

## **New Patient Information**

Brynn Graham, L.Ac., 925 NW Davis, Portland, OR 97209 503-525-9642

Thank you for choosing our clinic for your health care needs. To help make your experience with us as comfortable as possible, we have prepared the following list of frequently asked questions for you to read before your first visit.

The purpose of this clinic is to assist each individual in achieving their optimum health. Traditional Chinese Medicine, which primarily includes acupuncture and Chinese herbs, offers an approach that may differ from other methods but is complimentary to other medical approaches. We will work closely with you, as well as any other health care providers you may have in order to accomplish our stated purpose. If at any time you should have any questions regarding your health care, please do not hesitate to ask.

Q: Do I need to bring anything with me for my first visit to the clinic?

A: Yes. Please fill out ahead of time and bring the enclosed forms with you to your appointment. All information will be kept strictly confidential.

Q: Where is the clinic located?

A: Our clinic is located within Yoga Pearl at 925 NW Davis, which is in the Pearl District of NW Portland. This is two blocks north of West Burnside Street between NW 9<sup>th</sup> and 10<sup>th</sup>. There is on-street parking with pay meters as well as pay lots in the area. We are easily accessible from the Streetcar/Trolley line as well as TriMet.

Q: What should I do when I arrive at the clinic?

A: When you arrive for your appointment, please check-in with the front desk receptionist who will direct you to our waiting area in the back of the studio. Please be aware that you will be asked to remove your shoes and turn off your cell phone before going back to the waiting area. You can bring your shoes with you to the treatment room or you can store them in one of the “cubbies” near the reception desk.

Q: Should I eat or drink anything before my appointment?

A: Yes. Please make sure that you have eaten something before your appointment; it is not wise to have an acupuncture treatment on an empty stomach as you may become lightheaded after your treatment. You are also encouraged to take any prescribed medications that you would usually take. Please do not drink any caffeinated beverages before your appointment - this will make your treatment much more relaxing.

Q: How long will my appointment last?

A: In order to allow time for reviewing your complete health history, new patient appointments last 90 minutes to 2 hours. Follow-up visits last 60 to 90 minutes.

Q: I have never had acupuncture. What can I expect?

A: Traditional Chinese medical diagnosis seeks to determine the deeper, underlying causes of your illness or disorder. The diagnostic process uses skills and techniques of TCM that allow the practitioner to understand numerous aspects of your physiological processes. Be assured that each question is asked and each diagnostic step is performed to help determine the best therapeutic approach for your health needs. Please read the enclosed brochure to answer other questions you may have.

**Patient Privacy Notice** (short form)  
**Health Insurance Portability and Accountability Act (HIPAA)**

Brynn Graham, L.Ac. is dedicated in preserving your Personal Health Information. We are required by law to protect your health information and to provide you with a Notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practice describes your rights and Brynn Graham's duties with respect to your protected health information.

Brynn Graham, L.Ac. may use or disclose your Personal Health Information for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations. We may be required by law to use and disclose your medial information for other purposes without your consent or authorization.

Your Personal Health Information means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected health information relates to your past, present, or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed Notice of Privacy Practices (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current Notice in effect; please ask Brynn Graham, L.Ac., and you will be provided with a copy. We may revise our Notice from time to time. The effective date at the bottom of this page indicates the date of the most current Notice in effect.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact:  
**Brynn Graham, L.Ac. at 503-525-9642.**

**My signature below indicates that I have received, read, and understand this Notice of Patient Privacy.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Effective date: April 14, 2003.

## **Financial Policies**

Brynn Graham, L.Ac., 925 NW Davis, Portland, OR 97209 503-525-9642

**Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions, please ask.**

I am pleased to offer my services to you!

Fees: effective November 1, 2009, my fees for general acupuncture treatments are \$95 for initial visits and \$75 for each follow-up visit. Facial Rejuvenation acupuncture treatments are \$100 for individual treatments. I offer discounted rates for students and seniors at \$50 per visit. I also offer a discounted, prepaid general treatment package of \$700 for ten treatments.

Payment: payment for your treatment is due at the time of service. I do not bill insurance. Payment can be in the form of cash, check, Visa, Mastercard, or American Express. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you foresee any financial challenges, be sure to address them with me prior to your appointment.

Appointment Changes: if you should need to cancel or reschedule an appointment, I ask that you do so at least 24 hours before your scheduled appointment time. I reserve the right to charge for all missed appointments and all appointments cancelled or changed with less than 24 hours notice. I will make every effort to contact you in case of any appointment cancellation on my part. In the event of extreme weather, please call Yoga Pearl to make sure the facility is open and to check on my availability.

Appointment Scheduling: follow-up appointments can be scheduled with me directly during our appointment time or via my cell phone 503-789-7576. Appointments can also be scheduled through the front desk at Yoga Pearl 503-525-9642.

My goal is to remove the cause of illness as well as to treat the symptoms. After your initial evaluation, I will discuss a course of treatment that generally includes a series of acupuncture treatments and herbal therapy, if warranted, with specific goals.

**I have read, understand, and agree to the above statement regarding responsibility for my appointment and payment policy.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent for Treatment**

Brynn Graham, L.Ac. 925 NW Davis, Portland, OR 97209

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese herbal formulas/therapies provided by Brynn Graham, L.Ac.

I understand that acupuncturists practicing in the state of Oregon are not primary care providers. I understand that this clinic requests that all patients have a primary care provider as part of a conjunctive care program and that all patients provide medical records from their primary care provider upon request.

I understand that acupuncture is performed by the insertion of needles through the skin. Additionally, application of heat, electrostimulation, Chinese massage, cupping, and other Oriental medicine therapies may be applied in the treatment protocol. I have been informed that only disposable needles will be used during each treatment. I have been made aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatments at any time.

I understand that my acupuncturist may recommend substances from the Oriental materia medica (herbal therapies) to treat dysfunction or diseases, to modify or prevent the perception of pain, 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 do decide to take them. I have been made aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary 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 my acupuncturist as soon as possible.

**I have carefully read and understand all of the above information, and I give my consent to be treated.**

\_\_\_\_\_  
**signature**

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

\_\_\_\_\_  
**parent/guardian signature (if applicable)**

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

**Patient Health History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital status: \_\_\_\_\_ Gender: Male / Female

Occupation: \_\_\_\_\_ Social Security number: \_\_\_\_\_  
(only needed if you need invoice for insurance reimbursement)

Referred by: \_\_\_\_\_

**Contact information:**

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

If the need arises, how do you prefer that I contact you? \_\_\_\_\_

Would you like for me to contact you to remind you of future appointments? yes no

Emergency contact person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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Health concerns that have brought you in today:

Have you seen a MD, ND, or chiropractor for this/these condition(s)?

Please list your health history (injuries/accidents, illnesses, surgeries, major emotional/physical traumas, etc.) for the following periods:

Birth to age 12:

Age 13 to 20:

Age 21 to present:

Please list any medications or supplements you are currently taking:

Please list any allergies or hypersensitivities you may have (food, medications, environmental):

How would you rate the level of stress in your life? low medium high

What are the primary sources of stress in your life? (circle all that apply)

work family friends finances health other: \_\_\_\_\_

Have you ever been treated by: (circle all that apply)

acupuncture massage shiatsu chiropractic naturopathic osteopathic reiki

Please circle any emotions that are significant or recurring in your life:

excitement anger worry grief anxiety sadness/melancholy frustration fear other: \_\_\_\_\_

What would you like from your acupuncture treatment?

### **Lifestyle**

Please indicate what you typically eat for the for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you eat meals at regular times each day?

How many meals do typically eat each day?

Do you feel that you eat a healthy diet?

Do you exercise?

What forms of exercise and how often?

How many hours of sleep per night? \_\_\_\_\_ What are your typical hours of sleep? \_\_\_\_\_ to \_\_\_\_\_

Do you sleep well?

Do you ingest any of the following?

Caffeine? yes no amount:

Alcohol? yes no amount:

Tobacco? yes no amount:

Non-prescription drugs? yes no

drug(s):

amount:

Do you have a family history of any of the following health conditions?

Y/N Diabetes

Y/N Asthma

Y/N Mental Illness

Y/N Cancer

Y/N Migraines

Y/N High Blood Pressure

Y/N Heart Disease

Y/N Seizures

Y/N Stroke

Please **circle** any conditions experienced **now** and **underline** any experienced in the **past**:

Slow wound healing	Low libido	Hypothyroid
Bruise easily	Infertility	Hyperthyroid
Acne / Rosacea	Sexually transmitted disease	Hypoglycemia
Eczema / Psoriasis	Sexual difficulties	Osteoporosis
Low energy/fatigue	Prostate/male genital issues	Autoimmune disorder
Insomnia	Testicular pain/swelling	HIV
Headaches/migraines	Menopausal symptoms	Liver/Gallbladder disease
Sinus problems	PMS / Painful periods	Hepatitis (Type___ )
TMJ/Jaw problems	Gynecological pain	Edema
Asthma	Irregular menstrual cycles	Cold hands/feet
Difficulty in breathing	Bleeding between cycles	Night sweats
Pneumonia/Bronchitis/Pleurisy	Vaginal discharge	Unusual sweating
Emphysema	Yeast infections	Sudden weight gain/loss
Tuberculosis	Urinary tract infections	Varicose veins
Chest Pain	Painful/difficult urination	Bad breath
Heart Disease	Kidney disease	Skin sensitivities
High blood pressure	Kidney stones	Rashes
Heart palpitations/flutterings	Anemia	Frequent colds/illness
Irregular heart rhythms	Vertigo/dizziness	Difficulty in relaxing
Heartburn/indigestion	Poor memory/difficulty focusing	Anorexia or Bulimia
Irritable Bowel Syndrome	Neuropathies	Cold sores / canker sores
Constipation	Diabetes	Ear congestion/discomfort
Diarrhea/loose stools	Numbness/tingling	Unusual hair loss
Changes in appetite	Rheumatoid arthritis	Other:
Stomach/Oral ulcers	Osteoarthritis	
Crohn's Disease	Mental illness	
Mucous or blood in stool	Cancer	