Third Root Intake and Consent

Today's Date:______________

Personal Information

First Name__________________________________ Last Name________________________________
Gender Pronouns______________________
Email_______________________________________ Birthdate_________________________________
Phone Number_______________________________ Occupation_______________________________
Mailing Address____ Receive emails? Y ☐ N ☐
How did you hear about us?
Website: ☐ Yelp: ☐ Word of mouth: ☐ Neighborhood: ☐
Referral ☐: ____
Emergency Contact:
Name and Pronoun_______________________________ Relationship_____________________________
Phone____

Main Health Concern(s)

What issue(s) bring you here today?____

Other health issues/concerns?____

What modality (type of holistic healing service) are you receiving with us today? _____________________

Health Information

- Are you pregnant? Y ☐ N ☐ If yes, how many weeks? _________________
- Do you have a pacemaker? Y ☐ N ☐
- Are you taking Coumadin/Warfarin or any blood thinners? Y ☐ N ☐
- Have you ever been hospitalized for medical problems/mental health reasons? Y ☐ N ☐
- If yes, please list reasons and dates
  - ____
- Do you have high blood pressure? Y ☐ N ☐
- List any medications you are taking, including supplements:
  - ____
- List any significant illnesses you, your parents, or siblings have had:
  - ____
- Is there anything you would like to add about your history or current life? (postpartum; experiencing grief; depression; compulsion / addiction; survivor of physical, emotional, or sexual trauma)?

  ____

BODY SYSTEMS REVIEW *Please check if any of the following apply:*		
__ fatigue __ abdominal bloating __ low appetite __ loose stools __ forgetful __ overthinking/worry __ muscle spasms/twitches __ feeling of heaviness __ foggy thinking __ bruise easily __ dizzy upon standing __ joint pain	__ mouth sores __ ravenous appetite __heartburn/acid reflux __ thirst __ nausea __ history of sudden and/or rapid weight loss or gain, recent or in the past (please specify): _________________________ _________________________ _________________________	__ alt. diarrhea/constipation __ neck/shoulder tension __numb extremities __ dry or red eyes __ ear ringing __symptoms worse with stress __ irritable __ anger easily __ feel better after exercise __ headaches __ restlessness __ floaters in eyes __ PMS symptoms __ clots in menstrual flow __ cramps with period
__ spontaneous sweating __ allergies (medicine, food, seasonal, scented products), describe: _______________________________ _______________________________ __ asthma __ dry nose/mouth/skin/throat __ catch colds easily __ shortness of breath __ cough	__ feel worse after exercise __sore, cold or weak knees __low back pain __ frequent urination __ early morning diarrhea __impaired memory __ infertility __ ear problems __ hair loss __ low libido __ feel cold __ cloudy urine __ feel hot __ heat in palms or soles __night sweats	__ feel heart beating __ insomnia __ anxiety __ chest pain __ chest pain traveling to shoulder __ sores on tip of tongue __disturbing dreams

MORE ABOUT YOU

- Do you exercise and/or participate in any sports? **Yes / No** (*If yes, describe)*______________________________________
- Repetitive movement in your work, sports or hobby? **Yes / No** (*If yes, describe)* ___________________________________
- Stress in your work, family, or other aspect of your life? **Yes / No** (*If yes, describe)*

  ____
- Do you have a spiritual or mindfulness practice, i.e. yoga, prayer, qigong, etc? **Yes / No** (*If yes, describe)*________________
- Have you recently had an injury, surgery, or areas of inflammation or pain? **Yes / No** **(***If yes, describe)*__________________
- Have you received / participated in yoga, massage, herbal medicine, or acupuncture? **Yes / No** *If yes, describe* __________
- Are there any areas of your body you want us to avoid treating directly or touching? **Yes / No**
- *(If yes, describe)*____
- Do you have any requests regarding access that may affect your ability to be in our space? **Yes / No**
- (*If yes, describe)*____
- Anything you would like to add? ____

INFORMED CONSENT for Virtual Acupressure / Herbal Consultation, and In-Person Acupuncture / Herbal and Nutritional Consultation, Massage Therapy, and Third Root Consent

1. *VIRTUAL AND IN PERSON ACU AND HERBAL CONSENT*: I have read information regarding acupuncture and herbal medicine and agree to treatment.

Name (print) : ________________________ Date: ____________________

Signature: ____

Parent Signature (if minor under age 18): ____

PHYSICIAN'S NOTICE: In compliance with Article 160, Section 8211.1 of NYS Education Law I AFFIRM THAT I, __________________________, *(patient full name)* HAVE BEEN ADVISED BY ___________________________ *(acupuncturist full name)* TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH I SEEK ACUPUNCTURE TREATMENT.

2.*MASSAGE CONSENT:* I have read information regarding massage and agree to treatment.

I understand that massage treatments given to me by the therapist are for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or other health related reasons stated. I understand that massage treatments rendered are medically-based and not for the purpose of sensual and/or sexual pleasures. I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I understand that massage therapy is complementary to western medical care and that it is recommended that I work with my primary caregiver for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Signed consent for treatment:

Name (print) : ________________________ Date: ____________________

Signature: ____

Parent Signature (if minor under age 18): ____

3.*THIRD ROOT CONSENT:* I, ___________________________ *(full name in print)* understand that / agree to:

- Appointments cancelled with less than 24 hours notice will incur a cancellation fee equal to the minimum fee for the scheduled service.
- A written copy of the Privacy Practices (HIPAA) of Third Root Community Health Center LLC/Third Root Acupuncture and Massage PLLC has been provided to me. I have also been informed that if I require additional information about this notice I may contact Third Root.
- Should either the practitioner or patient feel professional boundaries have been violated during the treatment, either / both reserve the right to terminate the session.
- I agree to let my practitioner know if I'm pregnant or trying to get pregnant.
- For patients who intend to use insurance coverage for acupuncture appointments, Third Root will verify their coverage and bill the patient's insurance company for acupuncture appointments as a courtesy if their plan covers it. A $60 deposit is required to book the initial appointment, which will be used as payment if appointments are not paid in full by the insurance company, or otherwise be reimbursed to the patient. Please note that coverage is not guaranteed and the patient is responsible for all outstanding costs of treatment.
- I agree to reflect the inclusive values of Third Root to the best of my ability in my communication and actions in this space. If I have questions or need more information about the inclusion Third Root aspires to, I can ask staff for resources.

Name (print) : ____Date: ____________________

Signature: ____

Parent Signature (if minor under age 18): ____

INFORMED COVID-19 NOTICE AND CONSENT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with in-person receiving care, I confirm and understand the following
(Initial in all seven places provided)

- ▢ I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to person contact, in which COVID-19 can be transmitted.
- ▢ I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
- ▢ I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office.
- ▢ I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: *Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell I understand travel increases my risk of contracting and transmitting the COVID-19 virus.
- ▢ I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.
- ▢ I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19 including requiring masks at all times. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment.
- ▢ I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. I have been offered a copy of this consent form.
- ▢ I consent to being contacted for follow-up inquiry about my status regarding COVID-19 one to two weeks after visiting Third Root for my appointment.

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction. I have read or have had read to me, the above covid-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content and by signing below I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Name (print) : ____Date: ____________________
Signature: ____
Parent Signature (if minor under age 18): ____