WELCOME TO WELLSPRING NATURAL HEALTH
CONTACT INFORMATION

First Name: _____ Last Name: _____

Nickname: _____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Preferred: _____ (circle: Home Cell Work)

Other: Home _____ Cell: _____

Work: _____ Date of Birth: _____

Do we have your permission to send 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) _____ Website Newspaper
Walk-in_____ Health Fair _____ Other _____

MISSION STATEMENT

Wellspring Natural Health provides information, education, and access to complementary health services for people seeking wellness. Wellspring Natural Health connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

An acupuncturist in the state of Colorado is not licensed to prescribe pharmaceutical drugs or make medical diagnoses. If you want to treat a condition that is currently medicated we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency condition. If the patient decides they want to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so.

Signature: _____ **Date**: _____

Welcome to Wellspring Natural Health! I am thrilled that you are taking the time to make a change in your health! It is great that you are coming to me now because you deserve a healthier, more balanced life. Are you tired of experiencing pain and stress? Are you ready to feel energy and enthusiasm again about your favorite activities? Acupuncture and Chinese medicine can get you back on top of your game!

Relief

I specialize in helping professionals who may have gotten their dream job and later find it hard to continue their favorite activities because of back pain or injury. It can be depressing if you don't have the energy for your favorite activities in your free time. I help professionals get relief and love their lives again!

The Process

The process typically includes an initial appointment of 1.5hrs that includes a detailed health history, evaluation, acupuncture treatment, and treatment plan. All subsequent visits last one hour and include a re-evaluation and acupuncture treatment.

Clients usually come to my office once or twice weekly for one month to start achieving results. A simple condition may require 5 acupuncture visits, while more complicated and chronic conditions may require 6 months to a year of treatment.

Challenges

Common obstacles that clients face during treatment are committing to the dietary and lifestyle changes needed in order to experience optimal health, consistency in taking prescribed herbal medicines, and finding time for acupuncture treatments.

Solutions

I like to help my clients overcome those obstacles and get the most out of our work together by offering appointments on some weekday evenings, and all day Sunday. During our appointments, I am happy to offer support and guidance to help you move swiftly towards your health care goals. For most individuals, a series of treatments is needed, and there tends to be a slump in results around the 2-3rd treatments. On occasion, symptoms may become aggravated before they get better. This is completely normal and it is important to stay motivated and on track during this time so that you will see the results you want in a few weeks. I look forward to working with you and helping you love your life again!

Results

The goal of holistic medicine is to address the root cause of dis-ease, in order to restore health and eliminate symptoms. Because the body needs time to heal (this will vary depending on the severity of the issue) the process can take a few weeks to months of continued care in order to achieve the desired results. You will start to feel relief before your care is complete, and in order to maintain results, it is best not to discontinue treatment before your recovery has stabilized. That said, the body has an immense capacity to heal itself, and most people are amazed by their potential for health!

Acupuncture Patient Information

What results do you hope to achieve by working with an acupuncturist?_____

_____

Have you ever had acupuncture before? If yes, where/with who? _____

_____

What was your experience like?_____

_____

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? _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those that you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

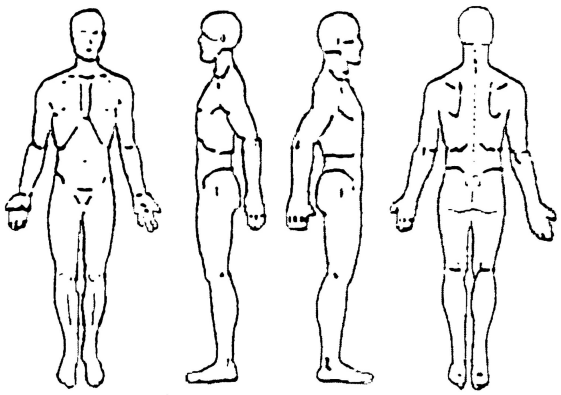
Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other: _____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other: _____

☐ Sharp ☐ Burning ☐ Aching
Other: _____
☐ Fixed ☐

Notes: _____

_____

_____

_____

PLEASE fill this form out completely, even if it does not seem applicable to your condition.

SYMPTOMS – **NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

BODY TEMPERATURE

Please check all the apply:

_____ Cold entire body
_____ Cold extremities
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

ENERGY LEVEL – *Please circle:*

Low 1 2 3 4 5 6 7 8 9 10 High

Georgia Carr, LAc

Georgia Carr received a Master's degree from the Oregon College of Oriental Medicine (a credentialed 44-month program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Georgia 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 acupuncture since 2011. Georgia has not had any license, registration or certification revoked or suspended.

COLORADO MANDATORY DISCLOSURE STATEMENT
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Wellspring Natural Health
Georgia Carr, L.Ac.

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.

Payment at Time of Service Fee Schedule

Initial Acupuncture Evaluation and Treatment	$125*
60 min Follow-up Acupuncture Treatment	$90
90 min Extensive Follow-up Acupuncture Treatment	$125
30 min Cupping Session	$45
30 min Guasha Session	$50

*Coupons or other special discounts may apply.
Herbal medicine is sold separately.
A 20$ preparation and handling fee will apply to personalized herbal formulas.

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 Agreement

I authorize Wellspring Natural Health to release any information needed to an attorney if required. I also authorize my medical provider to release my medical records to Wellspring Natural Health. 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 Wellspring Natural Health. 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 miss their appointments or fail to cancel 24 hours in advance may be charged in full 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 Wellspring Natural Health, or you can file a written complaint with the U.S. Department of Health and Human Services. Wellspring Natural Health 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.

Wellspring Natural Health 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 Wellspring Natural Health 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 to Treatment

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 Wellspring Natural Health. 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 Wellspring Natural Health 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 Georgia Carr, LAc 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. Wellspring Natural Health is not required to agree to the restrictions that I may request. However, if Wellspring Natural Health agrees to a restriction that I request, the restriction is binding on Wellspring Natural Health. I have the right to revoke this Consent, in writing, at any time, except to the extent that Wellspring Natural Health 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**

Email Communication Consent

At times, Georgia Carr uses email to correspond with patients regarding their health condition as a convenience. However, these emails are not encrypted and could theoretically be read by an outside party with the technical skills to intercept such correspondences. By initialing this section, you consent to allow Georgia to correspond with you via email despite these potential risks. _____

Financial Policy for Patient Care Services

Wellspring Natural Health wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1) Provide us with accurate and updated information on yourself.
2) Pay at the time of service for your entire balance.

Insurance

Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

I authorize Wellspring Natural Health 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 Wellspring Natural Health. 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 hereby authorize my insurance benefits to be paid directly to Wellspring Natural Health. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Wellspring Natural Health. I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to Wellspring Natural Health for any reason within a reasonable time (as determined by Wellspring Natural Health). 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.

Self-Pay Patients:

At this time, Wellspring Natural Health is in network with Cigna and United Health Care. For all others a super bill may be provided upon request. At this time you will be considered a “self-pay” patient. If you have a financial hardship, an application for financing or a financial hardship discount must be completed before or at the time of service.

Cancellation Policy:

In order to provide you with the best care, please arrive 10 minutes prior to your appointment—late arrival of 15 minutes or more may result in cancellation. We require 24 hours’ notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:

Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account over to a collections agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees. The responsibility for payment of medical services for you or your dependents is yours; due and payable at the time services are rendered unless financial arrangements have been made. You are responsible for all costs of collection, including attorney fees, collection fees, and court costs. Any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

Payment Options:

Payment may be made by cash, check, credit card, HSA or FSA cards.

_____

Patient’s Name (please print)

_____ _____

Responsible Party or Authorized Person Signature Date

_____ _____

Wellspring Natural Health Signature Date