ACUPUNCTURE INTAKE

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THE TEAL CENTER FOR THERAPEUTIC BODYWORK

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Name :	○**Male** ○**Female / Age:**	**Height ft in Weight lbs**	**BMI:**	**Telephone:**
Address :		**Occupation :**		**Email:**

Primary complaint	
Symptoms	
Health History	
Date of Onset	
How started	
What factors contribute to aggravation? When?	
What factors help improvement? When?	

_____

_____

_____

_____

Secondary complaint:_____ _____

Onset : _____

History :_____

_____

_____

_____

Current health issues: _____
Past health issues & surgery: _____
Current medications or supplements: _____
Known allergies or side effects:_____

Pulse : Floating, Deep, Slow, Rapid, Excess(강), Minute(약), String(현),

Tongue : Pale, Red , Thick, Thin, Swollen, Gloss peeled(경면설)

Basic Charting : Check the box or circle if it is applicable.

Sickness

① Cold with a sore throat : Easily get sore throated. Have a sore throat. Hurts to swallow

② Fever : Low ~ High

③ Body Aches : Feels chilly. Body aches. ④Cold : Runny nose, Phlegm, Coughing

Cold

★Easily trembles with cold because my body is generally cold. □Usually □Often □Sometimes □Rarely

★My lower abdomen gets cold. □Usually □Often □Sometimes □Rarely

Heat

★Get hot easily because I have a lot of heat in my body. □Usually □Often □Sometimes □Rarely

★My upper body and face flush. □Nervous □Excited □Hot □Drinking □Menopause

Perspiration & Hydration

♦I sweat □Usually □Often □Sometimes □Rarely

♦I generally drink water or beverage □A lot □Often □Rarely.

Appetite & Digestion

★My digestion is □Very good □Normal □Weak □Very Weak.

When I (□ Eat too much □ am stressed) I get upset stomach. □Usually □Often □Sometimes □Rarely

When I get upset stomach, I have symptoms of □Bloating in the stomach □Bloating in the whole abdomen □Stuffy chest □Headache

Defecation

♦ I generally pass my bowels ___ times every ___ days □ Constipation □Normal □Loose stool □ Diarrhea

★ When I don't pass my bowels □In the morning, □a day, □2-3dyas, □3-4days), I get (extremely, moderately) bloated and feel (extremely, moderately) discomfort.

★ I do get loose stools and diarrhea when I □get cold abdomen/ eat or drink □cold stuff □milk, □beer & alcohol □spicy food □oily food/ □get stressed □eat a lot

Urination

♦ I have □ very frequent □ frequent □ seldom urination than others.

♦I (□always □sometimes □rarely □never) have incomplete emptying of the bladder

Menstruation

♦Cycle (□ Regular □ Irregular) ♦ Cramp (□ very severe □ severe □ moderate □ little)

♦ Menstrual blood (□ heavy □ normal □ scanty □ dark □ pale □ clots)

Thorax

♦ I (□ always □ sometimes □ rarely □ never) get palpitation

♦ I (□ always □ sometimes □ rarely □ never get) chest congestion

Sleep

★ I normally sleep □ good □ bad

♦ I (□always □sometimes □rarely) can't fall asleep within (□30min □1~2hr □2~3hrs □3 or more hrs) especially when I'm (□stressed □ tensed □in other places □preparing for a big day tomorrow □hearing noises □sensing a light)

Whole Body

♦ Stamina (□very high □high □normal □low □very low)

★ I easily get swelling on my (□hands □ feet □ legs □face □whole body).

☐ My legs swell up easily when I walk or standing

♦ What brings you here?

①

②

③

■ This Questionnaire is about your average emotional state.

Please circle 1~2 options that describe most closely your average emotional state
Please cross out 1~2 options that describe your least likely average emotional state

1. Angry. Become irritable and angry easily. Bad-tempered, Petulant, frenzies

2. Easily get excited and nervous. You find it hard to stay calm.

3. Worry. You worry about small things and/or worry about my health all the time

4. Sensitive. You are very sensitive and easily get frustrated.

5. Nervous. You feel uncomfortable and unrested most of the time. You may frequently feel rushed, restless or impatient.

6. Sad. You often feel sad and want to cry.
You are easily moved to tears.

7. Fear. You frequently feel timid and get frightened easily.

8. You feel a great weight on your shoulders. You endure the anger and what others have to say but often feel unfairly treated.

9. Depressed. You rarely have fun and often feel dark, stagnant. You conceal yourself and/or avoid interactions with others. You feel passive, dependent or helpless.

FOR PRACTITIONER USE ONLY

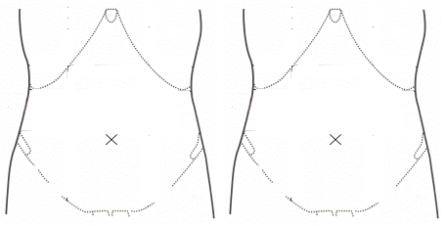
Yin and Yang

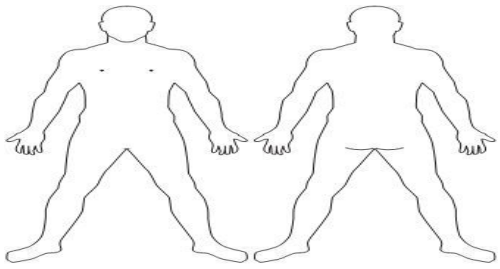
Yang	동적	언행급 성급 변화	외향	표출 쾌활 다언	공격	기세 강단 활력 체력 강	불안	예민 긴장 흥분 역노
Yin	정적	언행완 완만 꾸준	내성	삭힘 침울 과묵	방어	온화 유약 피로 체력 약	안정	우멍 이완 차분 관대

Emotion

①-1 Angry irritable and angry easily. Bad-tempered, Petulant, frenzy	**①-2 Excitement** Easily get excitement	**② Worry.** worry about small things Hypochondria – worry about my health all the time	**③Senstive** very sensitive and easily get frustrated,	**④Nervous** emotionally feel uncomfortable and unrested most of time.feeling being chased and rushed Restlessness, impatience, nervousness
⑤ Sad. Often feel sad and want to cry. feeling sadness, immediately moved to tears. couldn't help crying.	**⑤ Hwabyung** Endure the anger and what I have to say. Feel unfairly treated, hwabyung	**⑥ Fear**. : I'm a timid person and easily get scared. Fearful & get frightened easily Fear. : I'm a timid person and easily get scared. Fearful & get frightened easily	⑦ Depressed. no fun and depressed. dark, stagnation, concealment, avoidance, passive, dependent, helpless	

작약 : 이두박근, 배근육 대조 : 삼두박근, 어깨근육, 등배근육 협하: 시호, 황금





회	날짜	처방명	일수/ 첩수	비고
1회				
2회				
3회				
4회				
5회				

Detailed Charting (Practitioner Use)

♦What happens when you are stressed, tired, emotionally affected?

Cold & Heat

◆Body Temperature Scale: Heat ① ② ③ ④ □ ⑥ ⑦ ⑧ ⑨ ⑩ Cold ① ② ③ ④ □ ⑥ ⑦ ⑧ ⑨ ⑩

☐ I can't sleep in the cold □ Cold makes my body stiff and heavy.

☐ I need to wear more layers compared to other people when it's cold

◆ My (hands, feet or _____) are ☐ cold ☐ very cold and achy ☐ numb.
I wear socks during sleep even in the (☐ Spring, ☐ Summer, ☐ Fall) time.

◆ My (hands, feet or both) are warm. I have a burning sensation in my (hands, Feet or both)

Perspiration

◆ My (☐ hands ☐ feet) sweat a lot. □ After I sweat in sauna, I feel (☐ heavy ☐ light)

◆ I drink water and beverages, because I feel (☐ dry mouth, ☐ thirsty, ☐ habitually ☐ it's healthy)

◆ I drink alcohol ___times/week. From drinking alcohol, I easily get ☐ drunk ☐ face and body get very red ☐ sick

◆ I have a history of ☐ fatty liver ☐ jaundice ☐ hepatitis ☐ high liver enzyme level ☐ other liver conditions □family history

Digestion

◆ I (☐ often, ☐ sometimes) get (☐ acid regurgitation ☐ heart burn ☐ nausea belching) when (eating spicy food, drinking alcohol, stressed, early morning, empty stomach, car sick, brushing teeth)

☐ Have a weak stomach. ☐ Feels nauseous and throws up. ☐ Usually have a car sick. ☐ Burps often

◆ Generally, my appetite is (☐ very good, ☐ normal, ☐ little) and the portion is (☐ large, ☐ medium, ☐ small)

◆ When I miss a meal, I feel (☐ weak and tired ☐ normal) and ☐ get hungry right away

Defecation

◆ Usually have a ☐ constipation ☐ diarrhea ☐ I can't pass a bowel when I am stressed or at unfamiliar place.

◆ Laxatives: ☐ Now ☐ Before

◆ I frequently have feeling of Incomplete Bowel Movement (tenesmus). □ Severely □ Moderately □ Rarely

◆ Even though I get diarrhea, I feel (☐ light ☐ fatigue and heavy).

◆ I (☐ always ☐ sometimes ☐ rarely ☐ never) get severe gas retention.

Urination

◆ I generally urinate ___ times in daytime & ___ times at night. I have nocturnal enuresis ___ times a month.

◆ I (☐ always ☐ sometimes ☐ rarely ☐ never) have incomplete emptying of the bladder therefore ☐ I have to go more often and ☐ it gets worse when I'm stressed or tired.

◆ I have ☐ urgency ☐ incontinence ☐ hesitancy of urination or ☐ dysuria □hematuria ☐ cloudy urine and ☐ pain when bladder is full

Menstruation

◆ How many? Children ___ Abortion ___ C-section___ . Gets bruises often. Varicose veins, Sublingual blue vein, Blue tongue,

◆ Near My period I feel or get (☐ chills ☐ body ache ☐ low grade fever ☐ like to eat more ☐ like to meat ☐ like to eat sugary ☐ poor digestion ☐ poor appetite, constipation before the period ☐ loose stool or diarrhea after the period ☐ swelling and edema ☐ fatigue □sleepy ☐ nervous ☐ tensed ☐ petulant ☐ insomnia

Thorax

◆ I (☐ always ☐ sometimes ☐ rarely ☐ never) get palpitation when I'm (☐ stressed ☐ excited ☐ tensed ☐ tired) with (☐ nervousness ☐ flushed face ☐ spontaneous sweating ☐ shortness of breath)

◆ I (☐ always ☐ sometimes ☐ rarely ☐never) get chest congestion when I'm (☐ stressed ☐ excited ☐ tensed ☐ tired) with (☐ feeling oppressed ☐ feeling hot ☐ feeling squeezing ☐ feeling stiffness) in the chest and ☐ shortness of breath.

☐ I'm sighing all the time

☐ I get shortness of breath when I (☐ run ☐ walk fast ☐ walk up the stairs) that is (☐ very severe ☐ severe ☐ manageable)

Sleep

◆ I (☐ always ☐ sometimes ☐ rarely ☐ never) had sleeping issue before. ◆ I (☐ used to ☐ currently) taking sleeping medication.

◆ I (☐ always ☐ sometimes ☐ rarely) can't fall asleep within (☐ 30min ☐ 1~2hr ☐ 2~3hrs ☐ 3 or more hours) especially when I'm (☐ stressed ☐ tensed ☐ in other places ☐ preparing for a big day tomorrow ☐ hearing noises □sensing a light).

◆ I normally sleep ___ hrs a day from___PM/AM to ___ AM/PM. ☐ I'm sleepy all the time and ☐ I sleep more than others ☐ When I sleep 1-2hrs less than what I used to, I get very exhausted.

◆ I drink ___ cups of coffee. ☐ Coffee never bothers my sleep. ☐ Coffee disturbs sleep only when I drink it in the afternoon.

◆ Coffee disturbs my sleep (☐ a lot ☐ a little). ☐ When I drink coffee, I get (☐ palpitation ☐ jittery)

Whole Body

☐ Feel tired all the time and easily get tired. I never feel tired ☐ I'm still functional without sleep whole day.

◆ I easily get swelling on my (☐ hands ☐ feet ☐ legs ☐ face ☐ whole body)

☐ My legs swell up easily when I walk or standing too long

◆ When I am too stressed, I ☐ lose my voice ☐ have a sore throat. ☐ I need to clear up my throat often.

◆ When I am stressed □My lips feel dry. My mouth feels dry. I can taste bitterness.

◆ My eyes feel tired when I sit on the opposite direction of a train's direction or look out the windows in a car ride.

◆ My neck and shoulder feel sore. □ Usually □ Often □ Sometimes □ Rarely

☐ I get dizzy when I stand up. □ Usually gets cramp

◆ I have very sensitive skin that gets red, itchy and irritated by ☐ scratching ☐ wearing metal accessories ☐ using certain cosmetic product ☐ wearing synthetic fabrics

Personality and Emotional Questionnaire (Practitioner Use)

陽(Yang)	陰(Yin)
☞ When my body condition is poor and under stress I get or do:	
□ Go out and meeting people or do some activities □ Emotional Eating (eating without Hunger)	□ Never want to go out and avoid people just staying home □ Become very lazy and don't want to move at all
□ I'm always in a rush	□ slow and relaxed
□ extrovert	□ Introvert
□ Dynamic personality	□ Static personality
□ Bright and Cheerful	□ dark and depressed
□ Active	□ Passive □ Dependent
□ Always face the problem and try to solve it	□ avoid problems
□ Talkative	□ taciturn
□ Easily express emotions	□ Hard to express emotions
□ Have to say what's in mind □ When I have a problem with someone, I have to deal with it.	□ Endure the anger and what I have to say □ Even though other person did wrong, I don't mention and get over with it.
□ Easily get angry □ Petulant □ Easily get excited and frenzy □ bad-tempered □ Fierce □ Vigorous	□ I don't get angry □ I endure my anger □ I might get angry 1~2 times out of 10 in the situation that I supposed to be angry
□ Easily get frustrated and to be hurried	□ No rush and no Hurry for me
□ lack of patience	□ Very patient
□ decisive	□ Think too much, it is hard to make a decision
□ easily get tensed and nervous □ emotionally feel uncomfortable and unrested most of time	□ worry about small things □ Hypochondria – worry about my health all the time
□ fearless and brave □ There is definite line for right and wrong for me □ I cannot withstand wrongful things and justice is very important to me □ I have a clear measurement of like and dislike person. □ Easy for me to end Any relationship instantly and permanently □ have to finish what I have started □ I feel the need to do everything myself at work	□ Timid □ Easily get frightened □ I feel scared without no reason □ I hate scary movies and I cannot watch it alone I am scared to □ stay home alone □ walking alone at night □ stay alone in the dark room □ Fear of Bugs, Insects and rats
	□ Reduced affect display – lack of emotion
	□ depressed emotion □ lonesome □Sad □ feel like to cry sometimes □ Life is no fun □ cannot find meaning of my life □ I feel my self useless

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors , or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: _____

Date: _____

Office Signature: _____

The Teal Center for Therapeutic Bodywork, Ltd.
Acupuncture & Chinese Herbal Medicine Informed Consent

Please take time to read this form, which will provide you with some basic information about acupuncture treatment.

Important Things to Keep in Mind Regarding Acupuncture Treatment:

- Always feel free to communicate with your practitioner about what you are experiencing during the treatment or any questions you may have about the treatment.
- Clients experience a wide variety of sensations when receiving acupuncture treatment. You may not feel much, or you may feel a small, sharp sensation as the needle is inserted. Once the needles are in, it is common to feel a sense of general relaxation, tingling, movement, temperature change, or mild achiness at the site of a needle or elsewhere; these are all positive signs that your body is responding to treatment. If a needle ever continues to feel sharp past the moment of insertion, let your acupuncturist know so that the needle can be adjusted to a more comfortable position.
- If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please tell you acupuncturist immediately. These symptoms may occur and are generally caused by anxiety when receiving acupuncture for the first time.
- While the needles are in place, relax and breathe fully, but do not change your position or move suddenly, as you may experience some discomfort at the needle sites.
- Maintain good personal hygiene.
- You will be more comfortable during your treatment if you have eaten prior to the session but are not excessively full.

Acupuncture and Related Techniques

I understand that I may be treated with one or more of the following techniques. I understand that not all techniques are indicated for every person or condition, and I am free to ask my practitioner for more information about techniques to be used in my treatment.

- Insertion of needles into the body at various depths and locations
- Application of heat to the skin using moxa (an herb) or a conventional heat lamp
- A massage technique called "gua sha." This treatment leaves redness on the skin that may last from 1-5 days. Slight bruising or tenderness may persist after treatment.
- Cupping to promote circulation. Cups may produce a red/purple color on the area treated lasting for 1-5 days
- Electrical stimulation of the needles using an electro-acupuncture device
- The expression of a few drops of blood from an acupuncture point may be performed to improve circulation. A lancet is inserted into the skin and a few drops of blood are expressed.
- Therapeutic herbal consultation: Herbal and nutritional supplements (which are derived from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro intestinal upset or allergic reactions to the herbs, I will inform my acupuncturist

Infectious Disease Prevention

I understand that my acupuncturist uses only sterile, single-use, disposable needles and follows universally prescribed precautions such as clean needle technique and hand washing to prevent the transmission of infectious disease.

Risks / Possible Side Effects

I understand that in some cases acupuncture may result in certain side effects, including local bruising, slight bleeding, dizziness,

fainting, minor burns resulting from the use of heat therapies, temporary pain or discomfort, and/or temporary aggravation of symptoms existing prior to treatment.

Patient Responsibilities

I understand that it is my responsibility as a patient to inform my acupuncturist about all aspects of my health and, as treatment progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or possible adverse side effects, it is my responsibility to immediately notify my practitioner.

I acknowledge that I am ultimately responsible for my own health and self-care. Making healthy lifestyle choices can substantially support my healing process and enhance the outcome of the acupuncture treatments I receive.

Confidentiality

I understand that the confidentiality of my file and the information I share in the course of treatment will be honored and preserved. I acknowledge that my practitioner is ethically and legally required to report certain information pertaining to the abuse of minors and elders or serious threats of violence.

Treatment Outcomes

I understand that each individual responds uniquely to treatment and, for this reason, my practitioner cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their symptoms after the first few treatments. Others notice a steady, gradual improvement. Occasionally, some people notice that their symptoms seem to worsen before they improve. I agree to share my responses with my acupuncturist at each follow-up visit so that my treatment plan can be adjusted accordingly.

By signing this informed consent form, I acknowledge that I have read the information above carefully and that I consent to receive acupuncture treatment.

Name (Print)_____

Patient Signature_____ Date_____

Parent Signature (if patient is a minor)_____ Date_____

Recommendation for a Diagnostic Examination

WE, THE UNDERSIGNED, DO AFFIRM THAT _____ (*NAME OF PATIENT*) HAS BEEN ADVISED BY_____ (*NAME OF LICENSED ACUPUNCTURIST*), TO CONSULT A PHYSICIAN REGARDING THE CONDITION FOR WHICH ACUPUNCTURE TREATMENT IS BEING SOUGHT.

_____ _____

(Signature of patient) (Date)

_____ _____

(Signature of acupuncturist) (Date)

The Code of Virginia requires that prior to performing acupuncture, a licensed acupuncturist shall either "(i) obtain written documentation that the patient had received a diagnostic examination from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry with regard to the ailment or condition to be treated or (ii) provide to the patient a written recommendation for such a diagnostic examination." (§54.1-2956.9 of the Code of Virginia)

Instructions to Licensed Acupuncturist:

The law requires the Board of Medicine to adopt a standard form to be used by licensed acupuncturists in recommending a diagnostic examination. **Therefore, this form must be given to any patient seeking acupuncture treatment from whom the acupuncturist has not obtained written documentation of a diagnostic examination from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry for the ailment or condition being treated.**

- The form must be in duplicate with one copy to be given to the patient and one copy kept on file with the patient's records.
- The form must be signed and dated by both the patient and the licensed acupuncturist.
- If the patient does not understand English, the licensed acupuncturist must either provide the form in the language of the patient or ensure that it has been translated for the patient in his language.

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT AGREEMENT

HIPAA regulations require the following signed authorization:

I (name)_____(address)_____

give permission for my Teal Center practitioner to take notes about me, including health history/medical and/or personal information I choose to disclose. I understand that this information will be kept strictly confidential.

I also understand:

1. That massage therapy, bodywork and acupuncture

   - is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow;
   - is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

2. That the massage therapists, bodyworkers and acupuncturists

   - do not diagnose illness, disease or any other physical or mental disorder;
   - do not prescribe medical treatment or pharmaceuticals; and
   - do not perform any spinal manipulations.

3. That any and all of my appointment times are reserved exclusively for me and that I am responsible to remember them and to pay for appointments that I miss, cancel or reschedule with less than 24 hours notice.

I authorize The Teal Center to charge my credit card on file for the full amount of any appointment missed, cancelled or rescheduled with less than 24 hours notice.

I have stated all my known medical conditions, agree to keep my practitioners updated on my physical health and to update my medical history as necessary.

Name_____

Signature_____ Date_____

POLICIES

Please ***READ*** and ***INITIAL*** each of the following

Welcome! Thank you for choosing The Teal Center!

_____ Appointments missed, cancelled or rescheduled with less than 24 hours notice will be charged in full. To avoid being charged for a missed appointment, we invite you to send a friend or family member in your place. Also, if we can fill appointments that are missed, cancelled or rescheduled with less than 24 hours notice the client will not be charged. *It is your responsibility to remember your appointments.* Confirmation calls are made 36-48 hours prior to the scheduled appointment.

_____ The Teal Center and its practitioners abide by the ethical standards of practice established by their respective certification boards (NCBTMB and NCCAOM). All clients shall refrain from any behavior that sexualizes or appears to sexualize the client/therapist relationship. If such behavior occurs at any time, therapists are instructed to terminate the session; payment will be made in full by the client and the Teal Center reserves the right to prohibit the client from returning to the Teal Center.

_____ If you have a cold or other contagious illness, please call us before your appointment so we can check with your therapist to see if it is appropriate for you to come in.

_____ In order to preserve a peaceful environment, we ask that you silence your cell phones while at The Teal Center.

_____ Tips are appreciated but *never* expected. If you wish to leave a gratuity for your therapist we ask that you do so in cash or by check made directly to the therapist.

_____ If you move or change phone numbers, it is your responsibility to inform us. This is important so we can reach you in case of any emergency or any necessary and unforeseen scheduling changes.

_____ The Teal Center does not submit insurance claims. We are happy to provide you with medical receipts, any treatment notes and payment history for your personal records. We will communicate directly with your insurer *at their request only.*