ASCENT WELLNESS
4100 Grand Ave South, Minneapolis MN 55409
612-823-0368 | ascentacupuncture@gmail.com

Confidential Patient Data

NAME:_____ TODAY'S DATE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____ PHONE:_____
May we contact you via email? YES / NO May we contact you by phone/leave voicemail? YES / NO

DATE OF BIRTH:_____ GENDER:_____

OCCUPATION:_____

REFERRED BY:_____

EMERGENCY CONTACT: _____ PHONE:_____

PRIMARY PHYSICIAN: _____ PHONE:_____

What is/are your primary health concerns that bring you here?

When did the condition start?

What makes it better?

What makes it worse?

Have you been given a physician's diagnosis for this condition?

Please list all medications and supplements you are taking:

Please list all surgeries/hospitalizations with approximate date:

Do you currently have or have you had any of the following (please circle all that apply)

ALCOHOLISM/SUBSTANCE ABUSE	FIBROMYALGIA	MUMPS
ALLERGIES	HIV/AIDS	NEUROLOGICAL DISEASE
ANXIETY	HEART CONDITIONS	OSTEOPOROSIS/PENIA
ARTHRITIS	HEMOPHILIA	RHEUMATIC FEVER
ASTHMA	HEPATITIS	SINISITIS
AUTOIMMUNE DISORDERS	HIGH BLOOD PRESSURE	SKIN CONDITIONS
CANCER	IBS	SPINAL INJURY
DEPRESSION/BIPOLAR	JAW PAIN	STROKE
DIABETES	LONG TERM ANTIBIOTIC USE	THYROID PROBLEMS
DIGESTIVE DISORDERS	MENTAL ILLNESS	TRAUMATIC BRAIN INJURY
EPILEPSY	MIGRAINES	OTHER:
EXPOSURE TO TOXINS	MULTIPLE SCLEROSIS	OTHER:

Do any of the following conditions run in your family (please circle all that apply)

AUTOIMMUNE DISORDERS	CARDIOVASCULAR DISEASE	PSYCHIATRIC DISORDERS
CANCER	DIABETES	OTHER:

WOMEN ONLY:

Are you currently pregnant? _____ Are you on birth control? _____

# of pregnancies: _____ # of live births _____ # of miscarriages _____ # of abortions _____

How old were you when you had your first period? _____

Have you experienced menopause? YES / NO When? _____

If you are experiencing perimenopausal or menopausal symptoms, please describe: _____

_____

Vaginal discharge? YES / NO Clear / White / Yellow / Green Itchy / Burning / Pain / Odor

How many days between the start of each period? _____

When was the first day of your last period?_____

Average number of days of flow: _____ Flow is: Light / Moderate / Heavy Spotting? YES / NO

Do you experience any of the following before or during your period?

Before	During		Before	During	
		Breast distention			Insomnia
		Constipation			Irritability or weepiness
		Cramping			Migraines
		Depression			Nausea
		Diarrhea			Night sweats
		Fatigue			Water retention
		Headaches			Other:

_____

MEN ONLY:

Date of last prostate exam:_____ Results:_____

Please circle all that apply:

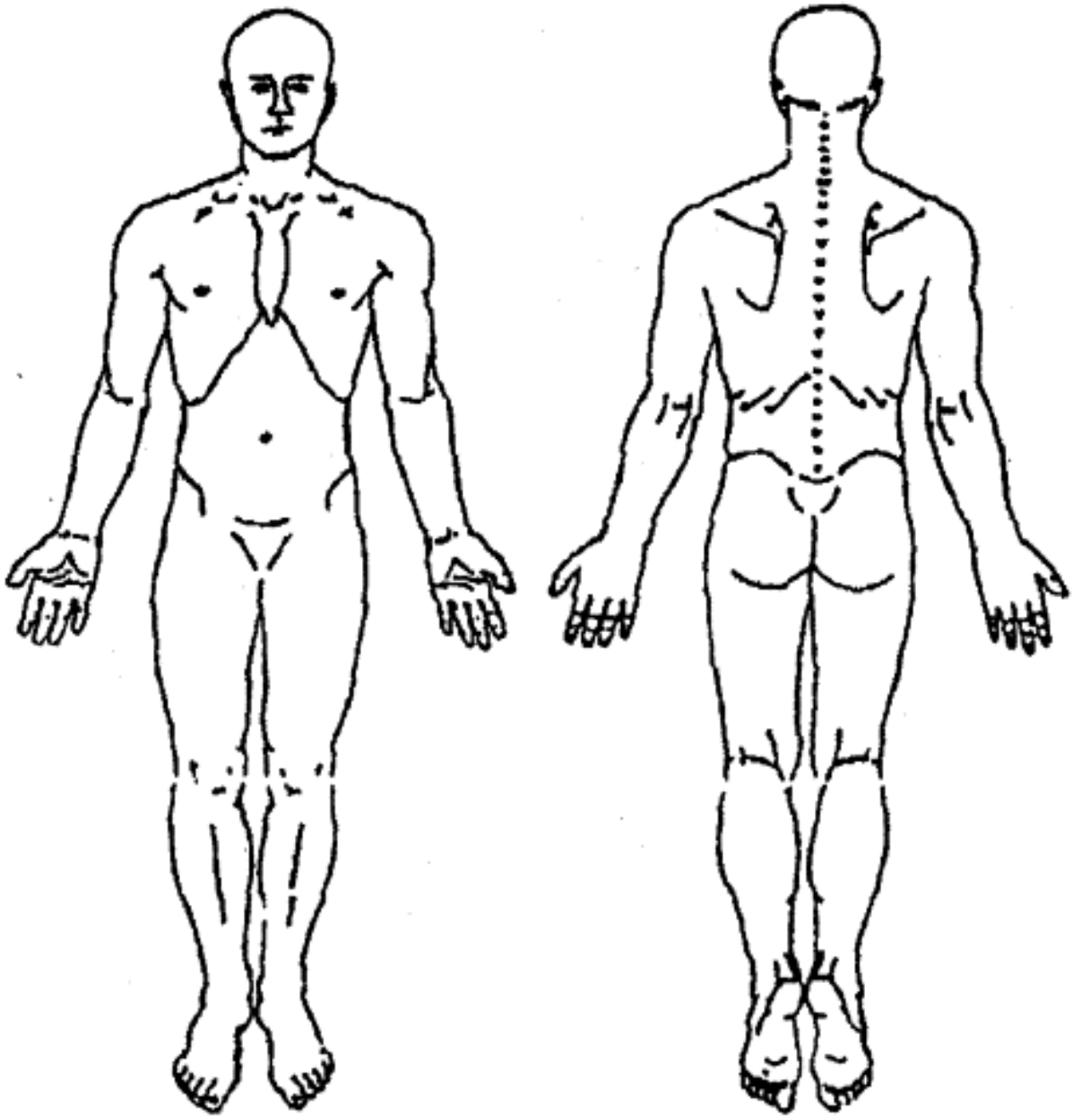
Decreased libido	Incontinence	Premature ejaculation
Dribbling urination	Increased libido	Testicular pain/swelling
Groin pain	Nocturnal emissions	Other:
Impotence	Painful urination	Other:

NAME:_____ DATE:_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	=====	OOOOO	XXX	/////	.....



LIFESTYLE

Please describe your diet:_____

Do you crave any particular foods? _____

Do you have food allergies/sensitivities? _____

Do you have regular mealtimes? _____ Do you eat on the go or while distracted? _____

Please indicate the frequency of the following:

	Yes	No	How much? How often?	Type
Coffee				
Tobacco				
Alcohol				
Water				Hot / Cold / Neutral temperature
Soda pop				Diet / Regular
Exercise				
Meditation/ Prayer				

Stress Level: LOW: 1 2 3 4 5 6 7 8 9 10 :HIGH

Source(s) of stressor(s): _____

How do you deal with stress? _____

Do you enjoy work? YES / NO Hours spent at work per week? _____

Hobbies: _____

Are you married or in a relationship? _____ Do you feel safe at home? _____

Children? YES / NO #_____ How old are they? _____

Do you have a happy home life? _____

Do you have any regular spiritual practices? _____

ASCENT WELLNESS PAYMENT POLICY

- I understand and agree that I am ultimately responsible for payment of my account balance, and that payment is required at time of service.
- I understand that Ascent is not an in-network insurance provider, and does not bill insurance. Ascent will provide a Superbill upon request that I may submit to my insurance company for reimbursement.
- Health Savings Accounts, and most Flexible Spending Accounts and VRBA Accounts may be utilized for acupuncture treatments. Ascent accepts cash, check, credit/debit cards, and the above-mentioned accounts.
- Ascent requests that you give 24 hours notice before cancelling or changing an appointment. If I cancel or reschedule less than 24 hours before my scheduled appointment, a $35 charge will be added to the balance of my next treatment. Emergency situations may be excluded at the discretion of the practitioner.

_____ _____

Client Signature Date

Ascent Wellness Informed Consent

Consent I hereby authorize my Licensed Acupuncturist (L.Ac.) to evaluate and treat according to the principles of Traditional Chinese Medicine; this authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Practitioner Qualifications All Licensed Acupuncturists (L.Ac.) possess at least a masters degree from an Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) accredited educational institution or program, and are certified by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM). Additionally, all Licensed Acupuncturists at Ascent Wellness are certified by the Minnesota Board of Medical Practice.

Scope of Practice Minnesota Law (Minnesota Statute Section 147B.06) defines Acupuncture practice as including, but not limited to, the following:

- Using Traditional Chinese Medical theory to assess, diagnose, and develop a plan to treat a patient in an attempt to improve overall body function and/or to relieve pain
- Using treatment techniques that may include: Insertion of sterile acupuncture needles through the skin, Acupuncture stimulation (including, but not limited to, electrical stimulation or the application of heat with moxabustion or heat lamps), Cupping, Dermal friction, Acupressure, Herbal therapies, Dietary counseling based on traditional Chinese medical principles, and Breathing techniques or exercise according to traditional Chinese medical principles

Possible side effects I understand that there are possible side effects to my treatment that are rare and may include the following: broken needles, minor pain or soreness in the treatment area, transient bruising, Infection, needle sickness (dizziness, nausea, fainting), sensations of heat, cold, tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue, gastrointestinal disturbance from herbal remedies, minor burns from moxibustion (heat stimulation)

Treatment Outcomes I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time.

Western Biomedical Diagnosis I understand that it is not within the scope of practice for acupuncturists to offer Wester medical (biomedical) diagnosis, and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

Payment I understand and agree that I am ultimately responsible for the balance on my account, and that all fees are payable at the time that service is received.

I HAVE / HAVE NOT (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the acupuncturist of the diagnosis.

I DO / DO NOT (circle one) have a pacemaker or bleeding disorder.

_____	_____
PATIENT WRITTEN NAME	WITNESS WRITTEN NAME
_____	_____
PATIENT SIGNATURE	WITNESS SIGNATURE
_____	_____
DATE	DATE

Ascent Wellness

Notice of Privacy Practices Acknowledgement and Consent

Ascent Wellness is committed to patient privacy and the confidentiality of personal health care entrusted to us. The ways in which we may disclose your health information are detailed in the Notice of Privacy Practices.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request Form.

Your Right to Request that Your Patient Record be Amended: You have a right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information Form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION . WITHOUT YOUR CONSENT, HOWEVER, ASCENT WELLNESS WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS, AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

BY SIGNING BELOW, I ACKNOWLEDGE RECEIPT OF THE ASCENT WELLNESS NOTICE OF PRIVACY PRACTICES.

_____	_____
PATIENT WRITTEN NAME	WITNESS WRITTEN NAME
_____	_____
PATIENT SIGNATURE	WITNESS SIGNATURE
_____	_____
DATE	DATE

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____