

Cameron Clinic of Oriental Medicine
1928 South 16th Street
Wilmington, NC 28401
(910) 342-0999
www.camclinic.com

What to expect on a first visit

Please complete the enclosed history form and bring it with you to your first appointment. Your first visit usually takes about 1½ hours. We spend time talking about your concerns. I will ask you different questions ó many you will expect and some will seem unusual or different from what you may have experienced when visiting other health care practitioners. As part of the examination I take your pulse and look at your tongue. If you are used to brushing your tongue, please **don't** do it on the days you come to see me.

We will talk about your Chinese Medicine diagnosis and what it means. If you are scheduled to receive acupuncture you will receive your first treatment at the time of your appointment. Most of my patients enjoy treatments and find them relaxing. All needles are sterile and used only one time. You may feel a small prick lasting a couple of seconds when the needle is inserted. Once the needle is in place you may not feel anything or it might feel heavy or achy or even have a slight electric sensation, but it should not feel painful or uncomfortable.

Infrequently, there may be bruising or slight bleeding when needles are removed. Since everyone responds differently to treatments you may want to plan your schedule accordingly. Sometimes patients want to go home and take a nap, others may feel energized after their treatment. It is a good idea to not get overheated or chilled for several hours after receiving a treatment. You want to be sure and drink plenty of water. If you are planning to go out to dinner and have a glass of wine or a drink, go slow because you may find that it affects you more quickly than usual. Remember you are not yet superman or superwoman after your first treatment, so if you are feeling great after your treatment you will still want to take it easy. If you push yourself you may find that you feel worse than ever. As I like to tell patients, we need to learn to be our own best friend!

Your treatment may include other modalities, such as:

Moxa ó an herb that is burned. It has many different forms ó I may put it on the end of the needle to burn or even send you home with a type that looks like a big cigar.

Cups ó a vacuum is created inside a glass cup and then it is placed on different parts of the body. It may stay in one place or be moved over an area such as your back.

Guasha ó a form of bodywork often using a Chinese porcelain spoon that is massaged over specific body areas.

Electroacupuncture ó electricity can be added to the needles, pads or probes. If we use microcurrent pads there will be a one time charge.

Herbal Formulas

Herbal formulas are an important part of Oriental Medicine. Several different types of herbal supplements are offered. I will typically prescribe one or two formula for each person.

Chinese Patent Medicines

These are prepared formulas generally in the form of pills, capsules or tinctures. Many of these are manufactured in China. The distributors I use test their products for the presence of heavy metals and other substances. A one week supply of pills will generally cost from between five and forty dollars. I use products from Golden Flower, Health Concerns, Evergreen, Minshan, Blue Poppy, Kan, Herbal Times, Far East Summit and Mayway. Chinese patent medicines may not be designed specifically for you, so you may be required to take more than one formula to get the best results.

Granules

A weekly dose for one formula is approximately 42 ó 64 gms. The weekly cost for each formula is about \$15.00. The granules are mixed in water and may have a slightly unpleasant taste. Granules have the advantage of being

tailored specifically for you and can be adjusted based on your response. For an additional charge we can make these into capsules for you or you may purchase supplies to make your own capsules.

Nutritional Supplements and Foods

We have a selection of probiotics, liquid vitamin D or B12, fish oil, arinica and red yeast rice to name only a few products that are available in the office. Need organic coconut oil or sea salt - we can help. Looking for a shampoo or moisturizer that has no additives ó we can help.

I want you to understand your treatment and will do my best to explain the process. If this is your first visit to an Oriental Medicine practitioner I am sure you are wondering what's going to happen and will have many questions to ask. There are many variations of oriental medicine ó Traditional Chinese Medicine (TCM), 5 element, Japanese, and Korean styles, so even if it's not your first time receiving acupuncture there may be some differences. I practice a style that combines a Japanese style taught by Kiiko Matsumoto and TCM (Traditional Chinese Medicine), both are based on the Chinese classics and modern medical pathophysiology. This style is very õhands onö and is based on palpation of active reflexes on the abdomen (the hara), neck, back and their corresponding treatment points. This system of palpation and feedback gives the practitioner and patient immediate feedback on both diagnosis and treatment. A treatment session generally begins by first treating active reflexes in the abdomen and neck. Change in how these reflexes feel gives us both a measure of effectiveness. The treatment often consists of treating one set of reflexes with acupuncture, leaving the needles in for 15-20 minutes and then treating another set of reflexes and leaving the needles in for 10-15 minutes. õFirst we must treat the root or core and then the branch or the symptomsö is a frequent saying in oriental medicine. Depending on the length and severity of your symptoms the length of treatment required will vary. Unfortunately there is no quick fix, but feeling healthy makes our life so much more enjoyable.

My practice is very busy and I make an effort to stay on time. Please try to get to the office 5-10 minutes before your scheduled treatment. This will give you time to get a drink of water, go to the bathroom or sit for a few minutes and take time to catch your breath. I often like to see patients weekly in the beginning. We have only scheduled you for a first visit, but you may want to call back and schedule additional appointments. My schedule books quickly and it may be difficult to schedule an appointment for you in that following week if you wait until you come in for your first visit.

I look forward to working with you.

Sincerely,

Nan Cameron, MSN, RN, LAc

Rev.7/28/08, 1/29/10

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Office Hours

Nan Cameron, MSN, RN, LAc

Tuesday, Wednesday, and Thursday 10a-5:30p

Important: Please notify our office 48 hours in advance if you must cancel your appointment. Patients are billed for cancellations with less than 24 hours notice (except in cases of emergency e.g. death in family or hospitalization).

Office Policy

We WELCOME you to our office and assure you that you will be receiving the best care available. Our acupuncturist, Nan Cameron, MSN, RN, LAc is happy to work with your physician and will send your physician monthly progress reports if requested.

Health and accident policies are an arrangement between you and your insurance company. All services will be charged directly to you and you will be personally responsible for payment.

It is customary to pay for professional services when rendered. We ask that you pay for your first visit with cash, check or Visa/MasterCard. We realize that it may be inconvenient or difficult to pay at the time of each visit and will be happy to help you with a **written financial agreement**.

Fee schedule

Initial evaluation and treatment	\$90.00	Rife machine	\$15.00
Follow up visits	\$75.00		
Initial herbal consult	\$60.00		
Herbal consult	\$30.00		

Herbal supplements, pads for microcurrent electrotherapy treatments are not included in the prices listed above

FOR PATIENTS INJURED ON THE JOB (Workers Compensation) Your employer is responsible for any costs in treating your work related injuries. If your injury is work related be sure and tell us before starting treatments. Preauthorization in writing is required before evaluation and treatment can begin. You are personally responsible for payment of any appointments cancelled with less than 24 hours notice.

FOR PATIENTS WITH INSURANCE we will provide you with a CMS1500 form which you may submit to your insurance company. We encourage you to check with your insurance company to find out their requirements for reimbursement to you. Medicare and Medicaid do not pay for acupuncture. We will be happy to assist you with this process. **If you request** a CMS1500, our receptionist will complete forms at the beginning of each month for the previous month. You will need to mail this form along with any additional paperwork required to you insurance company for reimbursement.

If you have any questions please don't hesitate to talk with us.

Thank you for coming to our office for your health needs. We welcome your comments and suggestions.

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Consent for Treatment

I hereby authorize and direct Nan Cameron, MSN, RN, LAc to perform acupuncture and oriental medicine procedures such as obtaining a health history, performing pulse and tongue evaluation, manual palpation, observation, range of motion evaluation, muscle, orthopedic and neurological assessment, modes of manual or physical therapy, such as massage, heat and/or cold therapy, the use of magnets and electrical stimulation, cupping (the application of suction cups, usually on the back), the prescribing of Chinese herbs, homeopathic preparations and nutritional supplements, dietary recommendations, advice regarding exercise and lifestyle counseling.

I have had the opportunity to discuss questions with my practitioner, if I had any, regarding the nature and purpose of acupuncture and oriental medicine procedures. I understand that although acupuncture and oriental medicine procedures have helped many people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of western medicine, in the practice of Oriental Medicine there are some risks to treatment. I understand that while the risks include but are not limited to; bleeding, bruising, light-headedness, inflammations, infections, general aches, burns, discomfort at the location where the needle was inserted or radiating from that location, nerve pain, temporary aggravation of current symptoms or puncture of organs. In 35 years there have been 202 adverse events related to acupuncture (*Altern Ther Health Med 2003:9(1):72-83*). I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the practitioner's judgment based on the facts known at the time.

I have read or have had read to me, the above consent. By signing below I agree to treatment with the procedures listed above, if applicable to my specific situation. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Office policies

Appointments: All patients are seen on an appointment basis only. You are encouraged to schedule well in advance so that a convenient time may be reserved for you. Please be advised that the full treatment fee will be charged for missed or cancelled appointments unless 24 hours notice is given. Initial_____

Payments: We make every effort to keep costs reasonable. It is customary to pay for services at the time rendered. If this is not possible, you are required to discuss this in advance of your appointment so that a form of Financial Agreement may be completed before treatment begins. We accept cash, checks, Visa or Mastercard as payment. A \$25.00 fee will be charged for any returned checks. Initial_____

Insurance: Most insurance companies do not cover treatments. If your insurance does cover acupuncture we will provide you with a superbill within 30 days of treatment so that your insurance company may reimburse you for the cost of treatment.

To be completed by patient
Patient's signature or guardian

Date: _____
Print patient's name

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make any significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us by using the information listed at the end of this notice.

Uses and disclosures of health information.

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to healthcare practitioners providing care to you.

Payment: We may use or disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use or disclose your health information in connection with healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing competence and evaluating performance of practitioners, accreditation, certification, licensing or credentialing activities.

Other circumstances in which your health information may be shared: Appropriate government authorities may be notified if we suspect you are a victim of abuse or neglect or domestic violence or a possible victim of other crimes. This disclosure will only be made when there is reason to believe there is a serious threat to your health and safety or the health and safety of others.

We may also be required to disclose to government authorities health information necessary to complete public health investigations or threats to national security or where required by law.

Your authorization: You may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us authorization you may revoke it in writing at anytime. Unless specifically stated in this Notice, we may only share your health information with your permission, with family, friends or personnel helping with your care. In case of an emergency, where you are unable to tell us what you want we will use our best judgment in sharing your health information.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders, such as voicemails or postcards or letters.

Marketing: Cameron Clinic of Oriental Medicine may send information to you about treatment alternatives and other health related benefits that we think you may find useful or beneficial.

Patient rights: You have a right to request reasonable restrictions on certain uses or disclosures of your health information, and we will make every effort to honor your requests. For example, you have a right to review and copy your patient record. Duplication of the material will involve a per page fee. In addition, you have a right to request that we communicate with you in a certain way. You may wish for us to only contact you at a specific number. You have a right to ask us for a description of how your information was used by our office for any reason other than treatment or payment. **Amendment:** You have a right to request that we amend your health information. Your request must be in writing and it must explain why it should be amended.

Questions and complaints: We encourage you to express any concerns you have regarding the privacy of your health information. You have a right to file a complaint with the Department of Health and Human Services if you believe your privacy rights have been compromised.

Contact Information:

Nan Cameron, MSN, RN, LAc
1928 South 16th Street
Wilmington, NC 28401
Tel: (910)342-0999
Fax: (910)342-0993

We will attempt to call you prior to your appointment as a reminder. The best number to call me is _____ . I understand this is done as a courtesy only. I am responsible for remembering the appointments that I schedule.

I, _____ have received a copy of this Notice of Privacy Practices. I understand that my health information will be used and disclosed consistent with Notice.

Patient Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Cameron Clinic of Oriental Medicine
New Patient Intake Form

today's date: _____

Name:	SS#	Birthdate: / /
	Marital Status:	Age:
Address:	<input type="checkbox"/> M <input type="checkbox"/> F	Ht. Wt.
Home Phone:	Work Phone:	Occupation:
Cell phone:	email:	
Emergency Contact - Name and Phone:		
Email address:		
Allergies (medication, food, etc.)		
Referred by/How did you hear about us?:		
Reason for visit today?	Have you had acupuncture Chinese herbal before? <input type="checkbox"/> Yes <input type="checkbox"/> No medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How long have you had this condition?		
Is it getting worse?	Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> other What?	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?		
Who is your physician?	Phone:	
What treatments are you getting for this condition? (physical therapy, massage, yoga, aromotherapy, etc.)		
Current Medications:		
Current Nutritional or Herbal supplements:		

Family Medical History:

- Heart disease Diabetes Cancer High Blood Pressure
 Stroke Asthma Seizures Alcoholism

Your Past Medical History

- AIDS/HIV Diabetes Multiple sclerosis Thyroid
 Alcoholism Emphysema Mumps TB
 Allergies Epilepsy Pacemaker Typhoid fever
 Appendicitis Goiter Pneumonia Ulcers
 Asthma Heart Disease Seizures _____
 Cancer Hepatitis Stroke _____
 Chicken Pox High Blood Pressure _____ _____

List any hospitalizations you have had during the past 5 years: _____

Surgeries: (list) _____

Your Diet

Appetite: Low Coffee Soft Drinks Sugar Artificial Sweetener
 Normal Tea Salty Food Stevia
 High Thirst for water: #glass/day _____

Average daily menu:

Morning _____ Snack _____
Snack _____ Evening _____
Noon _____ Snack _____

Digestive enzymes. Brand _____
 Probiotics. List what organisms are included and the # of organisms/capsule (or bring in your bottle)

Fish oil. Brand _____ mg EPA _____ mg DHA
 Vitamin D. _____ IU/day (Look to see if it is included in different supplements, such as calcium or vitamins or supplements for bone health.)

My blood type is: O A B AB

I use: table salt sea salt kosher salt

What oils do you use: coconut oil olive oil butter margarine peanut oil

Other: _____

I have trouble eating: milk dairy gluten meat shrimp soy salad

Other: _____

Has your digestion changed in the last six months? yes no

If yes, how? _____

Please bring any recent blood work such as Vitamin D levels, thyroid levels, results from any saliva tests.

Your Lifestyle

Alcohol Marijuana Stress Tobacco Drugs Occupational Hazards

Exposure to chemicals Exposure to mold

Regular Exercise: Type: _____ How Often _____

General Symptoms

Poor appetite Poor sleep Body feels heavy Chills
 Excess appetite Sleep too much Cold hands/feet Night sweats
 Strongly like cold drinks Dream disturbed sleep Poor circulation Sweat easily
 Strongly like hot drinks Fatigue Shortness of breath Muscle cramps
 Recent weight loss/gain Lack of strength Fever Vertigo or dizziness
 Bleed or bruise easily Peculiar tastes (describe) _____

Head, Eyes, Ears, Nose, Throat

Glasses Night blindness Sores on lips/tongue Recurrent sore throat
 Headaches Glaucoma Dry mouth Swollen glands
 Red eyes Cataracts Excessive saliva Lumps in throat
 Itchy eyes Teeth problems Sinus problems Enlarged thyroid
 Spots in eyes Grinding teeth Excessive phlegm Nose bleeds
 Poor vision TMJ Color of phlegm Ringing in ears
 Blurred vision Facial pain _____ Poor hearing
 Dry eyes Gum problems Other: _____

If yes, to sinus problems, headaches, facial pain please complete the following section. Check any items that apply to you.

As a child I had frequent colds As a child I remember being treated with antibiotics
 I have had antibiotics in the last 6 months I have had a yeast infection in the past 12 months
 I do sinus washes I use saline nasal sprays My house has mold

- I am sensitive to smells. Type _____ I am sensitive to chemicals
 I have been exposed to chemicals, fertilizers, paints, hair dye, other: _____

Respiratory

- Difficulty breathing when lying down Tight chest Cough Color of phlegm _____
 Shortness of breath Asthma/wheezing Wet or Dry? _____
 Pneumonia Thick or Thin? _____ Cough blood

Cardiovascular

- High blood pressure Low blood pressure Chest pain Palpitations
 Phlebitis Blood clots Fainting Difficult breathing
 Irregular heart beat Are you taking blood thinners or aspirin? Yes No

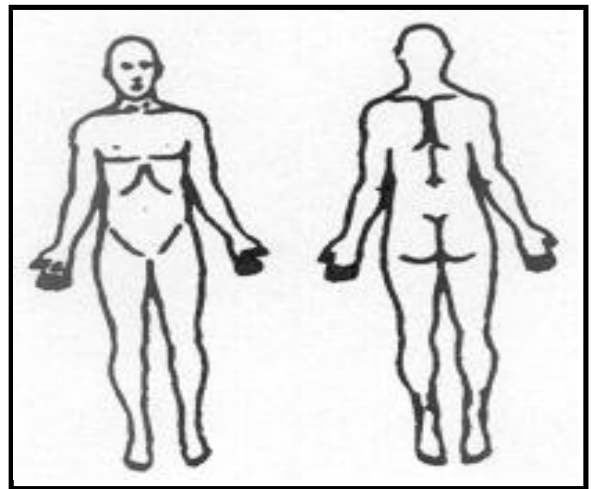
Gastrointestinal

- Nausea Diarrhea Intestinal pain or cramping Bowel Movements
 Vomiting Constipation Itchy anus Frequency _____
 Acid regurgitation Use laxatives Burning anus Color _____
 Gas Black stools Rectal pain Formed or loose _____
 Hiccups Bloody stools Hemorrhoids Strong odor: Yes No
 Bloating Mucus in stools Anal fissures
 Bad breath

Musculoskeletal

- Neck/Shoulder Pain Upper back pain Joint pain
 Muscle pain Low back pain Rib pain
 Limited range of movement Sciatica Paralysis
 Numbness

Mark areas of pain on the diagram



Skin and Hair

- Rashes Eczema Dandruff Change in hair/skin texture
 Hives Psoriasis Itching Fungal infections
 Ulcerations Acne Hair loss

Other hair or skin problems: _____

Neuropsychological

- Seizures Poor memory Irritability Considered or attempted suicide
 Depression Easily stressed Anxiety Seeing a therapist
 Tics Abuse survivor

Other: _____

Genitourinary

- Pain on urination Blood in urine Venereal disease Increased libido
 Frequent urination Unable to hold urine Bedwetting Decreased libido
 Urgent urination Incomplete urination Wake to urinate Impotence
 Kidney stone Premature ejaculation
 Testicular self exam

Gynecology

Age menses began _____	Duration of Flow _____	<input type="checkbox"/> Vaginal discharge color _____	<input type="checkbox"/> Breast lumps
Length of cycle _____	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> # pregnancies _____
<input type="checkbox"/> Date last period began _____	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Vaginal odors	<input type="checkbox"/> # live births _____
Age of menopause _____	<input type="checkbox"/> Clots	<input type="checkbox"/> Breast self exam	<input type="checkbox"/> # abortions _____
Other: _____	<input type="checkbox"/> PMS	Date of last PAP exam _____	<input type="checkbox"/> # premature births _____

If you have problems with fatigue, chronic pain, thyroid, chronic fatigue syndrome, fibromyalgia or infertility please complete the following section:

I have monitored my basal metabolic temperature in the past. If yes, what were your results _____

I have had chronic, recurrent infections for most of my life.

I would describe my mother as "healthy" I would describe my father as "healthy"

My eyebrows are thinner than they used to be, especially the outside third.

My skin has become dry, cold, rough, scaly I feel colder than I used to be

I get hot easily my symptoms get worse when I get overheated cold makes my symptoms worse

My fatigue is not relieved by rest or sleep I have problems thinking straight I have used birth control pills

I have had mononucleosis I have had yeast infections