cindy Haxel Acupuncture protects Your Health Information and Privacy

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.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation or with other medical practitioners that you authorize.

Safeguards in place at this office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records are kept on permanent file

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us
- From your medical history, treatment notes, all test results, and any communication records to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators

In certain states, you may be able to access and correct personal information we have collected about you.

We value our relationships, and respect your right to privacy. If you have questions at all about our privacy policies, please call us at 303-956-5817.



**Cindy Haxel Acupuncture
HIPAA Consent Form**

I give Cindy Haxel my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices of the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature: _____ **Date:** _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____



**Cindy Haxel Acupuncture
Informed Consent**

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me (or 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 have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, a punctured lung, infection, and bruising. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment that is in my best interest, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by the patient or patient's legal representative:

Print patient's name

Signature of patient or patient's legal representative

Date

Relationship to patient, if patient's legal representative: _____



Cindy Haxel Acupuncture Mandatory Disclosure

Education and Experience

Cindy Haxel earned her Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in August 2007. This 4-year program consists of 2850 hours of education including 1080 hours of clinical practice. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2007. This includes certification in Clean Needle Technique.

Cindy's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and diet and lifestyle recommendations. She also has specialized training in Cosmetic Acupuncture and Pediatrics.

Cindy is a member of the American Association of Oriental Medicine. She received her acupuncture license in Colorado in 2007. Her license, certificates, or registrations have never been suspended or revoked.

This clinic complies with the rules and regulates promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

Fee Schedule

	Per session	Discount Packages *
Cosmetic Acupuncture	\$120	\$1200 for 12 sessions
Initial Intake / 90 minute	\$90	
Follow-up Treatment / 60 minute	\$60	\$540 for 10 sessions
Children / Herbal Consult / 30 minute	\$45	\$400 for 10 sessions

* The patient may terminate this treatment at any time and any unused treatments will be refunded at the discounted rate.

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- If at any time the patient wishes to terminate treatment and they have purchased a discount package they will be refunded in full for any unused treatments at the discounted rate.
- 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.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone 303-894-2440.

I have read and understand this document.

Patients (Guardian's) Signature

Date



Cindy Haxel Acupuncture Health History

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION

Date: ___/___/___

Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ Secondary Phone: _____

To retain your privacy, may we contact you or leave messages at these phone numbers? Y/N

If No, what is the best way to reach you? _____

Email address: _____

Date of Birth: ___/___/___ Guardian (if under 18 years old): _____

Gender: _____ Height: _____ Weight: _____ Marital Status: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Family/Primary Physician: _____ Phone: _____

Date of last medical exam: ___/___/___ Type (physical, pap, etc.): _____

Emergency Contact
Name/Relationship/Phone: _____

Have you ever been treated by acupuncture or oriental medicine before? Y/N

Main conditions/symptoms that brought you here today (list in order of significance)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

How long ago did these problems begin? _____

To what extent do these problems affect your daily activities? _____

What kinds of treatments have you already tried? _____

How well have they worked? _____

II. PAST MEDICAL HISTORY

How was your childhood health? _____

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls: _____

Allergies (food, seasonal, environmental): _____

Circle any you have had in the past:

- | | | | | |
|-----------------|------------------|---------------------|-----------------|------------------|
| Allergies | Asthma | Cancer | Chicken Pox | CVA/Stroke |
| Diabetes | Emphysema | Epilepsy | Glaucoma | Heart Disease |
| Hemophilia | Hepatitis | High Blood Pressure | High Fever | HIV/AIDS |
| Jaundice | Kidney Disorder | Liver Disorder | Lung Disorder | Measles |
| Meningitis | Migraines | Mononucleosis | Mumps | Nervous Disorder |
| Paralysis | Pneumonia | Polio | Rheumatic Fever | STD'S |
| Spleen Disorder | Stomach Disorder | Thyroid Disorder | Tuberculosis | Vein conditions |

Other: _____

Family Medical History: Please circle all that apply in your immediate family

- | | | | | |
|-----------|----------|---------------|---------------------|----------|
| Cancer | Diabetes | Stroke | High Blood Pressure | Seizures |
| Allergies | Asthma | Heart Disease | | |

Other: _____

III. PATIENT PROFILE

Please list all medications taken in the last 3 months (including drugs, vitamins and herbs): _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? Y/N If yes, describe: _____

Are you on a restricted diet? Y/N If yes, describe: _____

How much water do you drink daily? _____

How many caffeinated drinks do you drink per day (coffee, tea, soda)? _____

Do you smoke? Y/N If yes, how many cigarettes per day? _____

Pain Conditions—Please fill out the following if you experience pain on a regular basis:

Indicate any areas of pain in the body and the location of any scars on the body: _____

Is the pain sensation (circle all that apply):

- | | | | | | | |
|-------|---------|--------|----------|------|--------|-------|
| Sharp | Burning | Aching | Cramping | Dull | Moving | Fixed |
|-------|---------|--------|----------|------|--------|-------|

Other: _____

Do any of the following lessen the pain (circle all that apply):

- | | | | |
|----------|------|------|----------|
| Pressure | Cold | Heat | Exercise |
|----------|------|------|----------|

Other: _____

Do any of the following worsen the pain (circle all that apply):

- | | | | |
|----------|------|------|----------|
| Pressure | Cold | Heat | Exercise |
|----------|------|------|----------|

Other: _____

Diet:

Please describe your average daily diet:

Breakfast: _____

Lunch _____

Dinner: _____

Snacks (what and when): _____

Any other problems you'd like to discuss? _____

Women only:

Do you practice birth control? Y/N What type and for how long? _____

Is there a chance you may be pregnant now? Y/N

Vaginal discharge: Y/N Frequent? Y/N Color? _____ Odor? _____

Regular menstrual cycle? Y/N Number of children: _____ Number of pregnancies: _____

Difficulties with pregnancy? Y/N Describe: _____

How long after giving birth until menses returns? _____

Age of first menstruation: _____ Age of menopause (if applicable): _____

Avg # days of flow: _____ Avg # days of entire cycle: _____ Quantity: Light / Medium / Heavy

Uterine bleeding/spotting between periods? Y/N How much and how often? _____

Do you experience any of the following pre-menstrual syndromes?

- | | | | |
|---------------|--------------|-----------------|-------------------|
| Nausea | Vomiting | Water retention | Breast swelling |
| Food cravings | Headaches | Migraines | Breast tenderness |
| Depression | Irritability | Anxiety | |

Other emotions: _____

Pain (sharp or dull and where): _____

Men only:

- | | | | |
|---|-----------------|-----------|-----------------------|
| Swollen testes | Testicular pain | Impotence | Premature ejaculation |
| Feeling of coldness or numbness in external genitalia | | | |

Other (describe): _____

Patient Signature: _____

Acupuncturist Signature: _____