

Jessica Tatieze, LAC, MAOM
Tel: 503-683-2138. Fax: (503) 459-4709
12732 SE Stark St, Plaza 125 Bldg G, Portland, OR 97233

Patient's Name _____ Age _____ Sex _____ Date _____ Tx _____

Chief complaints:

I. Subjective:

II. Objective:

III. Assessment:

IV. Plan:

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Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine. I understand that licensed acupuncturists practicing in Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

ACUPUNCTURE: I understand that acupuncture is performed by the insertion of needles at certain points on the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent perception and to normalize the body's physiological functions.

I have been made aware that certain side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

ELECTRO-ACUPUNCTURE: I understand that I may be asked to have electro-acupuncture administered with acupuncture, which will increase ACTH and cortisol levels in our bodies naturally to reduce inflammation and pain.

I have been made aware that certain adverse side effects may result which may include, but are not limited to: electric shock, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

TUINA/ACUPRESURE/MASSAGE: I understand that I shall also be given tuina massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions.

I have been made aware that certain side effects may result from this treatment. These could include, but are not limited to: muscles soreness and the possible aggravation of symptoms existing prior to the treatment.

CHINESE HERBS: I understand that I shall be asked to take Chinese herbs to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I decide to take them.

I have been made aware that certain side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Dr. Lu as soon as possible.

SCHEDULED APPOINTMENTS: I understand that if I am unable to make an appointment I should call the clinic that I won't be coming 24 hours before the appointment. Otherwise I will be charged \$15 for missing the appointment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I have also been asked if I want a more detailed explanation given to me and do not want more information. I give my permission and consent to my treatment.

I understand that no guarantees concerning the use and effectiveness of acupuncture and Oriental medicine are given to me and that I am free to stop treatment at any time.

Signature: _____ Date: _____

Printed Name: _____

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HIPAA Patient Consent Form Effective date: 04/15/2003

I, _____, consent to the use or disclosure of my protected health information by Yan Lu, LAc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Yan Lu, LAc.

I understand that diagnosis or treatment of me by Yan Lu, LAc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Yan Lu, LAc. is not required to agree to the restrictions that I may request, however, if Yan Lu, LAc. agrees to a restriction that I request, that restriction is binding.

“ Protected health information” means health information, include my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Yan Lu, LAc’s Notice of Privacy Practices prior to signing this document. Yan Lu, LAc’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Yan Lu, LAc..The Notice of Privacy Practices also describes my rights and the duties of Yan Lu, LAc. with respect to my protected health information.

Yan Lu, LAc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices contacting the HIPPA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Yan Lu, LAc. reserves the right to leave a message on the patient’s home answering machine/recorder. As the patient, I consent to this right.

I understand that if I, the patient, refuses to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient will be responsible for the entire bill and will be billed accordingly.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative (print)

Description of Personal Representative Authority

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All information on this form is considered strictly confidential and will not be released without patient's consent

PERSONAL INFORMATION

Name _____ DOB _____ Age _____

Address _____ City/State/Zip _____

SSN _____ Employer _____

Daytime Phone _____ Evening Phone _____

Emergency Contact (Name, Phone) _____

FINACIAL INFORMATION

I understand that payment is expected at the time of services. An itemized statement will be provided to enable collection on an insurance claim.

Signature _____ Date _____

PREVIOUS HEALTHCARE

Previous surgeries _____

Dates _____ Where _____

Presently Prescribed Medicines _____

Presently Unprescribed Drugs/Natural Medications _____

Known Allergies _____

PRESENT ILLNESS

Symptom or Condition _____

Duration of Condition _____ Treatment Received _____

Are any of these conditions related to your employment? Yes No

HEALTH HISTORY

Please indicate by circling whether you or anyone in your family has ever had:

- | | | |
|------------|---------------|---------------------|
| ALCOHOLISM | DIABETES | HIGH BLOOD PRESSURE |
| ALLERGIES | GOUT | PNEUMONIA |
| ARTHRITIS | HEART DISEASE | RHEUMATIC FEVER |
| CANCER | HEPATITIS | TUBERCULOSIS |

Please indicate by circling whether you currently have:

- | | |
|--------------------------|------------------------------------|
| MUSCULAR SKELETAL | CONSTIPATION |
| ABDOMINAL PAIN | BLACK STOOL |
| JOINT PAIN | LIVER PROBLEMS |
| WEAK MUSCLE | GALL BLADDER PROBLEMS |
| NEUROLOGIC | GEN-URIN SYSTEM |
| NUMBNESS TINGLING | FREQUENT URINATION |
| DIZZINESS | PAIN IN URIANTION |
| FAINING | SCANTY URINATION |
| HEADACHE | BLOODY URINATION |
| CONFUSION | MENSTRUAL PROBLEMS |
| DEPRESSION | PRE-MENSTRUAL SYNDROME |
| FATIGUE | VAGINAL DISCHARGE |
| HEART AND LUNGS | BREAST LUMP |
| CHEST PAIN | EYES, EARS, NOSE AND THROAT |
| SHORTNESS OF BREATH | EAR PAIN |
| CHRONIC COUGH | HEARING LOSS |
| COUGHING UP BLOOD | VISON PROBLEMS |
| RAPID HEART RATE | SINUS PROBLEMS |
| HIGH BLOOD PRESSURE | NOSE PROBLEMS |
| LOW BLOOD PRESSURE | SORE THROAT |
| DIGESTIVE SYSTEMS | HORSENESS |
| POOR APPETITE | PREVENTIVE HEALTH |
| EXCESSIVE THIRST | SMOKING |
| NAUSEA | HEIGHT/WEIGHT _____ |
| VOMITING | EXERCISE _____ |
| BLOODY STOOL | |
| DIARRHEA | OTHER _____ |

Name/phone No./address of your referral physician (or primary care physician)

How did you hear about Jessica Tatize? _____