



430 E. Avenida De Los Arboles #105, Thousand Oaks, CA 91360 • 805.768.4045 • EspirituAcuWellness@gmail.com

## PATIENT INFORMATION AND HEALTH HISTORY

### General Information (Please print)

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ GENDER \_\_\_\_\_ Marital Status: \_\_\_\_\_

### Emergency Information

CONTACT NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

CONTACT'S PHONE NUMBER \_\_\_\_\_

PRIMARY CARE PROVIDER'S NAME \_\_\_\_\_

CITY \_\_\_\_\_ PHONE NUMBER (if known) \_\_\_\_\_

TYPE OF CARE \_\_\_\_\_

SECONDARY CARE PHYSICIAN'S NAME(S) \_\_\_\_\_

### Cancellation Policy

Espiritu Acupuncture and Wellness requires that all scheduled appointments be given at least 24 hours notice of cancellation. Failure to provide at least 24 hours notice will be subject to the cancellation charge of \$50.00.

Initials of Participant or Guardian: \_\_\_\_\_

# MEDICAL HISTORY QUESTIONNAIRE

What is your main reason for making this appointment?

When was your last medical exam or check up?

Who referred you to acupuncture?

	<u>Yes</u>	<u>No</u>	<i>Please explain any answer:</i>
Have you had acupuncture before?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have the tendency to faint?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have Hepatitis A, B, C, D, E?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you HIV+?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you believe you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any traumas?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please further explain any of the answers above:

## Family Medical History

Please indicate if any of your blood relatives **now have** or **have had** any of these conditions?

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Fainting     |
| <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Paralysis           | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest pain/discomfort  | <input type="checkbox"/> Heart murmurs           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Obesity      |
| <input type="checkbox"/> Respiratory disorders  | <input type="checkbox"/> Dizziness/vertigo       | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Excessive Fatigue      | <input type="checkbox"/> Bleeding disorders      | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Anemia       |

## Physical Activity History

Please indicate the type and amount of exercise or activity that you do regularly. (What, how long, how often)

## Dietary Habits

Please describe how you typically eat. (What, when, how often, food allergies, cravings)

# GENERAL MEDICAL HISTORY

Please indicate if you have now or have any of these conditions by marking with a "C" for current and a "P" for past.

<p><b><u>Head and Neck</u></b></p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Enlarged Lymph glands</p> <p><input type="checkbox"/> Headaches</p> <p>Other _____</p> <p><b><u>Ears</u></b></p> <p><input type="checkbox"/> Infection</p> <p><input type="checkbox"/> Ringing</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Pain</p> <p>Other _____</p> <p><b><u>Eyes</u></b></p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Changes in vision</p> <p><input type="checkbox"/> Poor night vision</p> <p><input type="checkbox"/> Spots or floaters</p> <p><input type="checkbox"/> Inflammation/stys</p> <p>Other _____</p> <p><b><u>Nose/throat/mouth</u></b></p> <p><input type="checkbox"/> Bleeding</p> <p><input type="checkbox"/> Sinus infections</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Changes in taste</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Changes in smell</p> <p><input type="checkbox"/> Ulcers/Canker sores</p> <p><input type="checkbox"/> Sore/bleeding gums</p> <p><input type="checkbox"/> Toothaches</p> <p><input type="checkbox"/> Teeth problems</p> <p>Other _____</p> <p><b><u>Skin</u></b></p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Night sweat</p> <p><input type="checkbox"/> Excess sweating</p> <p><input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> Bruise easily</p> <p>Other _____</p>	<p><b><u>General</u></b></p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Thirst</p> <p><input type="checkbox"/> Changes in appetite</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Aversion to cold</p> <p><input type="checkbox"/> Aversion to wind</p> <p><input type="checkbox"/> Frequent dreams/nightmares</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Agitation</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> History of psychiatric treatment</p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Difficulty concentrating</p> <p><input type="checkbox"/> Sores that don't heal</p> <p><input type="checkbox"/> Surgical implants</p> <p><input type="checkbox"/> Unusual bleeding or discharges</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Epstein Barr (EBV) or Mononucleosis (Mono)</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Thyroid disorder</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Lupus</p> <p>Other _____</p> <p><b><u>Neurological</u></b></p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Epilepsy/convulsions</p> <p>Other _____</p> <p><b><u>Infection History</u></b></p> <p><input type="checkbox"/> Staph</p> <p><input type="checkbox"/> MRSA</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Genital warts</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> TB</p> <p>Other _____</p>	<p><b><u>Gastrointestinal</u></b></p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> IBS</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Bowel movement changes</p> <p><input type="checkbox"/> Frequent diarrhea</p> <p><input type="checkbox"/> Frequent constipation</p> <p><input type="checkbox"/> Dry hard stools</p> <p><input type="checkbox"/> Soft sticky stools</p> <p><input type="checkbox"/> Loose stools</p> <p><input type="checkbox"/> Bloody stools</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> Peptic ulcer</p> <p><input type="checkbox"/> Recent changes in weight</p> <p><input type="checkbox"/> Food cravings</p> <p>Other _____</p> <p><b><u>Cardiovascular</u></b></p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Chest pain or tightness</p> <p><input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Stroke</p> <p>Other _____</p> <p><b><u>Respiratory</u></b></p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Coughing up phlegm</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Wheezing/asthma</p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> COPD</p> <p>Other _____</p>	<p><b><u>Women</u></b></p> <p><input type="checkbox"/> Frequent vaginal infections</p> <p><input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Pain/itching of genitals</p> <p><input type="checkbox"/> Genital lesions/discharge</p> <p><input type="checkbox"/> Pelvic inflammatory disease</p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Irregular periods</p> <p><input type="checkbox"/> Emotional changes with menses</p> <p><input type="checkbox"/> Clots in menses</p> <p><input type="checkbox"/> Painful menstrual cramps</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> PCOS</p> <p><input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> Breast lumps/cysts</p> <p><input type="checkbox"/> Breast swelling/pain</p> <p>Other _____</p> <p>When was your last period? _____</p> <p>How many days between periods? _____</p> <p>Color? _____</p> <p>Clots? _____</p> <p><b><u>Men</u></b></p> <p><input type="checkbox"/> Pain/itching of genitals</p> <p><input type="checkbox"/> Genital lesions/discharge</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Prostate problems</p> <p><input type="checkbox"/> Infertility</p> <p>Other _____</p> <p><b><u>Urinary</u></b></p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Frequent UTI</p> <p><input type="checkbox"/> Weak stream</p> <p><input type="checkbox"/> Changes in bladder habits</p> <p><input type="checkbox"/> Kidney disease</p> <p>How many times do you urinate per day? _____</p> <p>How many times do you urinate at night? _____</p> <p>Other _____</p>
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Please explain any situation above:

Do you have any other condition not listed above? **Yes / No** If yes, please state:

# MUSCULOSKELETAL MEDICAL HISTORY

Please indicate if you have any of these conditions by marking with a "C" for current and a "P" for past.

## General

- Chest pain/discomfort
- Chest Pain with cough
- Pain when coughing
- Pain in the ribs
- Epigastric Pain
- Lower abdominal Pain

## Shoulder

- Pain L/R (circle one)
- Pain with movement
- Pain with overhead movement
- Loss of movement
- Shoulder "gives out"
- Swelling
- Frozen shoulder
- Dislocation
- Tendonitis
- Bursitis
- Rotator cuff

Other \_\_\_\_\_

## Hands/Wrist

- Cold/Hot hands
- Numbness/Tingling
- Loss of grip strength
- Pain with movement
- Swelling
- Carpal tunnel
- Arthritis

Other \_\_\_\_\_

## Abdomen

- Hernia
- Tenderness
- Belly button pain when coughing or sneezing

## Upper/Mid Back

- Pain when lifting
- Pain while standing
- Pain while twisting
- Pain as you stand up
- Disk problems
- Degenerative disc
- Herniated
- Stenosis
- Scoliosis
- Spinal fusion

Other \_\_\_\_\_

## Knee

- Pain L / R (circle one)
- Swelling or redness
- Pain with movement
- Loss of flexibility
- Pain bearing weight
- Pain going down stairs
- Pain going up stairs
- Pain or stiffness after sitting for long periods
- Stiff when getting out of bed
- Knee gives out or locks
- Grinding noise or feeling
- Stiff when getting out of bed
- Knee Replacement **L / R**
- Meniscus
- ACL / PCL / MCL
- Tendonitis
- Bursitis

Other \_\_\_\_\_

## Arms/Forearms/Elbow

- Cold/Hot hands
- Numbness/Tingling
- Loss of strength
- Loss of movement
- Pain with movement
- Tennis or golfer's elbow
- Psoriasis
- Arthritis
- Fractures or breaks
- Dislocation

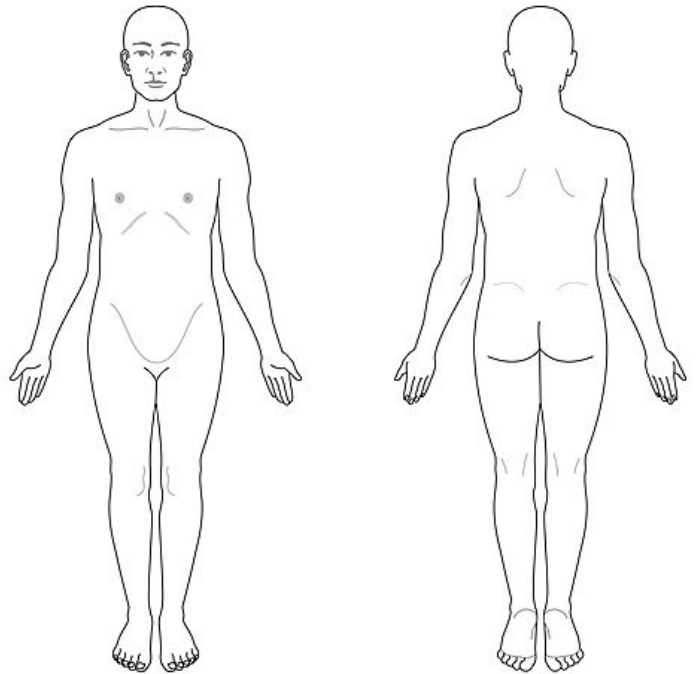
Other \_\_\_\_\_

## Low Back

- Sudden pain
- Pain comes on when constipated
- Pain as you defecate
- Pain radiates to groin
- Pain worse in morning
- Stiff when getting out of bed
- Unable to twist/turn at waist
- Degenerative disc
- Pinched nerves
- Stenosis
- Sciatica
- Herniated
- Spinal fusion

Other \_\_\_\_\_

Please mark with an "X" where you **currently** have pain.



Rate your pain (circle one)  
(Mild) **1 2 3 4 5 6 7 8 9 10** (Severe)

Quality of pain (circle one)  
**Dull Achy Sharp Burning Stabbing Numb**  
**Radiating Tingling Cramping Other**

## Neck

- Pain with movement
- Pain with tilting
- Pain with twisting
- Whiplash
- Loss of flexibility
- Stiff getting out of bed
- Stiff neck
- Grinding/popping noise
- Degenerative disc
- Pinched nerves
- Stenosis
- Herniated
- TMJ
- Spinal fusion

Other \_\_\_\_\_

## Hips/Pelvis/Legs

- Hernia
- Fractures or breaks
- Dislocation
- Hip Replacement
- Groin pain with coughing
- Stiff when getting out of bed

Other \_\_\_\_\_

## Feet/Ankles

- Psoriasis
- Numbness/Tingling
- Sprained ankle
- Arthritis
- Achilles tendonitis
- Fractures or breaks

Other \_\_\_\_\_

Please further explain any situation stated above:

Do you have any other condition not listed above? Please explain:

# MEDICATIONS

Please list all medications, herbal supplements, nutritional supplements, or vitamins and minerals that you take regularly as well as the reason why you are taking them.

Date:	Medication:	Reason:	Dose and How often:		Date of last dose:	Prescribed by:	Start date:
_____	_____	_____	_____	_____	_____	_____	_____
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# NOTICE OF PRIVACY POLICIES

This office is dedicated to providing services for your health and protecting your privacy. This notice will remain in effect until it is replaced or amended by changes in the law.

Personal Information is gathered from you in the following ways:

- Information received from you.
- Information received from other healthcare providers.

This information is used for the purposes of treatment, payment and healthcare operations. This office will use and disclose information about you only for those purposes.

You may specifically authorize us to use protected health information (PHI) for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any entity that you choose to have your protected health information.

## Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters or appointment reminders, by telephone, email, or mail. Please inform us if you do not want us to contact you for any of the above reasons. We do **NOT** sell your information or share your information with unrelated companies.

## Disclosure

This office may use or disclose your PHI when required by law.

## Patient Rights

Upon written request, you have the right to access, review, or receive copies of your healthcare records. For paper copies there is a copy fee of \$0.25 per page and this office will need 10 working days to process it. Upon written request you have the right to receive a list of items this office has disclosed. You have the right to request that this office place additional restrictions on disclosure of your PHI. You have the right to request that we amend your PHI; this request must be submitted in writing. You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact the office. Send written complaints to the U.S. Department of Health and Human Services.

## Acknowledgement of Receipt of the Notice of Privacy Practices

I, (print full name) \_\_\_\_\_, have read, reviewed, understand and agree to the statement of the Notice of Privacy Policy for healthcare services in this acupuncture office, Espiritu Acupuncture and Wellness.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_ **AM / PM**  
**Time**

\_\_\_\_\_  
**Print Name**

**Description of Personal Representative's Authority:**

\_\_\_\_\_

# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (print full name) \_\_\_\_\_, with my consent, Espiritu Acupuncture and Wellness may use and disclose my protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) when applicable. Please refer to Espiritu Acupuncture and Wellness' Notice of Privacy Practices for a more complete description of such uses and disclosures.

The PHI is any information that includes, but is not limited to:

- Demographics information.
- Information gathered by this practice as it relates to my past, present, and future physical or mental health.
- Information gathered by this office for past, present, and, future payments for providing healthcare services.
- Healthcare operations purposes will include quality assessment activities, business management and other general operations, procedures, or activities.

I have the right to review and have read the Notice of Privacy of Practices prior to signing this consent. Espiritu Acupuncture and Wellness reserves the right to revise its Notice of Privacy of Practices at any time.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may call my home or any other designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments, and any call pertaining to my clinical care, including laboratory results amongst others.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may mail to my home or any other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are clearly marked personal and confidential.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may email me appointment reminders and patient statements. I have the right to request that Espiritu Acupuncture and Wellness or any of its agents restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Espiritu Acupuncture and Wellness or any of its agents to use and disclosure of my PHI to carry out TPO.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Espiritu Acupuncture and Wellness or any of its agents may decline to provide me treatment.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_ **AM / PM**  
**Time**

\_\_\_\_\_  
**Print Name**

**Description of Personal Representative's Authority:**

\_\_\_\_\_

## OFFICE POLICIES SUMMARY

Welcome to Espiritu Acupuncture and Wellness. Our goal is to make you comfortable and give you the best care possible. At any time, please do not hesitate to ask any questions that you might have regarding your visit, your billing, or about any of our policies.

**FEES** The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We except cash, credit cards, and personal checks. Please note, there will be a \$25 charge for any returned check.

Initials: \_\_\_\_\_

**CANCELLATIONS** As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a \$50.00 fee for any missed appointment or any cancellation with less than 24 hours notice.

Initials: \_\_\_\_\_

### FINANCIAL AGREEMENT ASSIGNMENT OF BENEFITS

I, (print your full name) \_\_\_\_\_, am receiving or about to receive healthcare services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services and/or coinsurance/co-pays associated with my office visit. In addition, I also authorize insurance payments of medical benefits to Espiritu Acupuncture and Wellness.

By signing below, I agreed to comply with the office policies stated above which I have read and understood. I also authorize the use of my signature below on all insurance submissions.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_ AM / PM  
Time

\_\_\_\_\_  
Print Name

Description of Person Representative's Authority:  
\_\_\_\_\_



## **Informed Consent** (Please Read)

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient name above, for whom I am legally responsible) by an acupuncturist of Espiritu Acupuncture and Wellness and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back up for the Espiritu Acupuncture and Wellness, including those working at this clinic or office listed below or any other office of clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, tuina (Chinese massage), ear acupuncture/stimulation, Chinese medicine, Chinese herbal medicine, corrective exercises and methods and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the site that may last for a few days, and dizziness or fainting. The possible but unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles, seeds and instruments and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, diarrhea, rashes, hives and tingling of the tongue in addition to many others. I will notify the clinical staff member who is caring for me if I become pregnant or suspect that I may be pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks, complaints and/or complications of treatment, I wish to rely on the clinic staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand the results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but that all of my records will be kept confidential and will not be released without my written consent.

In addition to being treated at Espiritu Acupuncture and Wellness, I may also understand that I may be treated in the public space. Although, I will be receiving treatment in a public place, I understand that the acupuncturist will take all reasonable measures under the circumstances to maintain my privacy. However, I acknowledge and accept that my privacy cannot be guaranteed.

My photographic/video images, and/or testimonial may be used for: Social media and/or advertising. I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purpose by Espiritu Acupuncture and Wellness. I understand that the information disclosed pursuant to this authorization may be subject to disclosure and may no longer be protected by HIPPA privacy regulations. I understand that this authorization may be revoked at any time, but such revocation must be in writing and received by the practice via registered mail. Any revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from signing date.

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 I've had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

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Signature of Patient or Parent/Legal Guardian

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Date

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Printed Name of Patient or Parent/Legal Guardian

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Relationship to Patient