

Please Read First

Dear New Acupuncture Patient,

Thank you for making an appointment with me to begin improving your health with acupuncture. I congratulate you on your decision to take steps toward improved well-being. I look forward to working together to correct any imbalances that are presently causing your health challenges.

I would appreciate your careful consideration in answering the questions in the attached forms. By completing these forms with as much information as possible it will improve the accuracy of your assessment and allow us to have a more effective consultation. This reduces the need for extended consultation time and this subsequently saves you money and improves the care that I can provide for you.

Please fill out forms to the best of your ability and bring completed forms with you to your initial acupuncture consultation. If there are any questions you don't know how to answer, please leave them blank and we will discuss it at your appointment.

Acupuncture is unique in its approach to health. I practice acupuncture in the style of Classical Chinese Acupuncture. This type of acupuncture looks at the body as a whole and treats it accordingly to relieve symptoms and promote health and wellness. As looking at the body as a whole takes time, our first visit may involve acupuncture or may be assessment only depending on the complexity of your case. Acupuncture will start either in our first or second visit together.

In addition to being a Registered Acupuncturist, I am also a Naturopathic Doctor. If you are interested in exploring acupuncture as part of your treatment, this can be done either through my work as a Naturopathic Doctor or as my work as an Acupuncturist. Acupuncture can qualify for insurance reimbursement through either naturopathic benefits or acupuncture benefits depending on your benefit plan. In order to maximize your coverage from your benefits, before filling out this package of forms please check your benefit plan to ensure you have coverage for Registered Acupuncture. If you do not have any Registered Acupuncture coverage or you have both types of coverage, we recommend you fill out the Naturopathic New Patient forms rather than these forms. If you have coverage for Registered Acupuncture without available Naturopathic coverage or are an existing naturopathic patient at our clinic, please fill out this package of forms.

Thank you for your time in advance, and I look forward to working with you to achieve your optimum health.

***Dr. Carrie Meszaros, B.Sc., N.D., R.Ac.
Naturopathic Doctor & Registered Acupuncturist***

Acupuncture Patient Intake Form

Dr. Carrie Meszaros, N.D., R.Ac.

Date: _____

Name: _____	Age: _____	Date of Birth: _____
Address: _____	Occupation: _____	Home /Cell Phone: _____
City: _____	Weight: _____	Work Phone: _____
Postal Code: _____	Height: _____	Email: _____
Emergency contact: _____	Relationship: _____	Phone number: _____
Doctor: _____	Clinic: _____	Phone number: _____
Do you give us permission to send email and text reminders Yes No		
How did you hear about our clinic? _____		Do you want our e-newsletters (maximum of 3-4/year)? Yes No

What is your main concern? _____

What are your other concerns? _____

What seems to make you better? _____

What seems to make you worse? _____

Do you have any relevant or serious health conditions? _____

List any medications you are taking currently _____

List any allergies or sensitivities you have and the symptoms they cause:

Foods: _____

Drugs: _____

Environmental: _____

How many hours of sleep do you get? _____ Is it good quality? _____

Do you have any issues with falling asleep, waking through the night, restlessness, waking too early or trouble waking up in the morning (circle any that apply)?

What is your energy level (1-10): _____ When is your energy best? _____ When is it worst? _____

What is your stress level (1-10): _____ What do you do to relax? _____

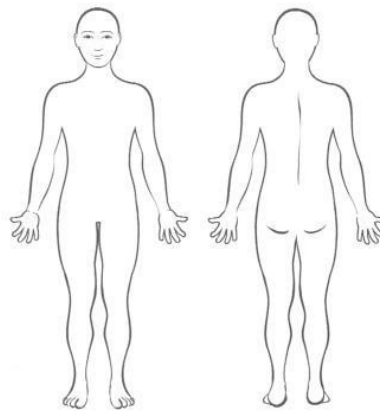
Do you have any issues with depression, anxiety, panic, irritability, anger, fear or other mood issues (circle any that apply)?

How frequent are your bowel movements? _____ (indicate per day or per week)

Do you have any issues with diarrhea, loose stools, constipation, straining or difficult bowel movements, gas, bloating, mucus in stool, blood in stool, or undigested food in your stool? (circle any that apply)

Do you have any issues with heartburn, reflux, excessive belching or vomiting? (circle any that apply)

Do you have pain? _____ Where, how intense (scale of 0-10), type of pain (mark on diagrams)? Provide additional information to the right of the diagrams, if desired.



Right side

Right side

History of major injuries/accidents/trauma/surgeries? Please describe: _____

Do you have headaches?: _____ If yes please describe frequency, intensity and location: _____

Family History (please circle all conditions that have affected you or members of your family)

Heart Disease

Diabetes

Stroke

Heart Attack

High Blood Pressure

Eczema

Allergies

Asthma

Inflammatory Bowel

Celiac

Other: _____

Cancer (what type?)

Have any of the following affected your health (currently or in the past)

HIV/AIDS

Fainting

Cancer

Bleeding disorders

Pacemaker

Stroke

Are taking blood thinners

Hepatitis

Heart Attack

Ring in the ears

Dry skin

Acne

Premature grey hair

Dry hair

Eczema

Dry throat/mouth

Hair loss

Psoriasis

Night sweats

Heart palpitations

Low libido

Hot flushes

Vaginal dryness

Excessive sweating

Sensitivity to heat

Sensitivity to cold

Anemia

Numbness/tingling

Muscle cramps

Low blood sugar

Any other information or concerns? _____

Women Only

Are you currently pregnant? Yes No If so, what is your due date: _____ How far along are you? _____

Are you currently trying to conceive? Yes No If so, how long have you been trying: _____

applicable, please indicate how many (#) of pregnancies _____ # of live births _____ # of miscarriages _____

Do you have periods? _____ How long is your cycle (i.e. 28 days) _____ How long is your flow? _____

Do you have any of the following issues associated with your period (circle all that apply): heavy flow, light flow, clots, spotting, PMS, pain, sore breasts, fibroids, endometriosis, fertility issues, bloating, ovulatory pain?

Registered Acupuncture Visits

*Initial Acupuncture Consultation (non-naturopathic patient) (60 min)	\$200
*Second Acupuncture Visit (for non-naturopathic patient) (45 min)	\$145
Acupuncture Treatment (without consultation up to 30 min)	\$ 85
Acupuncture with Consultation (up to 30 minutes)	\$105
Acupuncture with Consultation (up to 45 minutes)	\$145
Acupuncture with Consultation (up to 60 minutes)	\$185
Acupuncture Re-Assessment 45 min (18 months after last visit)	\$145

Naturopathic Visits (in person or phone/video visits)

Initial Consultation, adult and child patient (60 minutes)	\$200
Second Visit (45 minutes)	\$145
Extended Second Visit (up to 60 minutes)	\$185
Naturopathic Consultation (up to 30 minutes)	\$105
Naturopathic Consultation (up to 45 minutes)	\$145
Naturopathic Consultation (up to 60 minutes)	\$185
Naturopathic Consultation (up to 15 minutes)	\$ 60
Naturopathic Consultation (5 minute)	\$ 20
Naturopathic Re-Assessment 60 min(18 months after last visit)	\$185
Naturopathic Acupuncture Treatment (without consultation)	\$ 85
Naturopathic Acupuncture with Consultation (30 minutes)	\$105
Naturopathic Acupuncture with Consultation (45 minutes)	\$145

Services and Fees

Cancelled Appointment - with less than 48 hours notice	50% of scheduled visit
Missed Appointment - without notice	100% of scheduled visit

Patients that are currently naturopathic patients are exempt from the initial and second visit acupuncture assessments and will be booked instead for either a 30 or 45 minute acupuncture consultation for their first acupuncture visit. Reviewing supplement plans and recommendations and ordering or reviewing blood tests are naturopathic activities that are not within acupuncturist scope, if an acupuncture visit contains these activities the visit will be billed as either a naturopathic visit or a combination of naturopathic and acupuncture.

Within one business day of booking a new patient visit, \$100 deposit is required to finalize the booking (instructions on how to pay in your booking confirmation). This \$100 will be used toward payment for your first visit. If this deposit is not received within 48 hours of booking your appointment will be cancelled. Prior to 48 hours before a new patient booking this deposit can be transferred to a rescheduled appointment. Changes within 48 hours of a scheduled appointment will forfeit this deposit as per our cancellation policy.

We request a minimum of 48 hours notice if you cannot keep your appointment. Our answering machine and email are available during times when our office is closed. If you would like to reschedule 3 days or more before your appointment this can be done through our online booking. Adequate notice allows us to fill the time set aside for your appointment with a patient on our wait list. **Cancellations with less than 48 hours notice will be charged 50 % of scheduled visit cost. If your appointment is missed without a cancellation call or email you will be charged 100% amount of the visit.** We do understand extenuating circumstances might apply which may make 48 hours notice impossible and take these under consideration when enforcing our late cancellation policy (emergencies/illness/weather/unforeseen events).

Please note, if you arrive late for your appointment, only the balance of time that had been booked for you can be used and you will be charged for the full visit length. For the respect and convenience of our patients and for efficient operation of our clinic, we endeavour to keep scheduled appointments on time. However, complications and emergencies do arise and, in these circumstances, we appreciate your patience and understanding

Clarification emails or short phone calls (5 minutes or less) about existing treatment plans or to update us about significant health changes are encouraged without an associated fee. This would include clarifying instructions, reporting any new side effects associated with current treatment plans or any changes in prescription medications. Telephone consultations and emails that require lengthy responses are professional services and may be subject to a fee.

I have read and fully understood the above description of this fee schedule and office policies and I agree to honour it. In the case of a no show or last minute cancellation I accept the fees associated and authorize the charges. Fees for health services and supplements are due when services are rendered and may be paid by cash, cheque, Visa, MasterCard or Debit.

Patient's or guardian's signature _____ Dated _____

Consent to Collect and Release Information for The Naturopathic Care Centre

I, or my appointed representative, consent for The Naturopathic Care Centre to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations **in the event of an emergency or with my permission.**

In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life-threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used

Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist third party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

Acknowledgment

- I allow for medical personnel to use and disclose my information as outlined above.
- I understand that I can access my personal health information except as outlined above.
- I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used or disclosed if mandated by law.

Additional Comments or Restrictions:

Patient or Parent/Guardian Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____



Patient Informed Consent to Treatment for Acupuncture at The Naturopathic Care Centre

I, or the person listed below, have discussed with Dr. Carrie Meszaros N.D., R.Ac., the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles or moxibustion. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. Acupuncture is very safe but rarely can cause slight pain, light-headedness, headaches, nausea, soreness, bruising, bleeding or infection, and the very rare possibility of more serious medical consequences of needle punctures such as pneumothorax or nerve damage. As with any medical procedure there is also the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be paid in full at the end of each visit.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____

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