Welcome

Welcome to acupuncture and massage at Stonington Natural Health Center. We are so glad that you made it here. Soon you will experience a wonderful, relaxing treatment.

Here at Stonington Natural Health Center, we offer Oriental Medicine Treatments, the SNHC Customized Massage, Hot Stone Massage, Pregnancy Massage, Reiki, Reiki Healing Massage, and Ear Candling. Enjoy feeling your muscles release and be able to breathe more deeply, allowing your mind to rest. These Holistic Therapies help you to let go of your worries. Your body, mind, and spirit will thank you for this enjoyable rejuvenating treatment.

If you are here for Oriental Medicine today, your treatment may include some combination of acupuncture, tui na (twee nah) massage, herbal medicine, Qi gong (chee gung), or nutritional counseling. This is your time to discover the relaxation and bliss of these therapies as they unblock and promote the smooth flow of your Qi, or energy, and help you to heal.

For injuries or health complaints, it is recommended to come in for treatments for a series of days close together. You will receive the most benefit when being treated before the effects of the previous treatment disappear. During times of stress, anxiety, or depression, it is helpful to come in for acupuncture and massage treatments at least once a week. In China, it is common to see the acupuncturist for a series of days in a row, then slowly space the treatments apart as a tune-up to maintain good health. This allows us to shift the pattern of your energy more quickly and easily and with longer lasting effects. And that's our goal, to get you better quickly and to instill long-term good health.

If you have any questions, concerns, or feedback, feel free to talk with or email us at info@snhc.com.

We appreciate this opportunity to contribute to you on your path towards optimal health and happiness.
ALL OF US AT STONINGTON NATURAL HEALTH CENTER

All life is an experiment. The more experiments you make the better.
RALPH WALDO EMERSON

Enjoy the journey.
DEEPAK CHOPRA

Stonington Natural Health Center
***acupuncture * herbal medicine * bodywork**

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I whom I am legally responsible) by Megan Marco, Doctor of Acupuncture, Licensed Acupuncturist.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), shiatsu (Japanese Massage), acutonics (sound therapy), Neuro-Emotional Technique, Chinese or western herbal medicine and nutritional counseling.

I will discuss with Megan Marco, D.Ac., L.Ac. any questions or concerns that I have with my Acupuncture and Oriental Medicine treatments.

The goals of Acupuncture and Oriental Medicine treatments are to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment. Occasionally there may be some bruising or tingling near the needling sites that lasts a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are 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 Megan Marco, D.Ac., L.Ac.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. If I have any questions, I will ask. By signing below, I agree to the above named procedures. 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.

To be completed by the patient:

Patient's Name: _____

Signature _____

Date: _____

Are you pregnant? _____

Clinic/Office: Stonington Natural Health Center
107 Wilcox Road, Suite 103
Stonington, CT 06378

Name of Acupuncturists: Megan Marco, D.Ac., L.Ac.

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated:

Patient's Name: _____

Patient's Representative: _____

Relationship to Authority: _____

Witness: _____

Stonington Natural Health Center
***acupuncture * herbal medicine * bodywork**

FINANCIAL POLICIES FOR TREATMENT AND CARE

Oriental Medicine is excellent for helping you when you are not feeling well. If you have a cold, flu, illness or are in pain, those are the best times to come in. We prefer that you come in on time; however, if you are running late, we prefer that you arrive late rather than miss your appointment. If you need to change, reschedule, or cancel, we greatly appreciate your calling Stonington Natural Health Center as soon as you can and *at least two days, or 48 HOURS,* before your appointment.

"Minimum 48 Hours Cancellation Policy":

Your appointment time is reserved for you. **We prefer 48 hours notice. If LESS THAN 24 HOURS is given to Stonington Natural Health Center for rescheduling or canceling, your credit card will be charged for the appointment. Treatment packages will have one treatment deducted.**

SNHC Cancellation Policy means that if your appointment is 9am Monday, you have **up to 24 hours before**, or 9am Sunday, to reschedule in order not to be charged--please leave a message. We prepare our schedule days in advance, and while we know that situations arise, this policy must exist for us to be here for you. Thank you for understanding.

Payment: In an attempt to keep health care costs low, payment is required at the time of your service. Preferred payment methods are cash, check, Visa, Master Card, or Discover.

Treatment Plans*:* Dr. Marco or your Licensed Massage Therapist will develop your treatment plan to guide you to accomplish your goals and feel your best as soon as possible. Follow your Treatment Plan to achieve optimal results rather than experience a yo-yo effect.

Reduced Fee Treatment Packages and SNHC Massage Memberships: are available to (1) make check-out easier, (2) lower the price, and (3) make a commitment between practitioner and patient to help you complete your treatment goals. Treatment Packages and SNHC Memberships are not refundable and can only be used for the services purchased. Acupuncture Treatment Packages are good for a one year time period from the date of purchase and SNHC Massage Memberships have specific expiration dates.

Your credit card number is kept on file for payment of any missed or cancelled appointments and for guarantying personal checks. Your credit card information is kept private, confidential, and secure.

The following information is required to receive treatments:

Visa/MC _____ _____/_____ _____
(Please circle) Credit Card Number Month year 3 digit code on back

I have read, I understand, and I agree to the above information:

_____ _____ _____
Signature **Printed Name** **Date**

MEGAN MARCO, D.Ac., L.Ac.
STONINGTON NATURAL HEALTH CENTER
107 WILCOX ROAD, SUITE 103
STONINGTON, CT 06378

PATIENT NOTICE OF PRIVACY POLICY

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.

Patient Rights and Uses and Disclosures of Health Information:

PERSONAL HEALTH INFORMATION DISCLOSURE:

In the course of your care as a patient at Stonington Natural Health Center, we may use or disclose personal or health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

2. Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

3. Your name and address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, Stonington Natural Health Center newsletters, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you, or the reimbursement avenues associated with your care.

PERMITTED OR REQUIRED TO USE OR DISCLOSE HEALTH INFORMATION WITHOUT YOUR CONSENT OR AUTHORIZATION:

UNDER federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.

2. If we provide health care services to you in an emergency.

3. If there are substantial barriers to communicating with you, but in our professional judgment believe that you intend for us to provide care.

4. If we are ordered by the courts or another appropriate agency.

ANY USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, OTHER THAN OUTLINED ABOVE WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION

We normally provide information about your health in person at the time you receive services or care from us. We also may mail information to you regarding your health care, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing

PRACTIONER LEGAL DUTIES

We are required by state and federal law to maintain the privacy of your patient file and the protected health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

COMPLAINTS & QUESTIONS

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your questions to: Megan Marco, D.Ac., L.Ac. (860) 536-3880.

This notice is effective immediately. This notice, and any alternation or amendments made hereto, will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

Patient Name (printed) Signature

_____

DATE

STONINGTON NATURAL HEALTH CENTER

Patient Health History

Name: _____Date: _____
Date of Birth: _____ Age: _____ Gender: _____
(For insurance billing only: SS#: _____)
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone#: _____ Cell Phone#: _____
Work Phone#: _____ Occupation: _____
email: _____ Marital Status: _____
Hobbies and Interests:
_____
Emergency Contact: _____ Phone#: _____ Relationship: _____
Primary Care Physician:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____

How did you hear about Dr. Megan Marco?

_____

What is your primary health concern?

_____

_____

How long has this condition persisted?

_____

_____

What do you think is the cause?

_____

_____

How does it affect you?

_____

_____

Have you received other treatment for this condition? Yes No

If yes, what, when?

_____

Diagnosis given?

_____

What were the results of the treatment?

_____

Patient Health History

Name: _____Date: _____

What are your hopes and expectations from treatment with Dr. Marco?
_____
_____

Please list your most significant health problems in order of importance:
a. _____ c._____
b. _____d._____

Height _____ Weight _____ any recent weight loss or gain? Yes No

Do you have any reason to believe you are pregnant? Yes No
Do you have any chronic infectious diseases? Yes No
If yes, please explain: _____
Are you currently suffering from any chronic illnesses? Yes No
If yes, please explain: _____

Please list any hypersensitivities or allergies that you may have and your reaction:
Allergies--Foods: _____
_____
Allergies--Medications:
_____
_____

Please list any medications, vitamins or supplements you are currently taking (include dosage and duration of use):

Please list any major surgeries that you have had and the approximate dates they occurred:

Please list any significant traumas (i.e. car accidents, bone fractures, sprains, falls, etc.):

Have you experienced any significant emotional trauma? If so, what and when?

Patient Health History

Name: _____Date: _____

Please circle any symptoms that you currently have or have had within the past year.

General:
Low energy or fatigue
Allergies
Dry throat/mouth
Insomnia
Spontaneous sweating
Night sweats
Excessive thirst
Aversion to heat
Aversion to cold
Chronic infections

Gastrointestinal:
Nausea/vomiting
Low appetite
Abdominal pain
Gas
Belching
Bloating
Indigestion
Acid reflux/heartburn
Ulcers
Loose stools
Constipation
Blood in the stools
Black/tarry stools
Hemorrhoids

Neurologic:
Paralysis
Numbness/tingling
Seizures
Loss of balance
Epilepsy
Tics
Lyme Disease

Head and Neck:
Headaches
Blurred vision
Red/swollen eyes
Dry/itchy eyes
Eye pain
Glasses or contacts
Glaucoma or cataracts
Dizziness/vertigo
Recurrent phlegm
Sinus problems
Nosebleeds
Frequent sore throats
TMJ (jaw problems)
Earaches
Hearing loss
Ringing in ears
Fever blisters
Sores on tongue or in mouth
Loss of smell
Change of taste

Genitourinary Tract:
Painful urination
Burning urination
Kidney stones
Frequent urinary tract infections
Frequent urination at night
Venereal disease
Blood in the urine
Dark urine
Difficult urination
Incontinence

Respiratory:
Asthma
Pneumonia
Chronic bronchitis
Persistent cough
Shortness of breath
Frequent colds
Hay fever
Coughing up blood

Musculoskeletal: *(pain, numbness or weakness)*

Neck/shoulder	Arms
Legs	Feet
Joints	Knees/elbows
Mid/upper back	Hands
Lower back	Whole body

Muscle spasms/cramps (where?)
_____
Broken bones (where?)
_____
Sprains/strains (where?)
_____
Tendonitis (where?)
_____

Emotions:

Mood swings	Stress
Nervousness	Sad
Mental tension	Angry
Irritability	Frustrated
Anxiety	Worried
Depression	Afraid

Patient Health History

Name: _____Date: _____

Cardiovascular:
Heart disease
High blood pressure
Chest pain
Heart palpitations/fluttering
Heart murmurs
Varicose veins
Swelling of legs/ankles
Stroke

Male Reproductive:
Genital pain
Low sex drive
Impotence
Enlarged prostate
Testicular pain or swelling
Discharge

Female Reproductive:
Breast lumps/tenderness
Irregular periods
Painful periods
PMS
Short cycle (less than 24 days)
Long cycle (more than 35 days)
Bleeding between periods
Endometriosis
Abnormal PAP smear
Vaginal discharge
Difficulty conceiving
Low sex drive
Menopause

Family History:

	Mother	Father	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Check any of the following conditions that apply to members of your family						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____

Patient Health History

Name: _____Date: _____

Nutrition: Please describe what you generally eat at each meal.

- **Breakfast**

_____

- **Lunch**

_____

- **Dinner**

_____

- **Snacks**

_____

Do you smoke cigarettes? Yes _____ No _____
If yes, how much? _____

Do you consume caffeine? Yes _____ No _____
If yes, what and how much?_____

Do you drink soda? Yes _____ No _____
If yes, what and how much? _____

Do you consume artificial sweeteners (nutrasweet, splenda, saccharin)?
Yes _____ No _____
If yes, how much? _____

Do you drink alcohol? Yes _____ No _____
If yes, how much and how often? _____

What do you do for exercise and how often?_____
_____

Is there anything else about you or your condition that you would like me to know or address? _____
_____