Dana Rogers, L.Ac, Dipl. OM

3000 S. Jamaica Ct., #210, Aurora, CO 80014
720-242-8272

# Welcome to Insight Health Center

To help us serve you better, please fill out the following pages in as much detail as possible.

## Contact Information

First Name: ____________________ Last Name: ______________________

Nickname: ____________________ Gender: Male _____ Female _____

Address: ___________________________________________________________

City: _________________________ State: ____________ Zip: ____________

Telephone – Preferred: ____________________ (circle one) Home Cell Work

Other: Home _____________________ Cell: ________________________

Work: _______________________ Date of Birth: _____________________

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? Yes _____ No _____

**We will not sell or give your email to any other agency.*

**Email Address:** ________________________________________

**Emergency Contact:**

Name: ________________________________________ Telephone: __________________

Relationship: ________________________________

**How did you learn about us?** (Please circle)

Friend or Family (name) ____________________________

Internet Search Facebook Radio

Physician (name) _________________________________

Our Website Sign holder Newspaper Walk-in

Insurance Company __________________________ Health Fair _______________________

Other ______________________________

# Acupuncture Patient Information

First Name ____________________ Last Name ____________________ Date ____________

Gender (Please circle): M F Date of Birth _________________ Age ________

Marital Status (Please circle): Single Married Partnered Separated Divorced

Place of Employment ___________________________ Occupation______________________

Who referred you to us? ___________________________________________________________________

**Chief complaint:** ____________________________________________________________________________
How long? ___________________________ How often: ________________________________
What caused this (accident, lifestyle, drug, etc.)? __________________________________________
Describe the worst it can be: ______________________________________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
___________________________________________________________________________________________________
Get temporary relief? ___________ Fixes problem? ________ Causes side effects? ________________
How does this affect your life? _______________________________________________
Affect your family? ________________________ Affect your sleep? _________________
Affect your work? ___________________________ Affect your hobbies? _____________
What is your goal/plan if the problem continues 5/10/20 years? ________________________

**Complaint #2:** __________________________________________________________________________________
How long? _____________________________ How often: ________________________
What caused this (accident, lifestyle, drug, etc.)? ___________________________________
Describe the worst it can be: ______________________________________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
__________________________________________________________________________________________________
Get temporary relief? _____________ Fixes problem? _______ Causes side effects? ____________
How does this affect your life? _______________________________________________
Affect your family? _______________________ Affect your sleep? __________________
Affect your work? _________________________ Affect your hobbies? _______________
What is your goal/plan if the problem continues 5/10/20 years? ________________________

**Complaint #3:** ________________________________________________________________________________
How long? _____________________________ How often: ________________________
What caused this (accident, lifestyle, drug, etc.)? ___________________________________
Describe the worst it can be: ______________________________________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
____________________________________________________________________________________________
Get temporary relief? _____________ Fixes problem? _______ Causes side effects? ____________
How does this affect your life? _______________________________________________
Affect your family? _______________________ Affect your sleep? __________________
Affect your work? _________________________ Affect your hobbies? _______________
What is your goal/plan if the problem continues 5/10/20 years? ________________________

**Other Complaints:** 4) ________________________________________________________________________

# COLORADO MANDATORY DISCLOSURE STATEMENT

**Insight Health Center**
**3000 S. Jamaica Ct #210**
**Aurora, CO 80014**
**720-242-8272**

Dana Rogers, L.Ac. received a Master's degree from Southwest Acupuncture College (a credentialed 48-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Dana is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice acupuncture in the state of Colorado and has been practicing since 2016. Dana is also trained as a massage therapist with over 15 years of experience and held licenses in Missouri, Kansas and New Mexico. Dana has not had any license, registration, or certification revoked or suspended.

This office complies with all rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized; and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

## Cash at Time of Service Fee Schedule

| | | |
|---|---|---|
| Initial Acupuncture Evaluation and Treatment | | $ 140* |
| Follow-up Acupuncture Treatment | | $ 80 |
| Prepaid Family Plans: | | |
| 5-visit package | ($25 savings) | $ 375 |
| 10-visit package | ($100 savings) | $ 700 |
| 20-visit package | ($300 savings) | $ 1300 |

*Coupons or other special discounts may apply.
Herbs are purchased separately.
Acupuncture qualifies for use with HSA Health Savings Account

## Patient's Rights

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies. The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: 303 894-7800.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

**Patient's Name (Please print):** ________________________________

________________________________ ____________________
**Signature of patient or legal guardian** **Date**

# Acupuncture
# Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

**Payment Practices**

Insight Health Center requires payment at the time of treatment, unless payment arrangements have been made in advance. Insurance documentation – "Super Bill" can be provided on request.

**Payment Agreement**

I authorize Insight Health Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to Insight Health Center. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Insight Health Center LLC. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

**Cancellation Notice**

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

**Patient's Name (Please print):** ______________________________

______________________________ ____________________

**Signature of patient or legal guardian** **Date**

# Acupuncture
# Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Insight Health Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Insight Health Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Insight Health Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Insight Health Center and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

## Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Insight Health Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Insight Health Center for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Insight Health Center may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Insight Health Center is not required to agree to the restrictions that I may request. However, if Insight Health Center has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

**Patient's Name (Please print): ____________________________________________**

______________________________________________ ________________

**Signature of patient or legal guardian** **Date**