
Please print and complete the following new patient forms and bring them to your first appointment.
To cancel or reschedule an appointment, please give at least 24-hours notice to avoid cancellation or no-show fees.

Lil Bush, Licensed Acupuncturist, MS

Open Monday through Friday from 8:00 a.m. – 5:00 p.m.
6075 S Quebec Street, Suite 102
Centennial, CO 80111
303-888-3783
lilbushacu@gmail.com

Lil Bush, Licensed Acupuncturist

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Centennial, CO 80111

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New Patient Intake Form

Name _____ Birth Date _____

Address _____ Age _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Marital Status _____ Children _____

Emergency Contact Name and Phone _____

Referred by _____ Email _____



Family Medical History (Grandparents, Parents, Siblings)

- Alcoholism Arteriosclerosis Diabetes Seizures
- Allergies Arthritis Heart Disease Spinal Disorders
- Asthma Cancer High Blood Pressure Stroke
- Other _____

Your Past Medical History

- Aids/HIV Depression Hypertension Rheumatic Fever
- Alcoholism Diabetes Measles Scarlet Fever
- Allergies Emphysema Multiple Sclerosis Thyroid Disease
- Anxiety Epilepsy Mumps TB
- Appendicitis Gout Pacemaker Typhoid Fever
- Arteriosclerosis Heart Disease Pleurisy Ulcers
- Asthma Hepatitis Pneumonia Venereal Disease
- Cancer Herpes Polio Whooping Cough
- Chicken Pox
- Other _____

Health Habits

Type and Frequency

- Alcohol _____ Coffee/Tea _____ Tobacco _____
- Drugs _____ Stress _____
- Regular Exercise _____ Soft Drinks _____

Patient's Name: _____

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New Patient Intake Form, Page 2

List with dates **all Surgeries, hospitalizations, serious injuries or illnesses.**

List **Allergies** (medicines, food, environmental)

List **Medications** currently taking and reason (include prescription, non-prescription, supplements, herbs, vitamins)

Medication(s)	Reason taking

Patient's Name: _____

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Notice of Privacy Practices

Effective Date: 3/1/05

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a place for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel, agents of the practice or your personal practitioner.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate reasonable requests but may have to communicate health information by alternative means or at alternative locations.

Uses and Disclosures

How we may use and disclose medical information about you.

The following categories describe examples of the way we use and disclose medical information.

For Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We may also provide other healthcare providers with copies of various reports that should assist them in treating you.

For Payment: We expect payment at the time the services are rendered but in the event you file an insurance claim, we may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

(Example)

"Since you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you for your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services received."

For Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

For Worker's Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

For Emergencies: We may disclose your health information to notify a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

For Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

For Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

For Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Patient's Name: _____

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Notice of Privacy Practices, Page 2

For Deceased Persons: We may disclose your health information to coroners or medical examiners.

For Organ Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

For Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

For Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

For Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs or other community based initiatives or activities our practice is participating in. As a courtesy to our patients, it is our policy to call your home, usually the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Your Health Information Rights:

Although your health record is the physical property of the practice practitioner or facility that compiled it, you have the right to:

- **Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this is medical and billing records, but does not include psychotherapy notes or other notes which we are legally forbidden to disclose. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial is reviewed.
- **Amend:** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. We may deny your request for an amendment and if this occurs, you will be notified of the reason for this denial.
- **An Accounting of Disclosure:** You have the right to request an accounting of the disclosures. This is a list of the disclosures we make of medical information about you.
- **Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you have requested.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes.
- **A Paper Copy of This Notice:** You have the right to a paper copy of the *Notice of Privacy Practice* at any time upon request.

Changes to this *Notice of Privacy Practices*: We reserve the right to amend this *Notice of Privacy Practices* at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this *Notice*.

Complaints: Complaints about how your Privacy rights have been handled by the practice should be directed to this office. If you are not satisfied with how this is handled, you may submit a formal complaint to The Secretary of the Department of Health and Human Services.

By way of my signature on the *Acknowledgement of Notice of Privacy Practices*, I have provided this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment and payment as described in the *Notice of Privacy Practices*.

Patient's Name: _____

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Informed Consent

I hereby request and consent to receive acupuncture and Oriental Medicine treatment for my present and future health condition. I understand that treatment will be administered by Lil Bush, Licensed Acupuncturist (LAc.). On occasion if Lil is not available, I may consent to treatment by Debbie Harrington, LAc. who is also associated with Greenwood Acupuncture and Family Wellness.

Acupuncture and Oriental Medicine Treatment That May Be Administered

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise. Other possible risks from acupuncture include dizziness and fainting. I will report to the LAc. any dizziness or light-headedness that occurs during or after a treatment. Extremely rare risks of acupuncture (these have an extremely low incidence,) include nerve damage, organ puncture and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries, infrequently; one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to use of herbs, I understand that I should stop the herbs and that I am responsible for informing the LAc. of my symptoms. Some herbs are inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP Lamp: This is used to warm and area of the body. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat. Mechanical cupping is applied without heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks are applied in one area. Slight bleeding at the area is likely.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

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 acupuncture and other procedures, and have had an opportunity to ask questions. I intend for 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.

Patient Name (please print)

Date

Patient's (or Legal Representative's) Signature

If a Legal Representative has signed, please print your name: _____

Patient's Name: _____

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Consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

Name _____ Birth Date _____

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations--and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

Patient's/Legal Representative's Signature Date Witness Signature

Office Use Only:

Accepted _____

Denied Signature Title Date

Patient's Name: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of Greenwood Acupuncture and Family Wellness. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Patient's/Legal Representative's Signature

Date

Office Signature

Date

Patient's Name: _____

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Welcome. I am a Practitioner of Traditional Chinese Medicine (acupuncturist/herbalist) licensed in the state of Colorado. I am Board Certified in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique. I earned a Master of Science Degree in Traditional Chinese Medicine (MS TCM) from the Colorado School of Traditional Chinese Medicine in Denver, Colorado. This 3½ year program consists of 2,475 hours of education including 1,080 hours of clinical practice. This training includes adjunctive therapies in moxabustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. None of the licenses, certificates or registrations has ever been suspended or revoked.

This office complies with the rules and regulations promulgated by the Colorado Department of Health. Only single use needles are utilized.

Office Policy

Initial Intake and Consultation and Treatment	\$80 + cost of herbs
Follow up Treatment	\$65 + cost of herbs
Herbal Consultation only	\$40 + cost of herbs
Initial Pediatric Intake	\$50 + cost of herbs
Pediatric Treatment (under 12)	\$40 + cost of herbs

Payment is expected at the time of service. MC, Visa, check or cash are accepted. If you have insurance that covers acupuncture, a receipt for your claim will be provided.

If you must cancel your appointment, please give at least 24-hours notice in order not to be billed for a missed appointment.

Patient’s Rights

1. The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known.
2. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
3. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of Registration, Colorado Department of Regulatory Agencies.
4. If you have comments, questions or complaints, contact the Acupuncture Licensure office 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone 303-894-7800.

I have read and understand this document.

Patient’s/Legal Representative’s Signature Date

Patient’s Name: _____