Kristi Hundt MA, LAc

1610 Oak Street, STE 101 ◆ Solvang, CA 93464 ◆ PH 805.350.8028

Office use (DT of apt):

Patient Information

Name: _____

DOB: ____/____/____ (MM/DD/YYYY) Gender: M F ❑ Married ❑ Single ❑ Other

Address: _____

_____
City State Zip

Primary Phone: _____ ❑ Mobile

Secondary: _____ ❑ Mobile

eMail: _____

Detailed Information

Employer: _____

Occupation: _____

Work Phone: _____ Ext _____

Emergency Contact:

Name: _____

Relationship: _____ Phone: _____

Referred by: _____

Financial Policies

Financial Policy: All payments are to be made at the time services are rendered. All supplements, supports, or supplies must be paid for at the time of receipt. We accept cash, check, and Venmo™ payments. Checks must be dated for the date services or supplies are received. Any payment not received the same day of service may be subject to a $20 late payment fee.

There will be an additional charge of $30 for all returned checks due to insufficient funds.

Insurance Handling: This office does not deal with insurance companies directly. Patients who would like to seek reimbursement from their carrier will be given a superbill upon request. This office makes no guarantee of reimbursement.

Packages: Payment for packages must be made before services are rendered. Cancelling a package prior to completion will result in a refund based on services used calculated at current rates.

Cancelation Policy: Appointments cancelled with less than 24 hours' notice will be charged the full visit charge except in rare cases of emergency which are determined at the practitioner's discretion. Patients using a package will forfeit one session.

Informed Consent

I hereby request and consent to the performance of the services of acupuncture treatments and other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by the practitioner I see now or other practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for my practitioner, including those working at the clinic or office listed above, 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 (manual therapy), herbal medicine, and exercise and nutritional counseling.

If I elect to treat with acupuncture, 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 (pneumothorax). 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.

If I elect to treat with Tui-na/manual therapy, I have been informed that this is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment.

If I am prescribed or recommended to take herbs or supplements, I understand that the herbs and nutritional supplements that have been recommended are traditionally considered safe when prescribed by competently trained practitioners. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

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 treatment, and have had the 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 for which I seek treatment.

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YOUR PRIVACY **IS OUR PRIORITY**

HIPAA PRIVACY NOTIFICATION

I consent to the use or disclosure of my identifiable health information by Kristi Hundt MA, LAc for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by my provider 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 identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. My provider may is not required to agree to the restrictions that I may request. However, if my provider agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that my provider has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable 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 the right to review *Kristi Hundt MA, LAc's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at **www.kristihundt.com**. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

Kristi Hundt MA, LAc reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

PATIENT SIGNATURE

I have read the Financial Policies and Informed Consent as printed on the first page of this form. I understand and agree to the policies listed and hereby give my consent for treatment.

I have read the above notification and understand my rights to privacy as a patient.

Printed name of patient (or guardian)	Signature of same	Date

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Date

Basic Health Information/New

Name: _____ DOB: _____ Gender: M F

Reason for visit: _____

When did your symptoms begin? _____

What caused them? _____

Since onset, have your symptoms been getting ❑ Better ❑ Worse ❑ No change

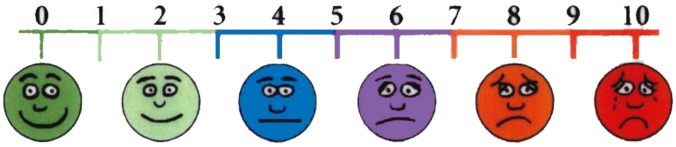
Other providers seen for this: _____

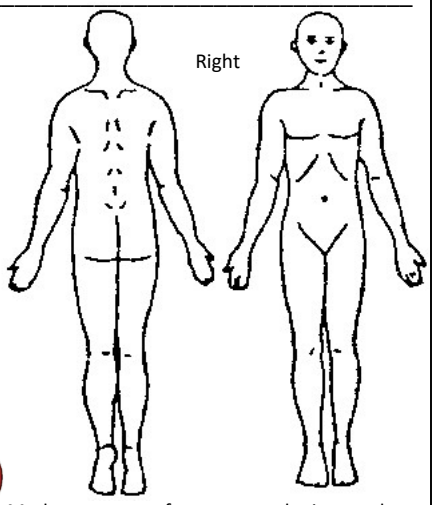
Does it interfere with your ❑ Sleep ❑ Work ❑ Daily Routine ❑ Recreation

What makes your symptoms better? _____

What makes you symptoms worse? _____

Please circle the number that corresponds to the severity of your symptoms.





Mark your areas of concern on the image above.

Surgical History

List with year:

Allergies or Reactions to Medication

Current Medication/Supplements

Please list all medications or supplements with dose:

Please check ☑ for you and ⊘ for family history.

Medical History - Personal and Family

❑❍ AIDs/HIV	❑❍ Emphysema	❑❍ Hepatitis	❑❍ Obesity
❑❍ Alcoholism	❑❍ Epilepsy	❑❍ Hyper/Hypo Thyroid	❑❍ Osteoporosis/penia
❑❍ Anemia	❑❍ Goiter	❑❍ Measles	❑❍ Parasites
❑❍ Arthritis	❑❍ Gout	❑❍ Mental Illness	❑❍ Pneumonia
❑❍ Cancer _____	❑❍ Heart Attack _____	❑❍ Multiple Sclerosis	❑❍ Stroke _____
❑❍ Diabetes _____	❑❍ Heart Disease _____	❑❍ Mumps	❑❍ Tuberculosis

Personal Health Information

Health Habits

Alcohol: _____glasses / day week month

Caffeine: _____glasses / day week month

Tobacco: _____packs / day week month

Stress: None Moderate Daily Heavy

Exercise: None Moderate Daily Heavy

Work Activity

❑ Sitting
❑ Standing
❑ Computer
❑ Light Labor
❑ Heavy Labor
❑ Hazards
❑ Repetitive

Female Health

Date of last menses: _____ ❑ Menopause
Age of first period: _____ ❑ PMS
Menses: ❑ Spotting ❑ Light ❑ Heavy
❑ Irregular ❑ Painful ❑ Clots ❑ Absent
Are you currently pregnant? ❑ Y ❑ N
Are you currently breast feeding? ❑ Y ❑ N
# of pregnancies: _____ # of live births: _____

Personal Signs and Symptoms

Please check ☑ for all that apply.

General

I do not experience any of the *general* items below ❑

❑ Bleed easily	❑ Fatigue	❑ Night sweats	❑ Poor sleep	❑ Swollen glands
❑ Bruise easily	❑ Fever	❑ Peculiar tastes	❑ Short temper	❑ Vivid dreams
❑ Chills	❑ Lack of strength	❑ Poor appetite	❑ Sweat easily	❑ Weight gain
❑ Cold hands/feet	❑ Muscle cramps	❑ Poor circulation	❑ Sudden energy drop	❑ Weight loss

Head, Ears, Eyes, Nose, and Throat (HEENT)

I do not experience any of the *HEENT* items below ❑

❑ Blurry vision	❑ Ear aches	❑ Excess saliva	❑ Nasal congestion	❑ Sinus pain
❑ Concussion	❑ Headache/migraine	❑ Grinding teeth	❑ Nose bleeds	❑ Spots in eyes
❑ Dizziness/vertigo	❑ Thyroid issues	❑ Itchy eyes	❑ Red eyes	❑ Sore throat
❑ Dry throat/mouth	❑ Eye pain/strain	❑ Mouth sores	❑ Ringing ears	❑ Teeth/gum problems

Respiratory

I do not experience any of the *respiratory* items below ❑

❑ Allergies	❑ Cough	❑ Frequent cold/flu	❑ Pneumonia	❑ Tight chest
❑ Asthma	❑ Coughing blood	❑ Phlegm	❑ Shortness of breath	❑ Wheezing

Cardiovascular

I do not experience any of the *cardiovascular* items below ❑

❑ Blood clots	❑ Edema/swelling	❑ Heart palpitations	❑ Irregular heartbeat	❑ Phlebitis
❑ Chest pain	❑ Fainting	❑ High blood pressure	❑ Low blood pressure	❑ Tachycardia

Gastrointestinal

I do not experience any of the *gastrointestinal* items below ❑

❑ Abdominal pain/ bloating	❑ Blood in stool	❑ Floating stools	❑ Indigestion	❑ Nausea
	❑ Constipation	❑ Gas/belching	❑ Intestinal pain/ cramps	❑ Odorous stools
❑ Acid reflux	❑ Dark stools	❑ Hemorrhoids		❑ Rectal pain
❑ Bad breath	❑ Diarrhea	❑ Hiccups	❑ Mucous in stools	❑ Vomiting

Provider Reviewed: _____ on _____

Musculoskeletal

I do not experience any of the *musculoskeletal* items below ❑

❑ Low back pain	❑ Redness/heat	❑ Limited range	❑ Rib pain	❑ Moving pain
❑ Neck/shoulder pain	❑ Swelling	❑ Limited use	❑ Dull/achy pain	❑ Stabbing pain
❑ Upper back pain	❑ Joint pain	❑ Muscle pain	❑ Fixed pain	❑ Throbbing/burning

Skin and Hair

I do not experience any of the *skin and hair* items below ❑

❑ Acne	❑ Dry/brittle nails	❑ Eczema	❑ Loss of hair	❑ Rash/hives
❑ Dandruff	❑ Dry skin	❑ Fungal infection	❑ Psoriasis	❑ Ulcerations

Neuropsychological

I do not experience any of the *neuropsychological* items below ❑

❑ Abuse survivor	❑ Considered or attempted suicide	❑ Easily stressed	❑ Poor memory	❑ Sudden weakness
❑ Anxiety		❑ Irritable	❑ Seeing a therapist	❑ Tics
❑ Confusion	❑ Depression	❑ Numbness	❑ Seizures	❑ Tingling

Genitourinary

I do not experience any of the *genitourinary* items below ❑

❑ Bedwetting	❑ Dribbling urine	❑ Incomplete urine	❑ Nocturnal emission	❑ Premature ejaculate
❑ Blood in urine	❑ Frequent urination	❑ Increased libido	❑ Pain with urination	❑ Urgent urination
❑ Decreased libido	❑ Impotence	❑ Kidney stones	❑ Painful erection	❑ Wake to urinate

Patient Signature

I have completed this document to the best of my ability and understand that any omissions may impact the ability of my provider to make an appropriate diagnosis and/or treatment plan.

_____ _____

Signature of patient (or guardian) Date