Welcome

Welcome to Stonington Natural Health Center. We are so glad you made it here. We provide *Custom Holistic Healthcare for the Whole Family in a Tranquil Waterfront Setting* with Acupuncture & Oriental Medicine, the SNHC Customized Massage which is a combination of Swedish and Deep Tissue Massage to your desired level of pressure, Deep Tissue Massage, Pregnancy Massage, Reconnective Healing, Reflexology, Reiki, and Herbal Consultations.

Our treatments help you to feel better, breathe deeper, rejuvenate, and let go of your worries. Your body, mind, and spirit will thank you. This is your time to relax and heal, initiate and speed up your healing process, so that you can live a longer, healthier, and happier life.

For injuries or health complaints, you will receive the most benefit by creating momentum by grouping treatments close together and coming in for treatments before the effects of the previous treatment disappear. Your practitioner will give you a treatment protocol. It is often recommended to group your treatments close together, which may be daily, twice a week or three times per week. During times of stress, anxiety, or depression, it is helpful to come in for Acupuncture and Massage treatments at least once a week, and in severe cases, daily. Once you are feeling better, we space the treatments apart at a pace that allows the positive effects to hold. Our goal is to shift the pattern of your energy quickly and easily, so that you will have long lasting effects. We focus on bringing you up to your highest healing potential. Once you are at your highest healing potential, regular tune-ups, which can range from once a week to once a month, are important in maintaining good health.

If you have any questions, concerns, or feedback, please talk with us 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

The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.

THOMAS EDISON

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

RALPH WALDO EMERSON

Enjoy the journey.

DEEPAK CHOPRA

INFORMED CONSENT FOR ACUPUNCTURE & ORIENTAL MEDICINE AND MASSAGE TREATMENT AND CARE

I hereby request and consent to the performance of Acupuncture and Massage Treatments and other complementary medicine procedures on me (or on the patient named below, for whom I whom I am legally responsible) by Megan Marco, Doctor of Acupuncture, Licensed Acupuncturist, and the other Practitioners of Stonington Natural Health Center.

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), Swedish Massage, Acutonics (sound therapy), Herbal Medicine, Nutritional Counseling, Applied Kinesiology, Detoxification, Homeopathy, physical examination, Reiki, and Vitamin Therapy.

I will discuss with Megan Marco, DAc, LAc any questions or concerns that I have with my Acupuncture and Oriental Medicine treatments, Massage, or holistic treatments.

The goals of Acupuncture and Oriental Medicine 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 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 gastrointestinal upset or allergic reactions to the herbs, I will inform Megan Marco, DAc, LAc.

I do not expect the Doctors and Health Practitioners to be able to anticipate and explain all risks and complications. I wish to rely on the Doctors and Health Practitioners to exercise judgment during the course of the procedure which Doctors and Health Practitioners feel 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 Acupuncturist: Megan Marco, DAc, LAc

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: _____

FINANCIAL POLICIES FOR TREATMENT AND CARE

Acupuncture & Oriental Medicine are excellent for helping you when you are not feeling well--if you have a cold, flu, illness or are in pain, these are the best times to come in. All of our modalities are excellent treatments for maintenance, prevention, and staying healthy.

Your treatment time is reserved for you. If you need to change, reschedule, or cancel an appointment, please call **at least two days in advance, or 48 hours, before your appointment** to allow us to reschedule your time. If no one is available to answer, please leave a message. **For Monday appointments, we ask that you call by noon on Friday. Because your treatment time is reserved for you and we have made preparations and staffing for your appointment, with less than 24 hours notice, you are responsible for the charge of your appointment.** Your credit card will be charged or one treatment will be deducted from your Membership Package. It is our courtesy that for appointments canceled with less than 24 hours notice, if you or we are able to fill your appointment, you will not be charged. If you can not make your appointment, we encourage you to substitute a friend or family member in your appointment time. If it is their first full Acupuncture appointment at SNHC, please let them know about the first appointment intake fee.

We appreciate your cooperation as this is **vitally important to our mutual success.** We make reminder calls as a courtesy; you are ultimately responsible, however, for remembering your appointments.

"Minimum 48 Hours Cancellation Policy": Your appointment time is reserved for you. **We ask for at least 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 or one treatment will be deducted from your Membership Package.**

If you are running late for an appointment, we would rather you come late and have a shorter treatment than miss your appointment; **we look forward to seeing you**, and you will benefit from the high quality of our treatments with any length of time. Please call to inform us if you are running late. Ideally, please arrive a few minutes before your appointment time to allow time for yourself to use the restroom and unwind before your appointment.

Payment: In an attempt to keep health care costs low, payment is required at the time of your service and preferred payment methods are cash or check. We also accept Visa, Master Card, Discover, or American Express.

Treatment Plans*:* Dr. Marco or your Health Practitioner will develop your treatment plan with you to guide you to accomplish your goals. Follow your Treatment Plan to achieve optimal results rather than experience a yo-yo effect.

Membership Packages: are available to (1) make check-out easier, (2) lower the price, and (3) help you complete your treatment goals. Treatment Packages are not refundable, can only be used for the services purchased, and expire one year from date of purchase.

Your credit card number is kept on file for payment of any missed or canceled appointments, for guarantying personal checks, for phone purchases, when special orders are made for herbs and Gift Certificates, or if you don't bring in your wallet for your treatment – patients enjoy this convenience. Your credit card information is kept private, confidential, and secure. This form is kept in a locked safe.

The following information is required to receive treatments:

Visa/MasterCard/American Express/Discover (Please circle one)

_____ _____/_____ _____

Credit Card Number Expiration Month Year 3 or 5 digit CVV code

_____

Billing Address

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

_____ _____ _____

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

All information within this document is considered privileged patient / provider communication by Dr. Marco, the Practitioners, and Staff of Stonington Natural Health Center, and is held as CONFIDENTIAL INFORMATION in accordance with federal HIPAA regulations.

MEGAN MARCO, DAc, LAc
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. (Health Insurance Portability and Accountability Act – "HIPAA")

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

PRACTITIONER 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, DAc, LAc, 860.536.3880.

This notice is effective immediately. This notice, and any alteration 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

Patient Health History

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate the best number to reach you and best number to leave messages:

Home Phone#: _____ Cell Phone#: _____ Prefer Texting? Y N

Work Phone#: _____ Occupation: _____

Spouse or Significant Other: _____

Email (to receive newsletters & coupons): _____
Hobbies and Interests: _____

Emergency Contact: _____ Phone#: _____ Relationship:_____

Primary Care Physician:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____

What are your 3 primary health concerns / health goals in order of importance?
1. _____
2. _____
3. _____

How long has each concern condition persisted?
1. _____
2. _____
3. _____

What do you think is the cause?
1. _____
2. _____
3. _____

How does it affect you?
1. _____
2. _____
3. _____

What treatment have you received for this condition?

_____
Diagnosis given?
_____
What were the results of the treatment?
_____

Patient Health History

What are your hopes and expectations from treatments at Stonington Natural Health Center?

_____

_____

Blood Type_____ Height _____ Weight _____ Any recent (circle): weight loss or gain?

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 to Foods: _____

Allergies to Environmental: _____

_____

Allergies to Medications: _____

Please list any medications, both prescription and over the counter, you are currently taking -- include dosages and duration of use:

Please list any supplements or vitamins you are currently taking -- include dosages and brand names:

Please list any hospitalizations or 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

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

General:
Low energy or fatigue
Allergies
Insomnia
Spontaneous sweating
Night sweats
Aversion to heat
Aversion to cold
Chronic infections

Gastrointestinal:
Nausea/vomiting
Low appetite
Abdominal pain
Gas
Burping
Bloating
Indigestion
Acid reflux/heartburn
Heavy feeling after eating
Ulcers
Loose stools
Constipation
Blood in the stools
Black/tarry stools
Undigested food in stools
Hemorrhoids
Rectal pain/itching

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

Head and Neck:
Headaches
Red/swollen eyes
Dry/itchy eyes
Watery eyes
Mucus or discharge from eyes
Eye pain
Blurry vision
Night blindness
Glasses or contacts
Glaucoma or cataracts
Dizziness/vertigo
Recurrent phlegm
Sinus problems
Nosebleeds
Frequent sore throats
TMJ (jaw problems)
Earaches
Difficulty hearing
Hearing loss
Noises or Ringing in ears
Ear discharge
Excess earwax
Fever blisters
Sores on tongue or in mouth
Loss of smell
Change of taste
Dry throat/mouth
Excessive thirst
Bad Breath

Neurologic:
Paralysis
Numbness/tingling
Seizures
Loss of balance
Epilepsy
Tics
Lyme Disease
Bell's Palsy

Respiratory:
Pain in lungs
Asthma
Wheezing
Pneumonia
Chronic bronchitis
Persistent cough
Shortness of breath
Difficulty breathing
Frequent colds
Hay fever
Spitting or coughing up blood

Musculoskeletal: *(pain, numbness or weakness)*
Neck/shoulder Arms
Legs Feet
Joints Knees/elbows
Hands Whole body
Lower back
Mid/upper back
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

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

Skin:
Acne or pimples
Hives
Stretch marks
Skin ulcers or sores
Cracks in corners of mouth
Dryness, roughness or scaling of skin
Dry or chapped lips
Hair loss or thinning
Dry course hair
Bruise easily
Cold sores or herpes
Nails weak, ridged or split easily
Brown spots or bronzing
Warts, moles, or skin tags
Sunburn easily
Cuts heal slowly or scar badly
Flush easily
Athlete's foot
Jock itch
Any other itchy areas

_____

Female Reproductive:
Breast lumps/tenderness
Nipple discharge
Irregular periods
Painful periods
PMS
Short cycle (less than 24 days)
Long cycle (more than 35 days)
Heavy periods
Bleeding between periods
Difficulty conceiving
Miscarriages
Endometriosis
Fibroids
Abnormal PAP smear:_____
Vaginal discharge
Vaginal itching
Vaginal pain
Pelvic Pain
Pain with intercourse
Hot flashes
Diminished or excessive sex drive
Difficulty reaching orgasm
Perimenopause
Menopause, age at last menses:_____

Genitourinary Tract:
Painful urination
Urinary urgency
Urinary frequency
Difficult urination
Incontinence
Kidney stones
Urinary tract infections
Frequent urination at night
Sexually Transmitted Disease
Blood in the urine
Dark urine

Male Reproductive:
Genital pain
Low sex drive
Difficulty conceiving
Low sperm count
Sexual difficulty / impotence
Enlarged prostate
Testicular pain or swelling
Genital discharge
Rashes or sores

Patient Health History

Family History:

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

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

Breakfast	
Lunch	
Dinner	
Snacks	

Patient Health History

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 (aspartame, 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?

_____

_____

How did you hear about Stonington Natural Health Center (so we can offer our SNHC Rewards)?

_____

As a part of the SNHC Rewards Program,
for every person that you refer,
receive a **complimentary 10 minute massage**
added onto your Acupuncture Treatment
($15 value!)
OR
save up five of your Referrals and receive a
Full One-Hour Acupuncture Treatment
($100 Value!)