Dr. Tonya Coutts Wirth RAc, DTCM - Acupuncture, Herbs, and TCM

Registration # 1200616

To assist in providing you the best possible care, please fill out the following form as accurately as possible.
All information will be kept confidential.

Name _____/_____
Frist Name Last name

Date of Birth_____/_____/_____ Gender _____ Ht_____ Wt_____
Day Month Year

Address _____

City _____ Province_____ Postal code_____

Contact number _____Cell/ Home/ Work

Emergency Contact: Name _____ Phone_____

How did you hear about our clinic? _____

E-mail _____

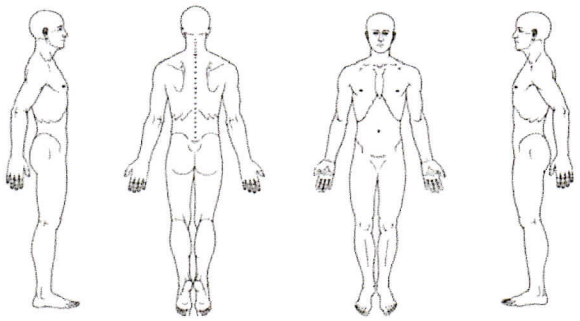
Please provide us with your e-mail so that we can send you a paperless receipt. Your email will be kept confidential.

☐ I would like to receive the Monthly newsletter via e-mail.

Health concerns and goals? 1_____ 2_____

3_____ 4_____ 5_____

Please circle any areas of pain or concern on the drawings. →



How long have you had this condition?

_____

What seems to be the initial cause?

_____

What seems to improve or aggravate this condition?

_____

Please list other therapies:

_____

_____

Please list Prescription drugs you are currently taking

1_____ 2 _____ 3_____

4 _____ 5 _____ 6_____

Please list over the counter medication, herbal medicines or other supplements you are currently taking

1_____ 2 _____ 3_____

4 _____ 5 _____ 6_____

Occupation _____ Shift work _____ Irregular hours_____

Comment on your weekly exercise _____

Comment on your personal stress levels_____

Comment on your sleep _____

How many hours of sleep per night do you typically receive? _____ Is your sleep interrupted? _____

Medical History – Please check any of the following conditions you currently have or have had in the past.

- ☐ Allergies
- ☐ Anticoagulant Medication
- ☐ Asthma
- ☐ Alcoholism
- ☐ AIDS / HIV
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Birth Trauma
- ☐ Bladder Condition_____
- ☐ Blood Clots
- ☐ Blood Pressure- High/Low
- ☐ Bowel problems
- ☐ Brittle Nails
- ☐ Bronchitis
- ☐ Cancer (Type) _____ _____
- ☐ Cankers
- ☐ Cough
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Digestion problems_____
- ☐ Diabetes (type) _____
- ☐ Dizziness
- ☐ Emotional Eating
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eczema
- ☐ Fainting
- ☐ Goiter
- ☐ Gout
- ☐ Grief
- ☐ High or low sex drive
- ☐ Hearing problems
- ☐ Heart Condition _____
- ☐ Hepatitis (Type) _____
- ☐ Impotence
- ☐ Insomnia / Sleeping problems
- ☐ Itching/ Pain / Rashes
- ☐ Lung Condition _____
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Herpes (Type) _____
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Pacemaker (date) _____
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Premature ejaculation
- ☐ Prostate problems
- ☐ PMS
- ☐ Reynaud's Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke (Dates) _____
- ☐ STI's (Type) _____
- ☐ Surgeries _____ _____ _____
- ☐ Swelling (where) _____
- ☐ Ulcers
- ☐ Visual/Eye problems
- ☐ Varicose Veins
- ☐ Whooping Cough
- ☐ Other _____

Please comment on family history of serious illness; _____

_____

_____

_____

_____

Any other information that you deem important to your health_____

_____

_____

_____

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Informed Consent for Acupuncture Care

Please read carefully before signing

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxibustion, cupping, electro-acupuncture, laser-acupuncture and other techniques within the scope of the practice of Traditional Chinese Medicine. These procedures would be performed by a registered acupuncturist, in accordance with the Alberta Acupuncturist Regulations. I have had the opportunity to discuss with the acupuncturist and/or with other clinical personnel, the nature and purpose of acupuncture care and its procedures. I understand that results are not guaranteed.

I have been advised that all needles are individually packaged, pre-sterilized and disposable; therefore the risk of infection is extremely rare. I further understand and have been informed that as with all health care, in the practice of acupuncture, there are some slight risks associated with treatment, including, but not limited to, temporary soreness, bruising, blistering, minor bleeding, and temporary aggravation of symptoms, nausea or fainting. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise his/her judgement during the course of my treatment, based upon the facts then known, to my best interest and benefit. **I understand and acknowledge that withholding or giving false information can lead to improper treatment which that therapist cannot be held liable for.**

Forms of payment: cash, interact, Visa, and Master card are accepted. I understand the cost of Acupuncture treatments is not covered by Alberta Healthcare and I am financially responsible to my acupuncturist for the entire treatment amount.

Third party Insurance coverage: Direct billing is available for some groups. Please ask the front desk if they have coverage for your insurance group. If your insurance is not available, we will provide you with a statement in order to be reimbursed, after the full fee is paid.

Missed Appointments: We require at least **24 hour notice** or a fee for the full cost for the scheduled appointment will be charged. Extenuating circumstances will be reviewed by the acupuncturist. Furthermore, we cannot guarantee that any patient arriving late will get their full scheduled time. Each patient is important to us, we will respect the start time for the next patient in the schedule.

Patient Confirmation of Consultation with Physician: Section 8(1) of Alberta's Acupuncture Legislation states that an acupuncturist shall not undertake the care of a person unless:

a) That person has already consulted with a physician or, in the case of dental issues, a dentist about the condition for which care and treatment from the acupuncturist is being sought;
b) That person has informed the acupuncturist that a physician or dentist has been consulted about the condition;
c) The patient has completes a patient consultation form.

Have you consulted a physician or dentist (as Appropriate) about the condition for which acupuncture treatment is now being sought? ☐ Yes ☐ No

I agree to see a physician regarding the condition(s) that I am seeking treatment for within two (2) weeks of my first acupuncture Appointment with Dr. Tonya Coutts Wirth RAc, DTCM. ☐ Yes ☐ No

_____	_____	_____
Signature	Print name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date

Dr. Tonya Coutts RAc, DTCM
Acupuncture, Herbs and TCM
tellurictherapy@gmail.com Registration # 1200616

Telluric Therapy - Informed Consent For Acupuncture Care

The purpose of this page is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

Procedure	**Estimated Time**	**Fee (Subject to Change)**
Initial Consultation and first treatment with discussion of treatment course	45 Minutes	$90.00 including GST $75.00 including GST (Senior)
Consultation/Herbal Consultation with discussion of treatment course - *ONLY*	30 Minutes	$45.00 including GST Herbal Prescription not included
Child(12 years old and under) Initial Consultation and first treatment with discussion of treatment course	45 Minutes	$75.00 including GST
Subsequent visits including follow-up consultation, treatment and discussion of treatment course	45 Minutes (Adult/Senior) 30 Minutes (Child)	$75.00 including GST $55.00 including GST
Chinese Herbs (per treatment course)		

Forms of Payment: Patients are responsible for full payment at the time of services rendered. We accept Interact, Visa, MasterCard and cash. Any credit card arrangements and discounts must be authorized in advance.

Third Party Insurance Coverage: All professional services are rendered and charged to the patient receiving care and not to an insurance provider.We will supply you with statements, or other documents for a fee, if applicable, as outlined above, to help you receive reimbursement from a third party.

Missed Appointments: With regard to any cancellation of scheduled appointments, we require at least **24 hours notice** or a fee for the **full cost of the scheduled appointment** will be charged. Extenuating circumstances will be reviewed. Furthermore, we cannot guarantee that anyone arriving late will run past his/her scheduled appointment time. **Each patient is important to us and we have to respect the next patients' schedule.** If for any reason we are running late, you will be guaranteed your scheduled appointment time.

I have read and understand the payment obligations listed above.

Parent/Guardian Signature _____ Date _____