



COLORADO MANDATORY DISCLOSURE STATEMENT

SOUTH DENVER ACUPUNCTURE AND HERBAL MEDICINE CLINIC

Christopher Shiflett, L.Ac

Phone: 720.260.1892

10730 E Bethany Dr., Suite 130

Aurora, CO 80014

Education and Experience

Christopher Shiflett earned his Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in December 2013. This three year program consists of 3,500 hours of education including 1,000 hours of clinical practice. He was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in March 2014. This includes certification in Clean Needle Technique, Acupuncture, Asian Bodywork and Chinese Herbology. Christopher has also earned a Bachelor of Science in Integrated Therapeutic Practices from Metropolitan State University. Christopher is a Colorado native and has practiced in the South Denver Metro area since April 2014.

Christopher's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.

Christopher is a member of the Acupuncture Association of Colorado. He is a registered acupuncturist in Colorado. This license has never been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health and Environment, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable factory-sterilized needles are utilized.

Christopher is trained and experienced in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts.

Fee Schedule

Intake and Consultation	\$80 + Cost of Herbs
Follow Up Treatment	\$60 + Cost of Herbs
Herbal Consultation only	\$40

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the 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 practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of Professions and Occupations, Acupuncture Licensure, 1560 Broadway, Suite 1350, Denver, Colorado, 80202. Telephone (303) 894-7800

I have read and understand this document

Patient or Guardian's Signature: _____

Date: _____

phone (720) 260.1892 | southdenvertcm@gmail.com | www.southdenvertcm.com
10730 E. Bethany Drive, Suite 130, Aurora, CO 80014



South Denver Acupuncture and Herbal Medicine Clinic

Acupuncture Informed Consent to Treatment Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or 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, Tui-Na (Chinese massage), heat lamp therapy, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 needling sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping. 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 and maintains a clean and safe environment. Burns and/or scarring are a potential risk of Moxibustion and cupping. 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, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment 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 that results are not guaranteed.

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

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 have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist:

Christopher Shiflett L.Ac Dipl. OM NCCAOM

X

Signature of Patient or Representative (indicate relationship if signing for patient)

Date



Office Policies

Cancellations & Missed Appointments

Please provide 24-hour notice of cancellation prior to your scheduled appointment. After the first missed appointment without 24hr notification a \$30 fee will be assessed. After the second missed appointment without 24hr prior notification a \$60 fee will be assessed for this and all future missed or late cancelled appointments.

Reasons for being dismissed/denied treatment:

Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

Financial Policy

Your payment is due in full at the time of service. For your convenience, we accept cash, check, or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a \$25 fee.

Insurance Policy

We are an in-network provider with National Blue Cross Blue Shield Plans not associated with American Specialty Health Networks. If your insurance company does not cover acupuncture or if we are not listed as an approved provider for your insurance, we will gladly give you a receipt for all of your treatments so you can submit them to your insurance company for reimbursement.

Procedure Code	Description of Service	Billed Charge
99203	New Patient Evaluation	\$95
97810	Acupuncture, first 15 minutes	\$70
97811	Acupuncture, additional time	\$50
97014	Electric Stimulation	\$10
97016	Cupping Therapy	\$20

Records Release & Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Christopher Shiflett, L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that my information may transferred by mail, phone, fax, and email. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Please indicate your understanding and acceptance of these policies by signing below.

Patient's Signature

Patient's Name

Date

phone (720) 260.1892 | southdenvertcm@gmail.com | www.southdenvertcm.com
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South Denver Acupuncture and Herbal Medicine Clinic

Patient Information and Disclosure

Name _____ Phone (H) _____ (W) _____

Age _____ Height _____ Weight _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Sex _____ Occupation _____

Employer's Name & Address _____

Marital Status _____ Number of Children _____

Personal Physician _____

Date of Last Completed Physical Exam _____

In Case of Emergency Contact _____ Phone _____

- Acupuncture, Acupressure, Tui Na, Massage, Reflexology, health or corrective exercises and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medical care. Therapies and advice offered shall not be construed by the patient to be a Western Medical diagnosis or treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any condition and get at least two medical opinions. It is your right and responsibility for your own health.
- The Colorado Acupuncture Practice Act states, "Practice of acupuncture means the insertion and removal of acupuncture needles, the application of heat therapies to specific areas of the human body, and traditional oriental adjunctive therapies. Traditional oriental adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, the recommendation of oriental therapeutic exercise, and subject to federal law, the recommendation of herbs and dietary guidelines." The "Practice of Acupuncture" shall be defined by traditional oriental medical concepts and shall not include the utilization of western medical diagnostic tests and procedures such as magnetic resonance imaging, radiographs, computerized tomography scans, and ultrasound. "Practice of Acupuncture" does not mean: Osteopathic medicine and manipulative treatments; Chiropractic medicine or chiropractic adjustments; or Physical Therapy.
- Acupuncture has been explained to me as a treatment consisting of the insertion of acupuncture needles through the skin at certain points on the body, as well as other oriental modalities as described by the Colorado Acupuncture Practice Act. The purpose being to alleviate or treat symptoms or disorders.
- I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of numbness, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms.

Patient further understands and agrees to hold harmless, to indemnify and protect against court action the individual practitioners, employees, and the South Denver Acupuncture and Herbal Medicine Clinic LLC, in the event of an accidental injury on the premises.

Do you have an allergy to latex exam gloves? _____ Yes _____ No

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How did you hear about us? (Please Check One)

- Google/Internet Search
- Groupon/Amazon Local (Circle One)
- Facebook
- LinkedIn
- Friend/Family/Co-worker Referral Who? _____
- Physician Referral Who? _____
- Lecture or Workshop Which? _____

Signed _____ Date _____



South Denver Acupuncture and Herbal Medicine Clinic

Permission to Call

Occasionally situations arise in which we may need to call you. For instance, there is a cancellation at a time you previously requested and we would like to call and offer that time slot to you. To protect the privacy of you, the patient, SDAHMC would like to know that if a situation such as the one described above or one similar to that should occur, can we contact you by phone and if so please let us know at which number(s) you would like to be contacted.

Please check the appropriate line

Contact me at any of my numbers listed on the Patient Information and Disclosure Form.

Contact me only at my work number. That number is _____

Contact me only at my home number. That number is _____

Contact me only at my cell number. That number is _____

Do not contact me at any of my phone numbers.

Signed _____ Date _____

Printed Name _____



South Denver Acupuncture and Herbal Medicine Clinic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

The South Denver Acupuncture and Herbal Medicine Clinic (SDAHMC) is required, by law, to maintain the privacy and confidentiality of your protected health information and how to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the SDAHMC.”

“It is our policy to provide a substitute healthcare provider, authorized by SDAHMC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We expect payment at the time the services are rendered but in the event you file an insurance claim, we may disclose your health information to your insurance provider and insurance billing services for the purpose of payment or health care operations, via phone, fax, email, or US Mail.

“Since you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Worker’s Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease and infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or translating organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

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We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:

“As a courtesy to our patients, we may call your home, usually the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the form. No personal health information will be disclosed during this recording or message other than the/date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable event to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal information about your condition for the purposes of SDAHMC sponsored fund-raising events.”

Change of Ownership

In the event that SDAHMC is sold or merged with another organization, your health information record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that SDAHMC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information. We will charge you reasonable cost-based fee expenses such as copies and staff time. The fee is set as base fee of \$25.00 for 10 pages or less; additional fee of \$1.00 per page for pages 11-60, \$0.50 per page for pages 61-400. The base fee must be paid at the time of the request and the balance paid at the time of pick up.
- You have the right to request that SDAHMC amend your protected health information. Please be advised, however, that SDAHMC is not required to agree to amend our protected health information. If you request to amend your health information has been denied, you will be provided with and explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right an accounting of disclosures of your protected health information made by SDAHMC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

SDAHMC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, SDAHMC is required by law to comply with this notice.

SDAHMC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact SDAHMC office by calling:(720)-260-1892. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how SDAHMC had handled your health information should be directed to the SDAHMC office by calling :(720)-260-1892. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complain, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 independence Avenue, SW
Room 509F HHHF
Washington, VA 20201

This notice is effective as of February 1, 2014. I have read the Notices of Privacy Practices and understand my rights contained in the notice



By way of my signature on the acknowledgement of Receipt of Notice of Privacy Practices, I have provided SDAHMC my authorization and consent to use and disclose my personal health care information for the purposes of treatment, payment of health care operations as described in the Notice of Privacy Practices.

South Denver Acupuncture and Herbal Medicine Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of South Denver Acupuncture and Herbal Medicine Clinic. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Signature

Date

Clinic Administrative Signature

Date



Health History Form

Please place a check mark for symptoms/ diseases you have had in the past. Circle the name of any symptoms/ diseases you are currently experiencing and write the frequency, intensity, and duration.

General Symptoms

- Tremors
- Headache
- Migraines
- Fever
- Chills
- Cold hands/feet
- Sweating
- Fainting/dizziness/vertigo
- Motion sickness
- Convulsions
- Loss of Sleep/ Insomnia
- Fatigue
- Nervousness
- Depression
- Loss of Weight
- Forgetfulness
- Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, feet (circle which apply)
- Confusion
- Other

Eyes, Ears, Nose & Throat

- Failing vision
- Eye pain or sensitivity
- Eye strain
- Blurry vision
- Cross eyed
- Eye inflammation
- Glaucoma
- Cataracts
- Color blindness
- Spots/ lines in vision
- Deafness
- Earache
- Loss of hearing
- Ear discharge
- Ear noises, ringing
- Nose bleeds, nasal obstruction
- Nasal drainage
- Loss of smell
- Sinus infection
- Hay fever
- Allergies
- Sore throat
- Hoarseness
- Difficult speech
- Difficult swallowing
- Loss of taste or change in tastes
- Dental decay
- Gum problems
- Tonsillitis
- Asthma/ Bronchitis/ Pneumonia
- Frequent colds/ flu
- Thyroid problems
- Enlarged/swelling of glands
- Other

Skin, Hair, Nails

- Skin eruptions
- Eczema/ Psoriasis
- Itching
- Clammy skin
- Dryness
- Bruise easily
- Cuts heal slowly
- Boils
- Rashes
- Mole/ Warts
- Sensitive Skin
- Hives or Allergy
- Hair Problems
- Finger/ Toenail problems

Respiratory

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficulty breathing
- Wheezing
- Other

Cardio-Vascular

- Rapid beating heart
- Slow beating heart
- Irregular beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous stroke
- Previous Heart Attack
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Varicose veins
- High Cholesterol
- Low Cholesterol
- Anemia
- Other

Muscle & Joints

- Stiff neck or neck pain
- Pain between shoulders
- Backache
- Tailbone, Foot, toe, or heel problems
- Hand, wrist or finger problems
- Hernia
- Spinal curvature
- Faulty posture
- Swollen joints
- Stiff joints
- Painful joints
- Arthritis
- Sore muscles
- Weak muscles
- Walking problems
- Sciatica
- Other

Genitourinary

- Frequent urination
- Scanty urine
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Bladder problems
- Foul smelling urine
- Discolored/ cloudy urine
- Urinary tract infections
- Other

Gastrointestinal

- Eating disorder
- Poor appetite
- Excessive hunger
- Difficulty chewing
- Belching
- Bad breath
- Nausea

- Gas
- Indigestion
- Heartburn
- Vomiting
- Vomiting of blood
- Pain in abdominal area
- Distention of abdomen/ bloating
- Constipation
- Diarrhea
- Undigested food in stool
- Black stool
- Blood in stool
- Mucous in stool
- Colon problems
- Anal problems
- Hemorrhoids (Piles)
- Intestinal Worms
- Liver Problems
- Gall bladder problems/ stones
- Jaundice
- Colitis
- Weight Problems
- Other

Female

- PMS
- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Period cramps or backache
- Previous miscarriage
- Vaginal discharge
- Vaginal pain
- Breast pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding
- Reduced sex drive
- Pregnancy
- Pregnancy complications
- Abnormal Pap Tests
- Pain during intercourse
- Other

Male

- Prostate problems
- Genital pain or problems
- Reduced sex drive
- Premature ejaculation
- Seminal emission
- Impotence
- Discharges
- Other

Other

- Edema
- Hepatitis
- Herpes
- Cancer
- Diabetes
- TB
- Epilepsy
- Alcoholism / Substance Abuse
- Depression
- Mental Emotional Disorder
- HIV+/AIDS
- Sexually Transmitted Disease
- Other

