Welcome to the Daoist Traditions College Acupuncture Clinic. We offer excellent and compassionate care for a wide range of health conditions.

Daoist Traditions College Acupuncture Clinic
222 S. French Broad Avenue
Asheville, NC 28801
(828) 253-8669

Appointments: Your acupuncture care will be provided by clinical interns supervised by experienced, licensed acupuncturists. Our goals are to provide you with the best possible care and give each of our interns equal opportunity to learn and build their skills. We do things a little differently to meet these priorities.

As a teaching clinic, we are not always able to honor requests for specific interns. We recommend trying different interns to find a that few you feel comfortable with so you can be consistent with your appointments even when your main intern is unavailable. Sticking with your treatment plan is more important than seeing any specific intern. Seeing other interns also gives you more perspectives on your health.

If your scheduled intern is unavailable, we will schedule you with another intern. We cannot notify you ahead of time if your regular intern is absent. We know this is different than other offices, but our interns have only 2 years to gain as much experience as possible. Our focus is to maximize each intern's opportunity to treat a wide variety of patients and conditions.

Patients may have a caretaker or family member present during their treatments as long as their presence is not disruptive to the healing environment of the clinic. Patients may bring a child to their treatment as long as the child is able to sit quietly and independently during the patient's treatment. All children under the age of 12 must always be accompanied by an adult, including in the waiting room and during the child's treatment.

Trained, registered service animals are permitted in our clinic. Due to the small size of our treatment rooms, advance notice will help us reserve a room that can accommodate your service animal. Service animals must be leashed or tethered unless your disability prevents using these devices or these devices interfere with the animal's tasks. In that case, other effective controls may be used. Service animals must not create a safety hazard while your intern is performing acupuncture, moxibustion, or other techniques. We reserve the right to exclude service animals that are not controlled; not housebroken; or disrupt the healing environment of the clinic. Pets and comfort/emotional support animals are not permitted in our facility.

Cancellations: Please make every effort to keep your scheduled appointment and to be on time. *If you are more than 15 minutes late, we may need to shorten or reschedule your appointment.* We understand that things sometimes come up, but we cannot fill your appointment slot without significant notice and our interns can't receive credit if they are unable to treat a patient. If you need to cancel your appointment, please give us at least 24-hour notice. Appointments cancelled without 24-hour notice will incur a charge of $30.00. Missed appointment fees must be paid at the next appointment.

Acupuncture can be extremely helpful for acute conditions. If something comes up, contact us to see if you should keep your appointment. If our schedule changes due to inclement weather, we will notify you by phone for planned changes and by text message for last-minute changes.

Fees & Payments: Payment for treatment and herbs is required at the time of service and can be made by check, cash or Visa/Mastercard. There is a $1.25 service charge for payments made by credit/debit card.

$40 for Adults (18 & older, if not a full-time student)
$30 for Full-time students with a valid ID, Children under the age of 18, and Veterans
Daoist Traditions Students receive a treatment discount
Herbs prices vary

Herbs must be paid for when they are prescribed. Please call to request herb refills, as they need to be approved by the intern(s) and supervisor. There is a charge of $35.00 for any returned checks. The total check amount and the $35 fee must be paid in cash before we can provide further service.

We do not provide billing for insurance claims. We do not provide letters or statements of medical necessity for insurance companies or other agencies, unless required to do so by law. Receipts are provided at the time of service. Please retain your payment records for income taxes, flex spending account, and health savings account purposes. We do not issue end-of-year account statements.

Medical Records: We do not send DTCC records to other Chinese Medicine practitioners or medical professionals because treatments at our clinic are not performed by licensed acupuncturists. We are happy to provide you with a copy of your records, upon written request. As a teaching clinic, interns must make a new diagnosis for each patient, at each appointment. Therefore, we do not allow students to use patient medical records from Chinese medicine practitioners outside of the DTCC. Interns may not follow a CM diagnosis, treatment principle, treatment plan, point protocol, herbal prescription, etc., from outside practitioners. Our clinic does not make requests for previous Chinese Medicine or Western Medicine records to be sent to our clinic. Please share details of your medical history on the health history forms and during your appointments.

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NOTICE OF PRIVACY POLICIES (HIPAA)

The Daoist Traditions College Acupuncture Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is a fundamental part of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

The Daoist Traditions College Acupuncture Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you. You may unsubscribe from email marketing at any time.

Disclosure

The Daoist Traditions College Acupuncture Clinic may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information:

Contact: Lissa Juedemann, Clinic Director
Telephone: 828-253-8669
Address: 222 South French Broad, Asheville, NC 28801

To send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

Health History Questionnaire

Daoist Traditions College Acupuncture Clinic

Name:	**DOB:**

How should we address you? ☐ Ms./Mrs./Mr. (circle one**)** ☐ First name ☐ Nickname:
Preferred Gender Pronouns:

Age: **Height:** **Weight:**

Address: **City:** **State:** **Zip:**

Email:

Phone #: **Cell:** **May we leave a voicemail?** ☐ Yes ☐ No

Occupation:

Emergency Contact Name: **Phone:**

Is this your first time receiving acupuncture? ☐ Yes ☐ No

Who may we thank for referring you?

Recent Health Care (Provider/Date/Service Provided):

What is Your Main Concern?

_____
_____
_____
_____

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is the diagnosis?

What kinds of treatment or therapies have you tried?

Hospitalizations/Surgeries/Accidents:

Allergies:

Family Health History

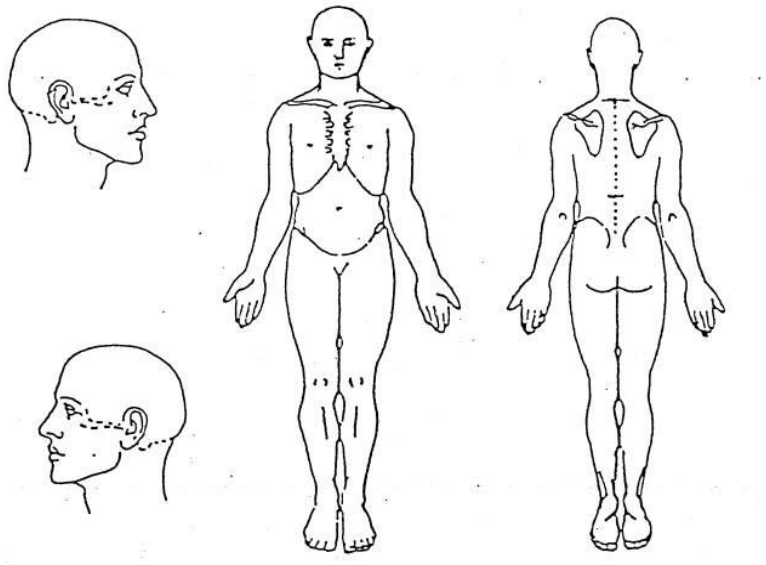
Family Member	Deceased Y/N	Age	Significant Diseases/Illnesses

Lifestyle

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)
Diet	Are you dieting? ☐ Yes ☐ No
	If yes, are you on a physician-prescribed medical diet? ☐ Yes ☐ No
	The number of meals you eat on an average day
	Describe daily diet:
Caffeine	How much per day? ☐ Coffee ____ ☐ Tea _____ ☐ Soda _____
Smoking	☐ Tobacco ☐ Vaping Amount/Frequency _____ # of years?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No
	If so, how many drinks per week?
Drugs	Do you use recreational drugs? If yes, what type? How often?

Please mark painful or distressed areas on the charts below.

Symbol	Reaction
Pain	
X XX XXX	little moderate strong
Swelling	
^ ^^ ^^^	slight moderate severe
Pulsing	
O OO OOO	slight moderate strong
Weakness/Temperature	
~ +	weak hot
Skin Problems	
*	skin issue



Personal History			
General	☐ Poor Appetite ☐ Insomnia ☐ Disturbed Sleep ☐ Localized Weakness ☐ Cravings	☐ Strong Thirst ☐ Weight Gain ☐ Weight Loss ☐ Sweating Easily ☐ Bleeding/Bruising ☐ Tremors	☐ Night Sweats ☐ Fever ☐ Chills ☐ Sudden Energy Drop ☐ Poor Balance
Skin and Hair	☐ Rashes ☐ Ulcerations ☐ Hives/Itching	☐ Eczema ☐ Pimples ☐ Dandruff	☐ Recent Moles ☐ Changes in Hair Texture ☐ Hair Loss
Head, Eyes, Ears, Nose, Throat	☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses ☐ Spots/Floaters ☐ Eye Pain ☐ Poor Vision ☐ Night Blindness ☐ Photophobia ☐ Gum/Teeth Problems	☐ Color Blindness ☐ Cataracts ☐ Blurry Vision ☐ Earaches ☐ Ringing in the Ears ☐ Poor Hearing ☐ Eye Strain ☐ Sinus Problems ☐ TMJ ☐ Jaw Clicks	☐ Recurrent Sore Throats ☐ Nose Bleeds ☐ Grinding Teeth ☐ Sores on Lips or Tongue ☐ Facial Pain ☐ Teeth Problems ☐ Headaches
Cardiovascular	☐ Dizziness ☐ Low Blood Pressure ☐ Chest Pain ☐ Irregular Heartbeat ☐ Tightening in Chest	☐ High Blood Pressure ☐ Fainting ☐ Cold Hands or Feet ☐ Swelling of Hands ☐ Palpitations	☐ Swelling of Feet ☐ Blood Clots ☐ Difficulty in Breathing ☐ Phlebitis ☐ Stroke
Respiratory	☐ Cough ☐ Asthma	☐ Bronchitis ☐ Shortness of Breath	☐ Frequent Colds or Flu ☐ Excessive Phlegm
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas/Bloating ☐ Parasites ☐ Colitis	☐ Belching ☐ Black Stools ☐ Blood in Stools ☐ Indigestion ☐ Bad Breath ☐ Diverticulitis ☐ Crohn’s	☐ Rectal Pain ☐ Hemorrhoids ☐ Abdominal Pain/Cramps ☐ Chronic Laxative Use
Genitourinary	☐ Pain in Urination ☐ Urinary Infections ☐ Blood in Urine	☐ Incontinence ☐ Decrease in Flow ☐ Kidney Stones	☐ Sores on Genitals ☐ Low to No Sex Drive

Musculoskeletal	☐ Neck Pain ☐ Muscle Pain ☐ Knee Pain ☐ Sciatica ☐ Migraines ☐ Varicose Veins	☐ Back Pain ☐ Muscle Weakness ☐ Numbness/ Tingling ☐ Tinnitus	☐ Hand/Wrist Pain ☐ Shoulder Pain ☐ Hip Pain ☐ Arthritis ☐ Foot/Ankle Pain
Neuropsychological	☐ Seizures ☐ Dizziness ☐ Loss of Balance	☐ Poor Memory ☐ Depression ☐ Concussion	☐ Anxiety ☐ Bad Temper ☐ Frequent Mood Swings
Other Illness	☐ HIV Positive ☐ AIDS ☐ Epstein-Barr ☐ Mononucleosis	☐ Rheumatic Fever ☐ Hypoglycemia ☐ Diabetes ☐ Underweight	☐ Eating Disorders ☐ Jaundice ☐ Hepatitis ☐ Overweight

Gynecological Health

Age at onset of menstruation:	Date of last menstruation:	
Period occurs every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies:	Number of live births:	
Are you pregnant or breastfeeding?	☐ Yes	☐ No
D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Hot flashes or sweating at night?	☐ Yes	☐ No
Menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	☐ Yes	☐ No
Breast tenderness, lumps, nipple discharge?	☐ Yes	☐ No

Genitourinary Health

Difficulty with erection or ejaculation?	☐ Yes	☐ No
Testicle pain or swelling?	☐ Yes	☐ No
Prostate enlargement or prostatitis?	☐ Yes	☐ No
Burning or discharge from penis?	☐ Yes	☐ No

Mental Health

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Please list all medicines, herbs, and supplements you currently take. Include dosages, if possible.

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Please initial each section and sign at the bottom of the page:

Acknowledgement of Receipt of Notice of Privacy Policies

I have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Daoist Traditions College Acupuncture Clinic.

Initials: _____

Patient's Consent for the Purposes of Payment and Healthcare Operations

I give consent to the Daoist Traditions College Acupuncture Clinic to use and disclosure of my Individual Identifiable Health Information or Protected Health Information for the specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:
Protected Health Information is any information that includes:

1. Demographic Information
2. Information gathered by this practice as it relates to my past, present and future.
3. Information gathered by this office for past, present or future payments for providing the healthcare services.
4. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

Initials: _____

Acknowledgement of Receipt of Clinic Policies

The Daoist Traditions College Acupuncture Clinic provides each patient with a statement of Clinic Policies.

I have read, reviewed, understand and agree to the statement of the Office Policies for healthcare services at the Daoist Traditions College Acupuncture Clinic.

- I agree to provide at least 24-hour notice of cancellation and accept the $30 fee for late notice cancellations or missed appointments.
- I understand that if I am more than 15 minutes late my appointment may be shortened or rescheduled.
- I understand that I may not always have the intern of my choice.
- I understand that if my regular intern is absent, I will be scheduled with another available intern and I will not be notified ahead of time of the change.
- I understand that my clinical intern may be working with a partner and that an observing student may also be present during my sessions.
- I agree to accept any Clinical Intern, Observer, or Supervisor assigned to me without discrimination.
- I acknowledge that there is a $35 processing fee for returned checks.

Initials: _____

Print Name: _____

Patient or Personal Representative Signature: _____ **Date:** _____

PLEASE RETURN YOUR COMPLETED FORMS TO THE FRONT DESK