INTAKE FORM

MARET KUNZE-ROCHE ACUPUNCTURE
114 Swift Avenue
Durham, North Carolina 27705
(949) 533-1254

Maret Kunze-Roche, OMD, LAc
Doctor of Oriental Medicine
Licensed Acupuncturist
North Carolina License: LAC-900
Employer Identification Number: 74- 3028309
National Employee Number: 1114086022

ACCOUNT #: ____________
REFERRED BY: ____________

Name: ____________________ Day Phone #: ____________
Address: ____________________ PM Phone #: ____________
City & Zip Code: ____________________ Email address:
Date Of Birth: ____________ Marital Status: ____M____D____S # of Children_____
Employer: ____________________ Occupation: ____________
Insurance Co.: ____________________ Policy #: ____________
Family Physician: ____________________ Social Security #: ____________
Emergency Contact: ____________________ Contact Phone #: ____________

Main Complaint:______________________________**Date of Onset:**_________
How does this interfere with your daily activities?______________________________
____

Previous Treatment:______________________________
Diagnosis:______________________________

☐ **Fever or Chills**
When: ____________________
How Often: ____________________
____

☐ **Headaches**
Where: ____________________
How Often: ____________________
What Gives Relief: ____________________

☐ **Perspiration**
What Extent: ____________________
When: ____________________

☐ **Appetite**
Extent: Excessive:_______Minimal:________
Cravings: ____________________

☐ **Thirst**
Extent: Excessive:_______Minimal:________

☐ **Sleep**
Extent: Excessive:_______Minimal:_______
Dreams: ____________________

☐ **Sex Drive**
Increase:_________Decrease:_________
Pain: Yes:__________No:__________

☐ **Urination**
Times Per Day:_______Times Per Night:________
Pain: Yes:__________No:_________

☐ **Menses**
_____Irregular
_____Menopause
_____Hormone Replacement
Birth Control Used: ____________________

☐ **Stools**
Times Per Day:_______Times Per Night:________
Pain: Yes:__________No:_________

DO YOU HAVE OR HAVE YOU EVER HAD:
☐ **Hepatitis** ☐ **AIDS** ☐ **High Blood Pressure** ☐ **Acupuncture**

ARE YOU NOW:
☐ **Pregnant** ☐ **Nervous** ☐ **Smoking** ☐ **Current Law Suit**
Packs Per Day:_______ Type:________________

PREVIOUS SURGERIES (DATE / TYPE)
____________________ ______________________________
____________________ ______________________________

COMMENTS____
____

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LIST ANY MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING:

________________ ________________ ________________
________________ ________________ ________________

CHOOSE TWO EMOTIONS THAT SEEM TO DOMINATE YOUR LIFE:
(frequently experienced, difficult to express, or in some way influential)
(1)____________________(2)____________________

LIST AND DATE ANY TRAUMATIC EXPERIENCES THAT YOU MAY HAVE HAD:
(divorce, injury, death in the family, change of residence, bankruptcy, etc.)

________________ ________________
________________ ________________

LIST HEALTH PROBLEMS THAT RUN IN YOUR FAMILY:
Maternal: ____________________
Paternal: ____________________
Siblings: ____________________

DESCRIBE THE TYPE AND FREQUENCY OF TYPICAL ILLNESS YOU GET:

____
____

FEMALE PATIENTS ONLY

☐ Vaginal Infections	☐ Abortions	☐ Children	☐ Last GYN Exam Date:________
☐ Yeast Infections	☐ Incontinence	☐ Hemorrhoids	☐ Cycle Length ________
☐ Bladder Infections	☐ Breast Lumps	☐ Anal Fissures	☐ Flow Length ________
☐ Ovarian Cyst	☐ Herpes	☐ Fibroid Tumors	☐ Last Period Date:________
☐ Positive PAP	☐ Genital Burning	☐ PMS	
☐ Cysts	☐ Infertility	☐ Menstrual Cramps	

MALE PATIENTS ONLY

☐ Prostatitis	☐ Burning Urination	☐ Impotence	☐ Hemorrhoids
☐ Incontinence	☐ Nocturnal Emission	☐ Pre-Mature Ejaculation	☐ Other:

PLEASE DESCRIBE YOUR TYPICAL DAILY EATING HABITS:

Breakfast ____________________
Lunch ____________________
Snacks ____________________
Dinner ____________________

Beverages (Qty / Day)	_______Water	_______Coffee	_______Alcohol
	_______Sodas	_______Juices	_______Tea

Drink Preference:____________________

Temperature:	☐ Hot	☐ Cold	☐ Room Temperature
Taste Preference:	☐ Spicy	☐ Sweet	☐ Salty

PLEASE DESCRIBE YOUR CURRENT FITNESS PROGRAM

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____

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PLEASE INDICATE IF YOU EXPERIENCE PAIN REGULARLY IN:
(Indicate right, left, upper, middle, lower, front, back)

☐ Ears	☐ Arm	☐ Abdomen	☐ Throat
☐ Back	☐ Hip	☐ Head	☐ Leg
☐ Wrist	☐ Fingers	☐ Foot	☐ Knee
☐ Muscles	☐ Toes	☐ Ankle	☐ Nose
☐ Neck	☐ Shoulders	☐ Stomach	☐ Face
☐ Joints	☐ Sciatica	☐ Groin	☐ Other:__________

INDICATE WITH ONE CHECK (X) ANY CONDITION THAT YOU SOMETIMES EXPERIENCE, USE TWO CHECKS (XX) FOR THOSE WHICH OCCUR OFTEN AND THREE CHECKS (XXX) FOR SYMPTOMS THAT ARE A MAJOR CONCERN:

FIRE ELEMENT

_____Heart Palpitations	_____Dry Mouth	_____Nightmares
_____Irregular Heart Beat	_____Teeth Grinding	_____Snoring
_____Chest Pain	_____Facial Flushing	_____Hot Hands / Feet

EARTH ELEMENT

_____Indigestion / Gas	_____Bad Breath	_____Diarrhea
_____Nausea / Vomiting	_____Sore Gums	_____Blood in Stool
_____Ulcers	_____Sores in Mouth	_____Black, Tarry Stool
_____Weight Gain / Loss	_____Nose Bleeds	_____Laxative Use
_____Difficult Swallowing	_____Easily Bruised	_____Stomach Bloating
_____Hoarse Voice	_____Hernia	_____Water Retention
_____Food Allergy	_____Anemia	_____Dizziness

METAL ELEMENT

_____Skin Rashes	_____Colds / Bronchitis	_____Constipation
_____Acne	_____Asthma	_____Hemorrhoids
_____Recent Moles / Warts	_____Allergies	_____Colitis
_____Dec. Sense of Smell	_____Cough	_____Diverticulitis
_____Recent Antibiotic Use	_____Shortness of Breath	_____Nasal / Sinus

WATER ELEMENT

_____Low Back	_____Hair Loss	_____Hearing Problems
_____Weak Knees	_____Premature Graying	_____Ringing in Ears
_____Afternoon Fever	_____Cold Hands / Feet	_____Kidney Stones
_____Night Sweating	_____Reduced Sex Drive	_____Yeast Infections
_____Impotence	_____Receding Gums	_____Diabetes
_____Fear	_____Urinary Discomfort	_____Circles Under Eyes
_____Poor Memory	_____Concentration	

WOOD ELEMENT

______Eye Problems	______Gall Stones	_____Migraines
______Muscle Spasms	______Indecisiveness	_____Headaches
______Spots Before Eyes	______Easily Angered	_____Shaking / Trembling
______Halos Around Eyes	______Lump in Throat	_____Soft / Brittle Nails
______Difficult Swallowing	______Easily Bruised	
______Digesting Oily Foods	______Shingles	

Comments

____
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RELEASE OF INFORMATION: I hereby authorize Dr. Kunze-Roche, OMD, LAc to release confidential health information about me by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed below:

I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. Additionally, I understand that I may revoke this authorization in writing at any time, except for that information which has already been released with consent and prior to my revocation.

HIPAA:
HIPAA regulations require that all practitioners obtain a signed release form from their patient before taking any information about them. Patients may receive a copy of their signed form upon request while a copy is retained in the patient's records. I give permission to Dr. Kunze-Roche to take notes including health history, medical and/or personal information I choose to disclose to her. I understand this information may be shared under legal obligations or with another medical professional or health care providers to enhance my quality of care.

CANCELLATIONS:
Notice of cancellation must be made a **full 24 hours** prior to your scheduled appointment. The full fee will be charged for late cancellations and missed appointments. Exception to this policy includes dangerous weather conditions, serious illness, or accident.

RATES:
Current session rates, payable by cash, check, credit card, PayPal, Venmo, or Apple Pay Cash are:
Initial Acupuncture Treatment (1 hour 15 minutes): $170.00
Initial Intermediate Acupuncture Treatment (1 hour 45 minutes): $240.00
Initial Comprehensive Acupuncture Treatment (2 hours): $275.00
Acupuncture Treatment (1 hour 15 minutes): $170.00
Additional 15 minutes: $35.00

SIGNATURE OF PATIENT:____**DATE:**__________________

FINANCIAL RESPONSIBILITY
I, the undersigned, agree to be financially responsible for all of the costs for the services rendered to me by **Dr. Kunze-Roche, OMD, LAc** and I agree to promptly pay for these services.

PRINT NAME:____**DATE:**__________________

SIGNATURE:____**DATE:**__________________

WITNESSED BY:____**DATE:**__________________

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Consent to Terms of Energy Reading

In Traditional Chinese Medicine, pulse and tongue readings are used as diagnostic tools to determine the state of organ and body health. Energy Readings are a self-taught method of interpreting this information using intuition, experience, and the knowledge of Oriental Medicine. The information from the Energy Readings gives Dr. Kunze-Roche a quick view into the patient's current state. This allows a level of trust to develop and can facilitate a deeper level of healing.

Both pulse and tongue examinations follow the Oriental Medicine protocol: during an Energy Reading, pulses are taken on each hand which correspond to various organ systems and, the tongue is examined regarding body, shape, color, coating, and organ correspondence.

I understand that Energy Readings are intended to ascertain my emotional, physical, mental, and energetic positions for purposes of assessing my internal framework and assist in the healing process. Energy Readings are done during the consultation part of the treatment hour. "Regular" or non-Energy Reading pulses are usually taken at the end of the treatment to evaluate progress made during the treatment session.

I understand that physical contact may be utilized by Dr. Kunze-Roche during the Energy Reading and I consent to the same. I further understand that I have the right to refuse or stop the Energy Reading at any time.

I understand that Energy Readings are merely intuitive advice and assessments and do not constitute professional, medical, emotional, psychological, or other advice, and may not be relied upon by me as such. Dr. Kunze-Roche makes no representations, warranties, or other guaranties, whether express or implied, with respect to the results or effectiveness of the Energy Reading. I further understand that other forms of assessment or treatment, including medical services, may be available and I have the sole responsibility to pursue such other methods. I expressly disclaim and hold harmless Dr. Kunze-Roche from any liability, including, without limitation, any loss or damage, whether physical or emotional, based on my reliance, in whole or in part, on the Energy Reading results or assessments.

I have carefully read and understand all of the above information and am fully aware of what I am consenting to. I understand that during the course of the Energy Reading that I am responsible for communicating my questions, concerns, and needs to Dr. Kunze-Roche so that she may conduct the Energy Reading in the best way possible.

By signing below, I hereby request and consent to the performance of an Energy Reading by Dr. Kunze-Roche.

Patient Name: ________________________________

Signature: ____________________________________ Date: ______________________

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Informed Consent for Acupuncture Treatment

By signing below, I hereby request and consent to the performance of acupuncture treatments on me (or on the patient named below for whom I am legally responsible) by Dr. Kunze-Roche, OMD, LAc, Doctor of Oriental Medicine and Licensed Acupuncturist.

I understand that acupuncture involves the insertion of sterile needles through the skin at certain points on the body in an attempt to normalize physiological functions, modify the perception of pain and treat certain diseases of the body.

I understand that acupuncture is generally a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Uncommon risks of acupuncture include nerve damage, organ puncture, and infection.

I do not expect Dr. Kunze-Roche to be able to anticipate and explain all risks and complications, and I wish for her to exercise judgment during the course of treatment, which she thinks at the time is in my best interest.

I understand that there are no guaranteed results concerning treatment and that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I represent that I have fully disclosed any medication, illness or injury for which I have or am receiving treatment from a health care professional on my application. Further, I have informed Dr. Kunze-Roche if I am pregnant. I understand that Dr. Kunze-Roche and her staff may review my medical records and lab reports that I may provide to them or that I authorize them to access, but that all medical records will be kept confidential and will not be released without my written consent.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that during the course of treatment I am responsible for communicating my questions, concerns and needs to Dr. Kunze-Roche so that she may support me in the best way possible.

Patient: ________________________________

Signature: ________________________________ Date: ______________________

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NOTICE OF PRIVACY PRACTICES
HIPAA (Health Information Portability and Accountability Act)

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 AND SIGN THAT YOU HAVE RECEIVED A COPY.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them.

I consider all information about our work to be confidential. Your signature on the “Receipt and Acknowledgment Form”, stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes (as needed for billing, insurance claims and collections). For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of your PHI. Unless you request otherwise, I may disclose your PHI verbally, on paper or electronically. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also my Office Practices and Policies Information on the last page of the intake form).

DISCLOSURE OF INFORMATION

*Whenever your PHI is released or obtained, it will be the minimum information necessary

*There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics. These include:

- *Emergencies
- *Reporting of abuse or neglect
- *Disclosures required by court order
- *Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public

YOUR RIGHTS REGARDING PRIVACY

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

- *The right to inspect and obtain a copy of your medical record
- *The right to request an amendment of any section of your medical record
- *The right to request restrictions of disclosure of your PHI for the purposes of treatment, payment and health care operations
- *The right to request an accounting of the disclosures that we make of your health care information
- *The right to request confidential communication
- *The right to a copy of this notice
- *The right to refuse to acknowledge receipt of this notice

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QUESTIONS AND/OR EXERCISING YOUR RIGHTS

If you have any further questions and/or concerns about this notice or to exercise any of your above rights, please contact Dr. Maret Kunze-Roche, OMD,LAc, Doctor of Oriental Medicine, Licensed Acupuncturist at 112 Swift Avenue, Durham, North Carolina 27705 or call the office at (949) 533-1254.

If you believe your privacy rights have been violated, you may file a written complaint with Dr. Kunze-Roche. You may also contact the Secretary of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201 or by calling (292) 619-0257. You will not be penalized for doing so.

I reserve the right to amend the terms of this notice.

THIS NOTICE IS EFFECTIVE NOVEMBER 1, 2016.

NOTICE OF PRIVACY PRACTICES

RECEIPT AND ACKNOWLEDGMENT OF NOTICE

PATIENT NAME: ____

DATE OF BIRTH: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notices of Privacy Practices of Dr. Kunze-Roche. I understand that if I have any questions regarding the Notice of my privacy rights, I may contact Dr. Kunze-Roche at the address and telephone number listed above.

____

SIGNATURE OF PATIENT DATE

____

SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE* DATE

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, Healthcare Surrogate, parent, etc)________________________________

__________PATIENT REFUSES TO ACKNOWLEDGE RECEIPT

____

SIGNATURE OF STAFF MEMBER