WELCOME!

Welcome to Flourish Acupuncture & Healing Arts! Your initial appointment will last 2 hours, with follow-up appointments lasting an hour to an hour and a quarter. While it is possible to get significant results after one or two treatments, most cases take longer. In general, the longer you have not been feeling well, the longer it takes to treat. I typically suggest starting your treatment plan with one treatment per week for 3 to 5 weeks, and then having an open discussion with you about continued treatments based on your progress and feedback. Once you are stabilized, it is suggested to come in for a "Tune Up" treatment with the change of each season. The idea is to get you in balance, and then keep you there. We will discuss your particular plan further during each treatment. For your comfort, we suggest wearing loose fitting, comfortable clothing during your session.

The cost of the initial treatment is $130, subsequent treatments are $110, plus the cost of any herbs or supplements if prescribed. Payment in the form of cash or check is preferred, though all major credit cards are accepted for your convenience.

If for some reason you need to change or cancel appointment times, please allow 24 hours notice. The Cancellation Fee within 24 hours is $50. Completely missing the appointment without any notification is charged the full amount of $110/$130. This allows for our best availability and care for all of our patients.

Should you have any questions, please contact us at (678) 622-0001. We look forward to meeting you!

In Wellness,

Tamara Clarke, L.Ac., Dipl. OM

PATIENT INTAKE FORM

Name_____Date_____

Birthdate_____Age_____Email_____

Address_____

_____

Preferred Phone_____ Alternate Phone_____

Emergency Contact Name/Number _____

Main Problem_____

When did it start?_____

Occupation_____Primary Care Doctor_____

Referred by_____

Past Medical History: (Please include dates)

Significant Illnesses: ___Cancer ___Diabetes ___High Blood Pressure ___Heart Disease
___Hepatitis ___Rheumatic Fever ___Thyroid Disease ___Seizures ___Other

Surgeries: _____

Significant Trauma: (auto accidents, falls, etc.)_____

Allergies (drugs, chemicals, foods):_____

Medicines taken within last 2 months (include vitamins, herbal supplements, etc.): _____

_____

Exercise:_____Stresses:_____

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other_____

Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma Allergies Alcoholism Other_____

General:

Poor Appetite	Heavy Appetite	Poor Sleep	Heavy Sleep
Insomnia	Fatigue	Tremors	Vertigo
Cold Hands	Cold Feet	Cold Back	Cold Abdomen
Fevers	Chills	Night Sweats	Sweat Easily
Cravings	Localized Weakness	Poor Coordination	Change in Appetite
Sudden Energy Drop	At _____(time)	Peculiar Tastes or Smells_____	
Strong Thirst (hot/cold drinks)_____		Bleed or Bruise Easily_____	

Skin & Hair:

Rashes	Ulcerations	Hives	Itching
Eczema	Pimples	Dandruff	Loss of Hair
Changes in Hair/Skin_____		Other Hair/Skin Problems_____	

Head, Eyes, Ears, Nose, & Throat:

Dizziness	Concussions	Migraines	Glasses
Eye Strain	Eye Pain	See "Floaters"	Night Blindness
Colorblindness	Cataracts	Blurry Vision	Earaches
Ringing in Ears	Poor Hearing	Nose Bleeds	Sinus Problems
Mucus	Dry Throat	Dry Mouth	Copious Saliva
Teeth Problems	Jaw Clicks	Grinding Teeth	Facial Pain
Gum Problems	Spots in Eyes	Recurrent Sore Throats	
Mouth/Lip Sores	Headaches	Other Head/Neck Problems_____	

Cardiovascular:

High Blood Pressure	Low Blood Pressure	Chest Pain	Irregular Heartbeat
Dizziness	Fainting	Cold Hands/Feet	Swollen Hands/Feet
Blood Clots	Stroke	Difficulty Breathing	

Respiratory:

Cough	CoughingBlood	Asthma	Bronchitis
Pneumonia	Difficulty Breathing When Lying Down		Tight Chest
Production of Phlegm (what color)_____			

Digestion:

Nausea	Acid Reflux	Vomiting	Bowel Movements:
Belching	Gas	Black Stools	Frequency_____
Bad Breath	Rectal Pain	Hemorrhoids	Texture/Form_____
Constipation	Watery Stool	Sensitive Abdomen	Blood?_____
Pain or Cramps	Laxative Use		Mucus?_____

Genito-Urinary:

Painful Urination Frequent Urination Urgent Urination Blood in Urine
Unable to Hold Urine Kidney Stones
Wake up to Urinate _____ times a night at _____(time)

Women's Health:

Number of Pregnancies_____Age at First Menses_____ Flow: Heavy or Light
Number of Births_____ Period (days)_____ Cycle Every____Days
Last PAP_____Vaginal Discharge Clots PMS
Menopause Breast Lumps Miscarriages Birth Control Type_____
Any discomforts of difficulties you would like to discuss?_____

Musculoskeletal:

Neck Pain Muscle Pains Back Pain (where)_____
Joint Pain (where)_____ Other joint or bone problems_____

Neuropsychological:

Seizures Areas of Numbness Poor Memory Concussion
Depression Anxiety Easily Angered Easily Stressed

Any treatment for emotional issues?_____

Other neurological or emotional issues?_____

Classical Questions

Preferences	Most Liked	Least Liked
Season	_____	_____
Taste	_____	_____
Climate	_____	_____
Time of Day	_____	_____
Temperature	_____	_____

Informed Consent for Treatment Procedures, Alternatives, and Risks

Tamara Clarke, L.Ac., Dipl. OM
(678) 622-0001

Acupuncture:

Acupuncture is the insertion of needles through the skin to adjust the body's energy. The goal is to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being. Side effects from acupuncture can include, but are not limited to: slight bruising, minor bleeding, fainting, and possible aggravation of symptoms. If any side effects are felt, it is important to contact me at (678) 622-0001. I encourage all patients to keep in contact with their Primary Care Physician at all times during the course of a treatment. There are many other medical alternatives to acupuncture, which include treatment by Primary Care Providers.

Moxibustion:

Moxibustion is the burning of an herb called mugwort. It is burned close to the skin either in its loose form or in the form of an herbal stick. It is used to warm and adjust the body's energy to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well being. Side effects can include, but are not limited to: reddening of the skin, risk of burn, risk of scarring, respiratory aggravation, and possible aggravation of symptoms. If any side effects are felt, please contact me.

Herbal Supplements:

Chinese herbs are used as remedies to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being. Side effects from herbs can include, but are not limited to: digestive complaints, headaches, and possible aggravation of symptoms. If any side effects are felt, you should discontinue the use of the herbs and call me to consult on the issue.

Massage:

I use two different types of massage in my practice, Japanese Zen-style Shiatsu, and Chinese Tuina. These types of massage are used to alleviate symptoms and to balance the body's energy. Side effects of massage can include, but are not limited to: bruising and soreness.

The treatment above has been explained to me, and I have had the opportunity to ask any questions I have regarding their application.

I understand that I may refuse any of these treatments, and discontinue treatment at any time.

Patient Signature: _____

Printed Name: _____

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: _____

CANCELLATION POLICY

At Flourish Acupuncture & Healing Arts your health and well-being are taken to heart. We set aside time especially for you to best address your personal needs.
Please be considerate and mindful of other clients needs by letting us know if you need to reschedule your appointment with as much notice as possible. This will allow others to benefit from this time if you are unable to make it.

The cancellation fee within 24 hours is $50. Completely missing your appointment without any notification is charged the full amount of $110/$130. Thank you for your understanding.

Patient Signature:_____

Print Name:_____

Date:_____

This Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

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 my office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our 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.

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 (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about these privacy guidelines, please call us during regular business hours at (678) 622-0001.

Sincerely,

Tamara Clarke, L.Ac., Dipl. OM
615 Green St. Suite 201
Gainesville, GA 30501
(678) 622-0001