East Acupuncture Wellness Boutique

2296 US-70, Swannanoa NC 28778
828.458.4139
info@eastacupuncturewb.com
www.eastacupuncturewb.com

- Initial Acupuncture Treatment and Health History Consultation $120
- Follow-up Acupuncture Treatment $80
- Facial Rejuvenation Treatment $140 (Packages of 6,12,15 at reduced costs)
- Mini Facial & Acupuncture Treatment $100
- Body Cupping/Moxa/Gua Shua (No Needle Treatment) $40
- Facial Cupping/Gua Sha and Herbal Mask Treatment $50
- Add Facial Cupping/Gua Sha to any Non-Cosmetic Treatment $25
- Affordable Care Acupuncture 30 minute Treatment for $30
- Massage 60min $85, Massage 90min $115, Massage 120Min $160

Scheduling and Payment Policies

- A 24 hour notice is required for cancellation, otherwise you will be billed for the full cost of the appointment
- If you are late to your appointment, that appointment will be shortened in order to complete the treatment at the scheduled time.
- Full payment is expected at time of service. We accept cash, check, and major credit cards. There is a $25 fee for returned checks.
- We do not accept Insurance at this time. A receipt for your office visit with all required coding will be provided upon request; you have the option to check with your insurance carrier to see if reimbursement is possible.

Your Arrival

My Address is 2296 US-70, in the blaze next to PSA Pharmacy and across stem street from Ingles. There is plenty of parking! Upon arriving, the office manager will greet you and instruct you on which room to enter.

Preparation

When possible, please print out the Initial Health History Forms, and fill them out before coming to your first appointment. If you are unable to print the forms, please arrive 15 minutes in advance of your scheduled appointment time to fill out the forms. Also, please remember to provide a list of any and all medications and or supplements that you are currently taking (with dosage). We request that you eat a snack or a small meal with in two hours your scheduled treatment time.

Your treatment

Treatments take place in a peaceful, private, comfortable environment. Your visit will begin by discussing health history and your specific goals for treatment, and in addition the intake will include pulse taking and tongue observation. Upon assessing your health condition, I may select from a variety of techniques to complement your acupuncture treatment. These techniques include: tui na massage, cupping, gua sha, moxibustion heat therapy, electro acupuncture or qi gong rehabilitation. Your treatment may also include dietary and exercise planning that will complement your acupuncture. Treatments will range from 60-90 minutes. To get the most out of your treatment, please take time to relax and reflect both during and after. Following treatment, it is best to keep work or exercise to a minimum for several hours. My goal is to provide you with the knowledge and tools to support your healing and I encourage patient participation with any questions and feedback.

Herbal Medicine

Chinese herbal medicine is tailored to the needs of each patient and used to treat both acute and chronic conditions. Primary options for herbal treatments are the use of teas, tinctured liquid extracts, teapills, powders, topical liniments and patches and essential oils. I may recommend herbal medicine, which you may choose to purchase

ACKNOWLEDGEMENT OF RECEIPT OF CLINIC POLICIES

I have read, understood, and agree to the office policies for healthcare services at Ashley Kuper, L.Ac.

_____

Print Signature Date

We greatly appreciate your support and involvement in EAWB.. We look forward to providing you with an excellent healthcare experience. Suggestions, questions and concerns may be directed to your acupuncturist or the receptionist

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INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists of Ashley Kuper, L.Ac.. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. I understand that I may refuse any of the following treatments at any time:

Acupuncture: I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

Moxibustion: Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin, intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa.

Electro-Acupuncture: I understand that I may receive electro-acupuncture, which involves the stimulation of acupuncture points with a mild electric current. This treatment is stimulating but not typically painful or shocking. I am aware that certain adverse side effects may result from this treatment., including, but not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

Gua Sha/Cupping: I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soupspoon. Cupping applies localized suction to the skin with glass cups, drawing the superficial muscle layer into the cup. Both are used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, soreness, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

Acupressure/Massage: I understand that I may receive acupressure or massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: I understand that Chinese herbs may be recommended as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These may include, but are not limited to: changes in bowel movement, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. If I associate any concerns with the use of the herbal substances, I should stop use immediately and call my acupuncturist.

Dietary & Exercise Advice: In conjunction with my treatment, I may be given advice and suggestions concerning changes in diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Suggestions concerning physical activity and exercises may also be included in my treatment. I will communicate with my practitioner about any difficulties I may have with specific dietary or exercise recommendations.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with acupuncture or herbal medicine.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature of Patient/Guardian/Personal Representative:

Date:

Printed Name of Patient/Guardian/Personal Representative:

Relationship to Patient:

Printed Name of Patient, if different from signer above:

Date:

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NOTICE OF PRIVACY POLICIES (HIPAA)

The Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services. You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

The Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

Disclosure

The Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information:
Contact: East Acupuncture Wellness Boutique
Telephone: 828.458.4139
Address: 2296 US-70, Swannanoa NC 28778

To send a written complaint to the U.S. Department of Health and Human Services:
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Clinic.

Patient's Signature: _____ Date: _____

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Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. We will also discuss these questions on the first visit. Thank you for being here!

Name: _____ Date: ____/____/_____

How did you Hear about us: _____

Telephone: _____

Mailing Address: _____

Email address: _____

Height_____ Weight_____ Age_____ Date of Birth: _____ Place of Birth: _____

Occupation (Current) _____(Past) _____

Single / Married / Partnered / Separated / Divorced / Widowed

Emergency Contact: _____ Relationship to you: _____ Contact #_____

Primary Care Physician: _____

How would you like to be reminded of your next appointment? phone call / email / text/ no reminder necessary

Have you ever used Chinese medicine for your health care? _____
For what reason? _____

Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1.			
2.			
3.			
4.			

Western Medical Diagnosis (if you have one)_____

With whom do you live?

Name	Age	Relationship

Children who don't live with you

Name	Age	Relationship

What do you hope for and what are your expectations from this session today?

_____
_____
_____

On a long term basis?

_____
_____
_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____
_____

Please list three things you would like to change about your health and well-being.

_____
_____
_____

Please list approximate dates and briefly describe any accidents, hospitalizations, surgeries, or major illnesses you have had._____
_____
_____
_____
_____

Please indicate areas of concern (pain, tension, numbness, tingling, swelling, etc.):

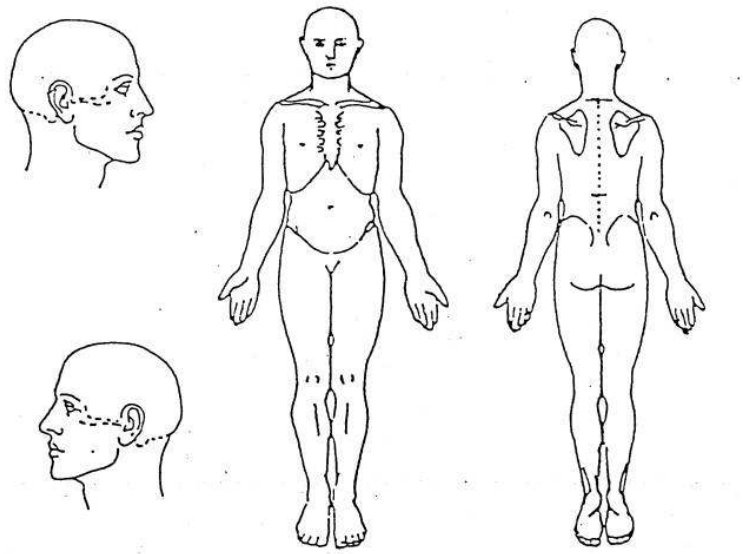
How long have you had this pain?_____
Describe the onset of your pain:_____

On a scale of 1-10 (10 worst), how strong is your pain?_____

What does your pain feel like?

_____

[ ] Dull [ ] Sharp [ ] Stabbing [ ] Sore [ ] Achy [ ] Cramping
[ ] Electrical [ ] Burning [ ] Constant [ ] Comes and goes
[ ] Fixed [ ] Moves around [ ] Other:



Does the pain radiate? Yes / No
If yes, where?_____
What helps the pain?_____
[ ] Ice [ ] Heat[ ] Rest[ ] Movement[ ] Pressure [ ] Moisture[ ]
Massage [ ] Nothing[ ] Other:

What aggravates the pain?_____
[ ] Ice [ ] Heat [ ] Rest [ ] Movement [ ] Pressure [ ] Moisture [ ]
Massage [ ] Nothing [ ] Other:

What other treatments have you tried for this pain?_____

Medications, Herbs, & Supplements

Please list all medications (prescription and over-the-counter) and supplements that you are taking or have taken in the past for longer than 3 months. Please also note the reason for which each is taken.

Dosage Reason How long

_____

_____

_____

_____

_____

Diet and Lifestyle

Please list when and what you ate yesterday:

Breakfast_____time: _____

Lunch_____ time: _____

Dinner_____time: _____

Snacks_____ time: _____

Alcohol _____drinks per day/week Tobacco _____ per day/week Caffeine _____ per day/week

Are you recovering from any addictions? Please be specific. _____If yes, how long have you been clean? __

Exercise (type(s)) _____ _____# times per week

TV/Video/Computer_____hours per day Do you use recreational drugs? If yes, what type?_____

How many hours per night do you sleep on average? _____ Do you wake rested? _____

How would you describe the quality of your sleep? _____

Have you experienced any major traumas? Y / N Explain: _____

Medical History

Please circle any symptoms or conditions you are experiencing either currently or have experienced in the past. Please indicate when each symptom or condition first appeared and for how long it lasted, if known.

Eyes

_____Blurred vision
_____Dryness
_____Redness, itchiness, or pain
_____Excessive tearing
_____Poor night vision
_____Spots or floaters
_____Double vision
_____Glaucoma
_____Cataracts
_____Other (describe)

Ears

_____Hearing loss
_____Ringing
_____Earache
_____Discharge or fullness
_____Other (describe)

Head and Neck

_____Dizziness or fainting
_____Vertigo
_____Headache/migraines
_____Swellings
_____Tension/stiffness
_____Other (describe)

Nose, Throat, and Mouth

_____Nasal congestion
_____Phlegm or discharge
_____Allergies
_____Sinus infection

_____Postnasal drip
_____Frequent cold/flu
_____Nosebleed
_____Dry nose
_____Dry mouth
_____Sores or swellings
_____Dental/gum problems
_____Jaw tension/tightness
_____Teeth grinding
_____Facial pain
_____Dry or sore throat
_____Strong thirst
_____Difficulty swallowing
_____Loss of voice
_____Other (describe)

Hot and Cold

_____Feel hot or cold
_____Cold hands or feet
_____Desire hot or cold

Skin

_____Rashes or hives
_____Acne
_____Eczema/psoriasis
_____Itching or redness
_____Dry or oily skin
_____Abnormal sweating
_____Easy bruising
_____Lumps or swellings
_____Varicose veins
_____Other (describe)

Chest

_____Difficulty breathing
_____Frequent sighing
_____Chronic cough
_____Cough up mucous/blood
_____Tight or stuffy chest
_____Pneumonia or bronchitis
_____Palpitations
_____Rapid/irregular heartbeat
_____Chest pain
_____High or low blood pressure
_____Heart murmur
_____Heart disease

Body and Limbs

_____Heaviness or stiffness
_____Limited range of motion
_____Numbness or tingling
_____Paralysis
_____Seizures or tremors

Sleep

_____Difficulty staying asleep
_____Disturbing dreams
_____Waking due to pain
_____Night sweats
_____Fatigue or energy drops
_____Restlessness or hyper
_____Waking to urinate
_____Other (describe)

Urinary

_____Urinary/kidney infection
_____Burning/hot urination
_____Cloudy urine
_____Strong odor
_____Blood in urine
_____Disrupted flow
_____Incomplete emptying
_____Frequent or urgent
_____Difficult urination
_____Incontinence
_____Other (describe)

Gastrointestinal

_____Low or excessive appetite
_____Bloating/flatulence
_____Abdominal heaviness
_____Nausea or vomiting
_____Belching or hiccupping
_____Heartburn or reflux
_____Abdominal pain
_____Change in weight
_____Altered taste
_____Bad taste in mouth
_____Bad breath
_____Diarrhea/loose stools
_____Constipation
_____Difficult bowel movements
_____Blood in stool

Reproductive (male and female)

_____Low or high libido
_____Pain or itching of genitals
_____Genital discharge or lesions
_____Other (describe)

Male

_____Impotence
_____Premature ejaculation
_____Nocturnal emissions
_____Lumps in testicles
_____Hernia
_____Enlarged prostate
_____Other (describe)

Mental/Emotional

_____Poor memory
_____Foggy headedness
_____Difficulty focusing
_____Depression
_____Mood swings
_____Irritable/frustration/anger
_____Difficulty relaxing
_____Loneliness
_____Sensitivity
_____Shyness
_____Frequent crying
_____Worry
_____Anxiety
_____Compulsive behaviors
_____Suicidal thoughts
_____Eating disorder
_____

Female

_____Pregnant (current)
_____# of pregnancies
_____# of live births
_____# of miscarriages
_____# of abortions
_____Age at first period
_____Menopause
_____Painful periods
_____Irregular periods
_____Heavy or light blood flow
_____Menstrual blood clots
_____Vaginal discharge
_____Breast tenderness
_____Breast lumps
_____Painful intercourse
_____Abnormal pap smear
_____Vaginal infections
_____Uterine fibroids
_____Endometriosis
_____Other (describe)

FAMILY HEALTH HISTORY

	Age	*Important Diseases/Illnesses*	*Deceased Y/N*
Father			
Mother			
Children			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Do you have any info about your birth?

_____

Your mother's pregnancy?_____

Is there anything else you would like me to know?

_____

_____

_____

_____

Thank you for taking the time to complete this form. I look forward to working with you!