



FRACTAL DRAGON ACUPUNCTURE & ORIENTAL MEDICINE, LLC
Susan Gallagher, MSOM, Dipl. OM (NCCAOM)

TODAY'S DATE _____

Name _____ Home Phone () - _____

Address _____ Work Phone () - _____

City _____ State _____ Zip Code _____

Birthdate _____ Social Security # _____

Age _____ Sex _____ Height _____ Weight _____

Occupation _____

Employer's Name _____

Employer's Address _____

Marital Status _____ Number of Children _____

Personal Physician _____ Phone Number _____

Date of Last Physical _____

Emergency contact _____ Phone #(s) _____

How did you hear about us? _____

Have you tried acupuncture before? _____

Party Responsible for Payment (if other than above) _____

Address _____ Phone #(s) _____

Insurance Company _____ Policy Holder _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Relationship of Patient to Policy Holder _____

Policy Number _____ Group Number/Name _____

What is your reason for coming today? _____

Please list your major health concerns: _____

What are the major stressors in your life? _____



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Informed Consent To Health Care by Traditional Oriental Medical Practitioner

I hereby request and consent to the performance of the following on me (or the patient named below, for whom I am legally responsible) by Susan Gallagher, Dipl. OM.: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, and manual palpation on a variety of areas on my body; observation, range of motion evaluation, muscle, orthopedic, and neurological testing; modes of manual and physical therapy such as massage, manipulation of joints and/or viscera; heat and/or cold therapy; and electrical and or magnetic stimulation. The prescription of herbal medicines and dietary supplements, dietary recommendations, advice regarding exercise; and lifestyle counseling may also be included.

I have had the opportunity to discuss with Susan Gallagher, Dipl. OM questions I have regarding the nature and purpose of acupuncture and oriental medical procedures and potential risks of treatment. I understand that while acupuncture has helped millions of people, no guarantee of cure or improvement in my condition is given or implied. I do not expect Susan Gallagher, Dipl. OM to be able to anticipate and explain all risks and complications and during the course of treatment. I wish to rely on her judgment based on the facts known at this time.

I understand and am informed that there are some risks to treatment. I understand that, while unlikely, possible risks include but are not limited to: bleeding, bruising, inflammations, infections, burns, general aches, sprains, strains, dislocations, fractures, disc injuries, strokes, puncture of organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, aggravation of current symptoms, and appearance of new symptoms.

The herbs and supplements (which are from plant, animal, or mineral sources) that may be recommended are traditionally considered safe in oriental 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. Herbs may need to be prepared and herbal teas may be consumed according to instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Susan Gallagher, Dipl. OM of any unanticipated or unpleasant effects associated with the consumption of herbs.

I understand that acupuncture and oriental medicine is not a substitute for Western medicine, and that certain health disorders may require a Western medical diagnosis and treatment. I am free to seek Western medical advice and treatment at any time, either in lieu of or concurrently with oriental medicine. I realize that I may withdraw from treatment at any time. I understand my patient records will be kept confidential and will not be released without my written consent.

I understand that in general the recommended treatment frequency is once a week and as my condition improves, treatment frequency is decreased. The number and frequency of treatments may vary greatly, depending on such factors as the patient’s vitality, their health history, the type of condition, the length of time that the condition has existed, the patient’s lifestyle, and many other factors. I understand it is not possible to initially determine how many treatments I may need. However during the course of treatment, my options with regard to treatment frequency and the number of treatments I may need will be discussed.

By signing below I agree to the above named procedures and have read and have had the opportunity to ask questions about the above consent. 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. The following is to be completed by the patient or patient’s representative, if necessary, that is, if the patient is a minor or physically or legally incapacitated.

Print Name of Patient

Print name of patient’s representative (if applicable)

Signature of Patient

Signature of patient’s representative (if applicable)/relationship

Today’s Date



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Disclosure Statement

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12, Article 29.5. Every effort to comply with these rules and regulations, as well as those set forth by the Department of Health, is made by this clinic, including proper cleaning and sterilization of equipment and the office. Only single use, sterile, disposable needles are used.

The Department of Regulatory Agencies (DORA) regulates the practice of acupuncture. Any complaints should be directed to the Director of the Division of Registrations in the Department of Regulatory Agencies: 1560 Broadway, Suite 1340, Denver, CO 80202-5140. Telephone (303) 894-7851.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. Your relationship with this office is strictly confidential. No license, certificate, or registration has been suspended or revoked. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

My training and experience include the recommendation and application of adjunctive therapies and herbs consistent with traditional Oriental medical concepts. Your therapy may include recommendations for adjunctive therapies or herbs.

Education

- Masters of Science in Oriental Medicine, Southwest Acupuncture College, Boulder, CO, 2002 – 3-year program.
- Masters in Business Administration, University of Colorado, Denver, CO, 1993 – 3-year program.
- Bachelor of Science, Forest Science, Pennsylvania State University, 1979, attended 1973 –1974, 1976 – 1979.

Current Professional Memberships

- Acupuncture Association of Colorado

Certifications, Licenses, and Registrations

- Clean Needle Technique Certificate, 2000
- Master of Science, Oriental Medicine, 2002
- Licensed Acupuncturist, State of Colorado, since 2002
- Certified Herbalist, since 2002
- Diplomate Oriental Medicine, since 2005

Fee Schedule (subject to review each January and July)		
	Paper Work Plan (Insurance)*	Paper Work Reduction Plan**
Initial Evaluation	\$120+individual services	\$85
Standard Treatment	\$97.50+individual services	\$65

Herbal prescriptions, patents, or other herbal products are priced separately.

*** Necessary Paper Work Plan:** For patients requiring paperwork. This plan has a higher fee schedule due to the amount or time and services required in billing a third party. I authorize payment of medical benefits to Susan Gallagher, Dipl. OM, MSOM and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I understand that I am responsible for charges including those not covered by insurance. Worker’s Compensation fees are set by the State of Colorado.

**** Paperwork Reduction Plan:** Patients who pay immediately after services are rendered; no paperwork other than a receipt of payment.

Cancellation Policy: I ask that you make every effort to notify the office as far in advance as possible, if you are unable to keep an appointment. I ask for 24 hours advance notice for cancellation. A fee of \$25 will be assessed for excessive cancellations.

I have carefully read and understand the above, and agree to the terms of this Client Disclosure Form.

Patients Initials

Date

303-979-0342 (office)
720-261-1680 (cell)



FINANCIAL AGREEMENT

Patients must select a payment plan. If he/she chooses to switch from a Self-Pay Plan to the Billing Plan, it is understood that our office will not produce claims retroactively. Instead, we will bill claims according to the appropriate fee schedule from that date forward. Each time a patient must switch between financial plans, he/she must sign a new financial agreement.

Please refer to the disclosure form for the fee schedule and payment policy.

If you have any questions, please ask for clarification.

By signing below, I agree to the following Financial Plan

_____ Self-Pay Plan _____ Billing Plan

OR, I am switching to the following Financial Plan (beginning the date below)

_____ Self-Pay Plan _____ Billing Plan

I, _____, have read and understand the above statements, including those on the Disclosure form, regarding fee schedules and financial agreement. By signing below, I agree to accept these policies.

Patient Signature (or Guardian if a Minor)

Date

Office Signature (Office Use)

Date

I have been offered and read HIPPA policies

Date



FRACTAL DRAGON ACUPUNCTURE & ORIENTAL MEDICINE, LLC
Susan Gallagher, MSOM, Dipl. OM (NCCAOM)

Your Name: _____ Today's Date: _____

Personal Health History:

If you have had any of the following symptoms, check a box specifying whether it was in the past or if it is a current concern. Also, circle one of the numbers that appears to right of the symptom, indicating how much of a concern this symptom is to your health – circle 0 for no impact, 4 for severe impact.

Past	Now	Symptom	0	1	2	3	4	Past	Now	Symptom	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/Stomach Pain	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too Cold	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Always Hungry	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too Hot	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Constipation (less 1/day)	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Difficulties	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Gas	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Sounds/Ringing in Ears	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Lack of Appetite	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Overweight	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Corrective Lenses/Glasses	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Unusually Thirsty	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Taste in Mouth	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Weight Changes	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Itching or Burning Skin	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Easily	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Urination	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Bruising Easily	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Burning Urination	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Pressure	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Urination	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells or Blackouts	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Pounding Heart Beat	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Urination at Night	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Racing Heart Beat	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Chest Colds	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Depression	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Frequent / Severe Headache	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Congested Nose	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Getting to Sleep	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Staying Asleep	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Smoking	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or Trembling	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Chills	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Stuttering or Stammering	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Back Trouble / Pain	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Fever	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Pain / Swelling – Any Joint	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Lack of Perspiration	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Painful Feet	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Painful Muscles	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Stiff or Painful Neck	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Frequent/Extended Hoarseness	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Feet or Legs	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	Pain – Other Locations	0	1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	Other Symptoms	0	1	2	3	4



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Your Name: _____ Today's Date: _____

Personal Health History (continued):

Please check if you have had any of the following diagnoses:

<input type="checkbox"/> AIDs/HIV Positive	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Allergies	<input type="checkbox"/> German Measles	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Antibiotic Use	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Smallpox
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis / Jaundice	<input type="checkbox"/> Spinal Meningitis
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stomach or Duodenal Ulcer
<input type="checkbox"/> Bone Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hives	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Thyroid/ Goiter Trouble
<input type="checkbox"/> Cancer or Tumor	<input type="checkbox"/> Kidney or Bladder Infection	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Colon / Bowel Disease	<input type="checkbox"/> Elevated Liver Enzymes	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Lupus	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Drug / Alcohol Addiction	<input type="checkbox"/> Malaria	Other Illnesses (list):
<input type="checkbox"/> Drug Sensitivity/ Reaction	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Emotional/Mental Problems	<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Pancreatitis	_____

Please list surgeries and hospitalizations and Doctor's name (if you remember): _____

What kinds of foods do you eat, or are there any kinds of food that you do not eat? _____

List current medicines and supplements/herbs: _____

Family History:

Parents' Age and Health or if deceased, Parents Age at Death and Cause of Death: _____

Number of Siblings, Age, Health Status or Cause of Death if Deceased: _____

Number of Children, Age, Health Status or Cause of Death if Deceased: _____

Check if you have family history of any of these:

<input type="checkbox"/> AIDs/HIV Positive	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Problems with Alcohol
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other potentially-inherited disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	