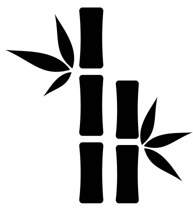


New patient intake form

1110 W. William Cannon Drive, Ste 403, Austin, TX 78745
512.431.7997

To help us provide you with the best possible care, please fill this form out as accurately as possible. The information provided will be confidential.

Today's Date: ______/______/______
Month Day Year

Name: ____________________ Sex: ❍Male ❍Female Date of Birth: ______/______/______ Age: ______
Month Day Year

Height: ____'____" Weight: ______lbs Marital Status: ______________ Occupation: ____________________

Home Address: ____
Street City State Zip Code

Mailing Address: ____
Street City State Zip Code

Home Phone: ______________ Work Phone: ______________ Mobile Phone: ______________

Emergency Contact Name, Phone Number & Relationship ______________________ Relationship: ______

Your E-mail Address: ____

How did you hear about us?

What is your reason(s) for this visit? ____

____

____

____

How long have you had this condition? ____

What seems to make the condition better? ____

What seems to make the condition worse? ____

What treatments have you tried? How did your condition change? ____

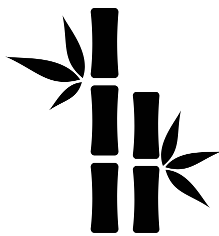
____

How would you rate your condition today? Please circle the number: Normal 1 2 3 4 5 6 7 8 9 10 Unbearable

Have you had NAET or acupuncture treatments before? ❍Yes ❍No If yes, for what condition? ______________________

Are you willing to take supplements if prescribed by your practitioner for more effective treatment as an addition to your treatments?
❍Yes ❍No ❍Open to discussion

If yes, are you a vegetarian or vegan, and strongly opposed to Chinese herbs derived from animals? ❍Yes ❍No ❍Open to discussion



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family medical history

❍ Allergies ______________________ ❍ Asthma ❍ Alcoholism ❍ Cancer ______________________ ❍ Diabetes ❍ Heart Disease
❍ High Blood Pressure ❍ Seizures ❍ Stroke ❍ Other ____

past medical history

- ❍ Addiction _________
- ❍ AIDS
- ❍ Alcoholism
- ❍ Anemia
- ❍ Appendicitis
- ❍ Arteriosclerosis
- ❍ Arthritis
- ❍ Asthma
- ❍ Breast Lumps
- ❍ Breathing Problems
- ❍ Bronchitis
- ❍ Bursitis
- ❍ Cancer _________
- ❍ Candida
- ❍ Chicken Pox
- ❍ Chronic Fatigue
- ❍ Colitis/ Bowel Disease
- ❍ Diabetes
- ❍ Digestive Disorders
- ❍ Eating Disorder
- ❍ Elevated Liver Enzymes
- ❍ Emotional Imbalance
- ❍ Emphysema
- ❍ Epilepsy
- ❍ Food, Chemical, Drug Poisoning
- ❍ Fibromyalgia
- ❍ Gall Stones
- ❍ Glaucoma
- ❍ Goiter
- ❍ Gout
- ❍ Heart Disease
- ❍ Hernia
- ❍ Hepatitis ________
- ❍ Herpes
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Hypertension
- ❍ HIV Positive
- ❍ Kidney Stones
- ❍ Malaria
- ❍ Measles
- ❍ Meningitis
- ❍ Mononucleosis
- ❍ Multiple Sclerosis
- ❍ Mumps
- ❍ Nephritis
- ❍ Neuralgia
- ❍ Paralysis
- ❍ Prostate Problems
- ❍ Rheumatism
- ❍ Scarlet Fever
- ❍ Seizures
- ❍ Stroke
- ❍ STD
- ❍ Thyroid Problems
- ❍ Tonsillitis
- ❍ Tuberculosis
- ❍ Typhoid Fever
- ❍ Ulcers
- ❍ Urinary Problems
- ❍ Whooping Cough

Other: ____
____
____

Surgeries: ____

Significant Traumas (auto accidents, falls, loss of loved one, etc): ________________________________

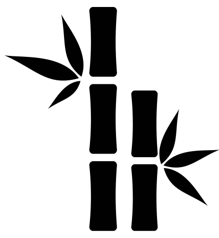
Allergies and adverse reactions: ____
____
____

Medications taken in last 2 months, including vitamins, supplements, over-the-counter medicines, recreational drugs, herbal medicines: __________
____
____

Do you exercise regularly? If so, what and how often do you do?: ________________________________

Are you wearing any electronic device(s), such as pacemaker and hearing aid?: ❍ Yes: ______________________ ❍ No

Do you have any of the following conditions currently? ❍ Cold/ Flu ❍ Infection/ Inflammation ❍ Menstruation ❍ Pregnancy/ Lactation



BAMBOO FIELD
NAET & Acupuncture

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current medical information

habits

❍ Tobacco ❍ Coffee ❍ Tea ❍ Soft Drinks ❍ Alcohol ❍ Recreational Drugs ❍ Sugar ❍ Artificial Sweetener ❍ Salt ❍ Other ________

general

- ❍ Poor appetite
- ❍ Localized weakness
- ❍ Sudden energy drop (what time?) ______
- ❍ Bleed or bruise easily
- ❍ Significant change in appetite
- ❍ Cravings (what?)_______
- ❍ Strong thirst
- ❍ Preference of cold drinks
- ❍ Preference of hot drinks
- ❍ Excessive antibiotic use
- ❍ Fatigue
- ❍ Excessive sleeping
- ❍ Sleepy all the time
- ❍ Difficulty to fall asleep
- ❍ Difficulty to stay asleep
- ❍ Excessive dreaming
- ❍ Disturbing dreams
- ❍ Spontaneous sweating
- ❍ Night sweats
- ❍ Feel hot often
- ❍ Fever
- ❍ Chills
- ❍ Feel Cold often

Other: ____

head, eyes, ears, nose and throat

- ❍ Dizziness
- ❍ Headache
- ❍ Migraine
- ❍ Tension headaches
- ❍ Concussions
- ❍ Color blindness
- ❍ Recent change in vision
- ❍ Cataracts
- ❍ Glaucoma
- ❍ Spots in the eyes
- ❍ Night blindness
- ❍ Blurry vision
- ❍ Eye pain
- ❍ Dry eyes
- ❍ Red eyes
- ❍ Itchy eyes
- ❍ Ringing in ears
- ❍ Poor hearing
- ❍ Earaches
- ❍ Sinus problems
- ❍ Runny nose
- ❍ Sneezing
- ❍ Nasal congestion
- ❍ Peculiar smells
- ❍ Nose bleedings
- ❍ Facial pain
- ❍ Sore throat
- ❍ Sores in lips or tongue
- ❍ Grinding teeth
- ❍ Jaw clicks
- ❍ Gum problems
- ❍ Teeth problems
- ❍ Excessive saliva
- ❍ Excessive phlegm
- ❍ Peculiar tastes

Other: ____

respiratory

- ❍ Cough
- ❍ Bronchitis
- ❍ Emphysema
- ❍ Asthma / wheezing
- ❍ Pneumonia
- ❍ Shortness of breath
- ❍ Difficulty breathing when lying down
- ❍ Sleep apnea
- ❍ Pain with deep breath
- ❍ Tightness of chest
- ❍ Frequent colds / flu

Phlegm:
Color ______________
Amount ____________

Other: ____

cardiovascular

- ❍ High blood pressure
- ❍ Blood clots
- ❍ Irregular heartbeat
- ❍ Palpitations
- ❍ Chest pain
- ❍ Fainting
- ❍ Problems with heart valves
- ❍ Heart murmur
- ❍ Swelling of hands
- ❍ Swelling of ankles / feet
- ❍ Poor circulation
- ❍ Cold hands and/or feet
- ❍ High cholesterol
- ❍ Anemia

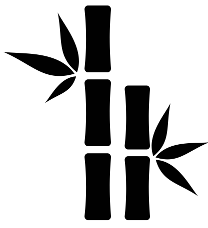
Other: ____

gastrointestinal

- ❍ Constipation
- ❍ Diarrhea
- ❍ Blood in stool
- ❍ Undigested food in stools
- ❍ Foul smelling stools
- ❍ No smell to stools
- ❍ Blood in stools
- ❍ Black stools
- ❍ Light colored stools
- ❍ Burning sensation of anus
- ❍ Rectal pain
- ❍ Hemorrhoids
- ❍ Chronic laxative use
- ❍ Pain with defecation
- ❍ Incomplete feeling of defecation
- ❍ Gas/ bloating
- ❍ Indigestion
- ❍ Abdominal cramps
- ❍ Nausea
- ❍ Vomiting
- ❍ Hiccups
- ❍ Belching
- ❍ Bad breath

Bowel Movement:
Frequency ___________
Color ______________
Odor ______________
Texture/ form ________

Other: ____



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512.431.7997

musculoskeletal

❍ Neck pain	❍ Hip pain	❍ Muscle weakness	❍ Foot/ ankle pain	❍ Tremors
❍ Upper back pain	❍ Hand/ wrist pain	❍ Shoulder pain	❍ Elbow pain	❍ Numbness
❍ Lower back pain	❍ Muscle pain	❍ Knee pain	❍ Limited range of motion	❍ Paralysis

Other: ____________________

skin and hair

❍ Rashes	❍ Change in hair or skin texture	❍ Eczema	❍ Subcutaneous bleedings	❍ Oily hair
❍ Itching		❍ Psoriasis	❍ Boils	❍ Dandruff
❍ Dry skin	❍ Ulcerations	❍ Acne	❍ Hives	❍ Premature gray
❍ Oily skin	❍ Fungal infections	❍ Recent moles	❍ Dry hair	❍ Loss of hair

Other: ____________________

neuropsychological

❍ Stress	❍ Thoughts of suicide	❍ Abusing of children	❍ Addiction	❍ Lack of coordination
❍ Anxiety	❍ Physically abused	❍ Abusing of elderly	❍ Poor memory	❍ Unfocused/ confused thoughts
❍ Bad temper	❍ Emotionally abused	❍ Mania	❍ Seizures	
❍ Worry	❍ Sexually abused	❍ Schizophrenia	❍ Concussion	❍ Long-term resentment
❍ Depression	❍ Abusing of animals	❍ In therapy	❍ Loss of balance	❍ Long-term sadness

Other: ____________________

genito-urinary

❍ Pain on urination	❍ Wake more than once to urinate at night	❍ Bedwetting	❍ Sore on genitals	❍ Increased libido
❍ Urgency to urinate		❍ Sperm in urine	❍ Itchiness on genitals	❍ Decreased libido
❍ Decrease in urine flow	❍ Unable to hold urine	❍ Urinary Tract Infections	❍ Herpes	❍ Erectile Dysfunction
❍ Blood in urine	❍ Incomplete feeling after urination	❍ Kidney stones	❍ Current outbreak of herpes	❍ Premature ejaculation
❍ Frequent urination		❍ STD		❍ Ejaculation during sleep

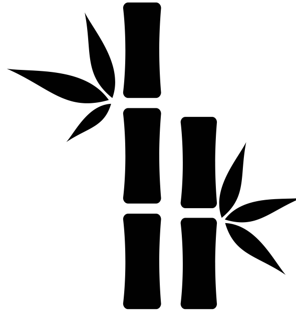
Other: ____________________

gynecological (even though you've already had menopause, please describe your past menstruation.)

			Menstruation:	**Pregnancy:**
❍ Painful periods	❍ Abnormal / excessive vaginal discharge	❍ Endometriosis	Age of first period _______	Number of pregnancies ___
❍ Irregular periods		❍ Fibroids	Menstrual cycle _____days	Number of births _______
❍ PMS - breast distension	Color _______________	❍ Menopausal symptoms	Length of periods ___ days	Number of miscarriages ___
❍ PMS - emotional change	Odor _______________	Age of menopause ______	Color _______________	Premature births _______
❍ Abnormal uterine bleeding	❍ Yeast infections / vaginitis	❍ Infertility	Amount _____________	
	❍ Breast lumps / nodules	Date of last pap smear ____	Start date of last cycle ____	
❍ Clots	❍ Mastitis	__________________		

Other: ____________________

Thank you.



Bamboo Field

NAET & Acupuncture
1110 W. William Cannon Drive, Ste 403, Austin, TX 78745
512.431.7997

Notice of Privacy Policies

Effective August 1, 2016

We understand that your health and medical information is personal, and we are committed to protecting your privacy and ensuring that your health and medical information is not used inappropriately. This notice describes how we may utilize and/or disclose your health information to carry out treatment, collect payment for your care, or health care operations and for other purposes that are permitted or required by law. This notice describes our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide to you, and this record will include your health and medical information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. This notice will remain in effect until it is replaced or amended by changes in law.

How we may use or disclose your health information:

◆For treatment◆

Only with your written approval, we may disclose your health information to your physician or other health care providers to be sure those parties have all the information necessary to diagnose and treat you. Your protected health information may be provided to a physician, chiropractor, dentist, acupuncturist or whomever you have been referred, to ensure that the physician has the necessary information to diagnose or treat you. We may call your name in the lobby when we call you for an appointment.

◆For payment◆

We may utilize and disclose your health information to others so we can receive payments for treatments rendered. For example, a bill may be sent to you or your insurance company. The bill may have your name, your diagnosis, and treatment and supplies used in the course of treatment. We may disclose your information to a third party that performs services, such as bill collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

◆Appointment reminders◆

We may use your information in order to contact you and remind you of an upcoming appointment for treatment by phone or email. We may also contact you to inquire about your well-being after receiving a treatment.
In addition, we may send you correspondence, newsletters, greeting cards, coupons and flyers that may benefit you to provide you with the latest information and incentives by postal mails or e-mails.

We are required by law to utilize and/or disclose your health information without your authorization for the following purposes:

◆Disclosure◆

We may use and disclose your health and medical information when required to do so by federal, state, or local law, for example, to comply with a court order, warrant, subpoena, summons, or similar process.

◆Workers' Compensation◆

We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

◆ Other uses & disclosures of your health information◆
Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health and Medical Information
You have the following rights regarding health information we maintain about you:

◆Right to Request Restrictions◆
You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. We are not required to agree to your request. If we do agree, we will comply with your request to the best of our ability. To request restrictions, you must make your request in writing.

◆Right To Request Confidential Communications◆
You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or at home. To request confidential communications, you must make your request in writing. We will not ask the reason for your request. We will attempt to accommodate all reasonable requests.

◆Right to Inspect and Copy◆
Upon written request, you have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. The acupuncturist will provide a copy of your medical information except if the acupuncturist determines that access to the information would be harmful to the physical, mental, or emotional health of the patient. The acupuncturist may delete confidential information about another person who has not consented to the release. There is a documentation fee of $20 for the first 20 pages, and ¢50 every page of copying after that. Mailing/deposition and other fees are charged separately. Please allow 20 business days for preparation.

◆ Right to Amend◆
If you feel that your health information is incorrect or incomplete, you may request in writing that you want us to amend your information and why. We have the right to deny the request when the medical record is accurate and complete. You will be notified the reasons why we don't amend the record in writing. You then have additional right to submit a written statement of disagreement.

◆Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice at any time.

◆Right to Complain◆
If you have any questions about this notice, or would like to file a complaint about our privacy practices, please direct your inquiries in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

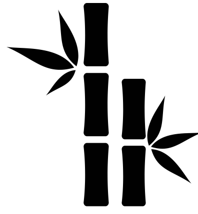
Changes to This Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will give you a current copy of the Notice at the front desk and check out areas when the changes are made. Each new version of the Notice will have an effective date listed on the first page.

To learn more, contact Bamboo Field Naet & Acupuncture at 512-431-7997 or email us with your questions.

I acknowledge that Bamboo Field NAET & Acupuncture's "Notice of Privacy Policies" has been provided to me. I understand a paper copy is available at the clinic and also the website at www.bamboofieldacupuncture.com.
I have read and agreed to the "Notice of Privacy Policies".

Name of Patient or Personal Representative (Print) Relationship

Signature of Patient or Personal Representative Date



BAMBOO FIELD
NAET & Acupuncture

1110 W. William Cannon Drive, Ste 403, Austin, TX 78745
512.431.7997

Acupuncture Informed Consent to Treat

(Please complete even if you are only doing NAET treatments for now in the event you decide to have acupuncture treatments in the future)

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Megumi Uppena, L. Ac., and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for her, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage or 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. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or may become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

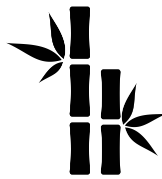
By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____

Name of Patient Or Personal Representative (Print) Relationship

____

Signature of Patient or Personal Representative Date



BAMBOO FIELD
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1110 W. William Cannon Drive, Ste 403, Austin, TX 78745
512.431.7997

Arbitration Agreement

Patient Name: ____

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.

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, and 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 or preceptors interns who now or in the future treat patient while employed by, working or associated with or serving as 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.

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 the 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 the date of first professional services.

If any provision of the 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.

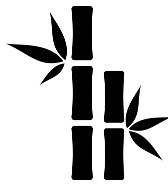
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY IN A COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____

Signature of Patient or Personal Representative   Relationship   Date

____

Office Signature   Date



BAMBOO FIELD
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512.431.7997

Notification Form Regarding Evaluation of Patient by Physician

(NAET only patients also please complete in case you decide to have acupuncture treatments in the future)

In the state of Texas, we are required to have you respond to the following statements before you may be treated with acupuncture. **Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statement is no**, unless your condition being treated is smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relat-ing to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) ____________________________, am notifying Megumi Uppena, L. Ac. of the following:

◆I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist. ❍ Yes ❍ No

◆I have received a referral from my chiropractor within the last 30 days for acupuncture. ❍ Yes ❍ No

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature ____________________________ Date ______________

If you answered no to both questions above, I, Megumi Uppena, L. Ac. am requesting that you see a physician for your condition being treated by me. It is your responsibility and your choice whether to follow this advice.

(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow her advice.

Patient's Signature ____________________________ Date ______________

Acupuncturist's Signature ____________________________ Date ______________

Cancellation Policy

We require 24 hours notice if for ANY reason the patient is unable to make their scheduled appointment.

In today's hectic world, unplanned issues (or events) come up for all of us. If you need to cancel an appointment, please do so a minimum of 24 hours in advance so that others needing treatment can take advantage of an open time slot.

If you do not cancel 24 hours in advance, you **WILL** be charged the normal rate for that session. **This will be done by charging your current credit card on file with us that was used for your last appointment. Our PCI compliant credit card system encrypts and keeps all cards you use on file automatically.**

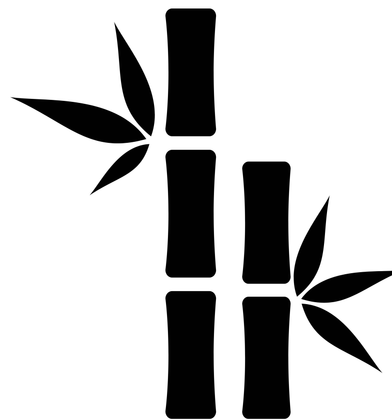
Our intention is not to collect missed appointment fees, but to provide timely treatments for all patients. Your cooperation and consideration are greatly appreciated. To cancel or reschedule your appointment, please call 512-431-7997**, email us** or go to **our website** and use the online scheduler.

Exceptions: Medical/dental emergencies, death in the family, car accidents, **illness, etc.**
No exceptions: No shows, change of your work or school schedule, meetings, someone else's lateness (ie. your service man was late, thus you could not make the appointment), etc. If you think your schedule for the day of the appointment is uncertain, please reschedule to a day you know you won't miss the appointment.

I, ____ understand and accept the cancellation policy as stated above.

Signature ____ Date______________________

Megumi Uppena, L.Ac.
Megumi Uppena
Bamboo Field NAET & Acupuncture
1110 W. William Cannon Drive #403
512-431-7997



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