BOULDER ACUPUNCTURE AND HERBS
Norah Charles, L.Ac.
info@boulderacupunctureandherbs.com / P. (720) 668.6638 / 350 Ponca Boulder, CO 80303

Colorado Mandatory Disclosure Statement

Education and Experience

Norah Charles earned her Master of Acupuncture and Oriental Medicine degree from the Boulder campus of Southwest Acupuncture College in 2015. This four-year program consists of over 3,000 hours of classroom education and over 800 hours of clinical practice. She was certified as a Diplomat in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2015. This includes certification in Clean Needle Technique and Chinese Herbology. Norah's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, and dietary and lifestyle recommendations. Norah is a licensed acupuncturist in the state of Colorado and has never had her license suspended or revoked.

Fee Schedule*/**

New patient private acupuncture treatment: $95 / 75 minutes
Return acupuncture treatment: $80 / 60 minutes OR $60 / 45 minutes
New patient herbal consult (no acupuncture): $60 / 60 minutes
Return herbal consult (no acupuncture): $30 / 30 minutes
New patient community acupuncture treatment: $40 / 60 minutes
Return community acupuncture treatment: $30 / 45 minutes
Ear acupuncture only treatment: $10 / 30 minutes

** Treatment length is determined by the practitioner according to patient's health condition and constitution.*
***Please add an additional fee of $20 for house calls within the City of Boulder, CO.*

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

Each patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. Patients may also 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 immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. If you have comments, questions or complaints, contact the office of the Director of Professions and Occupations, Acupuncturist Licensure at 1560 Broadway, Suite 1350, Denver, Colorado 80202, call 303.894.7800 or email dora_acupunctureboard@state.co.us.

I have read and understand this document:

Patient or guardian signature _____

Printed name _____ Date _____

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Chinese Materia Medica by a licensed acupuncturist in this clinic.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment may occur. 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.

Chinese Herbs: I understand that substances from the Chinese Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances. If I do choose to take Chinese herbs, I am advised to follow the directions for administration and dosage so that the maximum medicinal benefit will be achieved. I am aware that certain adverse side effect may result, such as changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems associated with these substances, I should suspend taking them immediately.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment and that certain adverse side effects may result from this treatment. These could include, but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment.

I understand that I may refuse treatment by any of these modalities at any time and that I may ask my practitioner for a more detailed explanation of any of the above methods. By my signature below, I indicate I have carefully read and understand all of the above information and give my permission and consent to treatment.

Patient signature: _____ **Date:** _____

Patient's printed name: _____ **Date of birth:** _____

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PATIENT INFORMATION

Name: _____ Birth date: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Current gender identity: _____

How do you prefer to be contacted? _____ text _____ phone _____ email

Name of your physician: _____ Contact number (if known): _____

When was the last time you visited a medical doctor? _____

Name of emergency contact: _____ Phone: _____

Who may we thank for referring you to our office? _____

CONFIDENTIALITY AND PRIVACY AGREEMENT

We value our relationship and respect your right to privacy. Our office complies with HIPAA rules and procedures regarding confidentiality. We do not share your medical information without your written consent. If you have specific questions about our privacy guidelines, please ask your practitioner.

NON-DISCRIMINATION COMMITMENT

Our practice respects all aspects of people including age, gender, race, ethnicity, religion/no religion, national origin, language, education, marital status, body size, political affiliation/philosophy, sexual orientation, gender identity/expression or variance, physical and mental ability, social-economic status, genetic information and HIV and veteran status.

BOULDER ACUPUNCTURE AND HERBS FINANCIAL POLICIES

Our office accepts payment by cash, check or credit card on the day services are rendered. We do not accept payment through insurance, though we can provide a receipt for services paid for use with your Health Savings Account or reimbursement through your insurance provider.

Please note that our clinic has a 24-hour appointment cancellation policy. If you cancel your appointment less than 24 hours in advance, you will receive an invoice for the full cost of services scheduled. Thank you for your consideration.

Patient signature: _____ **Date:** _____

Printed Name: _____

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CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ Date of birth: _____ Current gender identity: ___
What is your primary reason for visiting our office today? _____

_____

_____

When did this illness/injury start? _____ Were symptoms gradual or acute? _____
Are symptoms worse at a particular time of day or after a specific activity?

_____

_____

What makes the symptoms better? _____ Worse? _____
Do you have specific questions you would like to discuss today?

_____

_____

Please list all allergies, including medical, environmental, food, etc.

_____

_____

Medications, supplements and herbs you currently take, with dosages:

_____

_____

_____

Surgeries and hospitilzations, including dates:

_____

_____

_____

Have you been diagnosed with any chronic, long-term or infectious illnesses (for example, diabetes, autoimmune disorders, hypertension, hepatitis, asthma, etc.)?

_____

_____

Have you been diagnosed as “pre-diabetic” by your physician? _____
Are you currently undergoing a difficult life transition, such as a change in career, a divorce, a move, or caring for an aging parent? _____
Is there anything else you would like us to know about you?

_____

_____

_____

Thank you.