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

What you need to do before your first visit.

1. Go to our website: **camclinic.com** and click on the link for **Pre-visit Forms**.
2. Complete the pre-visit forms – adult or child. You may email them to thecameronclinic@bellsouth.net, fax to (910)342-0993, drop them off at the office or mail them to us.
    - What to expect on your first visit
    - Office Policies
    - Patient Intake Form
    - Consent For Treatment
    - Privacy Policy
    - Metabolic Assessment (adult)
    - NTAF form (adult)
3. Obtain copies of your lab results, pathology reports, x-rays, CT scans and MRI reports for the past 2 years. You may request these be faxed to our clinic – 910-342-0993
4. If you have not had any lab work done in the past two years you may want to call the office and arrange to have a Comprehensive Wellness Panel completed before your first visit. This test screens for glucose, fluid and electrolytes, complete blood count, lipids, thyroid, liver and kidney function. The cost is $97.00.
5. **Once we have received all of your information you will be contacted to schedule an appointment**. I spend 2-3 hours before you even come in for a visit reviewing and analyzing your information so that we can make the most of your first visit.

Your first visit usually takes about 1½-2 hours if you are also receiving acupuncture and 1 hour if you have scheduled a consult only. We spend time talking about your concerns and goals for treatment. I will ask you different questions – 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. **For best results, don't come to your appointment hungry or skip eating your breakfast or lunch.** Acupuncture works with your body's energy and food is our energy source.

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!

"First we must treat the root or core and then the branch or the symptoms" 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.

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 – 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 taught by Kiiko Matsumoto and TCM (Traditional Chinese Medicine), both are based on the Chinese classics and modern medical pathophysiology. This style is very "hands on" 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.

Chinese Medicine views the kidneys as our energy foundation. The kidney energy is the source of our brain and bone marrow and loosely corresponds to the adrenals and hormones. The kidneys/adrenals/cortisol/genes are easily depleted by 'overwork'- physical, emotional, chronic pain, chronic lack of sleep, chronic sympathetic nervous system response (body emergency stress response), chronic immune system activation, sugar balance issues, etc. The liver is responsible for sending energy smoothly throughout the body so that all our physical functions e.g. digestion and emotions are smooth and easy. The liver manufactures more than 13,000 chemicals and has more than 2000 enzymatic pathways and is responsible for producing bile to emulsify fats, changing fat soluble hormones into water soluble ones for excretion from the body, detoxify chemicals, most vitamins and minerals must be processed in the liver before they can be made available to the cells to name only a few. The spleen and stomach can be viewed as our checking account. A strong sple en and stomach – good nutrition and digestion protects the kidneys or energy reserves. Chinese medicine says emotions are the biggest cause of internal disharmony. Each organ has specific emotions, e.g. the liver is related to stress, irritability, frustration, anger, depression. The Chinese have been saying for thousands of years that the spleen and stomach plays an important role in clear thinking. In western science, we know that the Vagus nerve runs between the gut and brain and they greatly influence each other.

Treatment in Chinese Medicine is the return to balance in the body, mind and spirit. Strengthen the root to support the branches to resolve symptoms. Functional medicine takes advantage of the best of western science or biomedicine and may utilize laboratory testing to evaluate nutritional status and the biological terrain to provide information about specific imbalances in the body. This enhances the ability to target and prioritize ways to strengthen the root or core to resolve the symptoms or the branch. The Brain, the GUT (Digestive system), the Immune (inflammatory) system and Endocrine system (hormones, adrenals, thyroid, etc.) cannot function without each other and greatly influence each other's function.

1. Treatment involves:
    a. **Fortify the root or core of the individual.** One of my favorite Chinese medicine teachers says, "if you have anything chronic you know that your mind, body and spirit are no longer in balance and what you are doing is no longer working for you and without self judgment, the way to heal is to turn your life inside out and upside down". How does your body function – the brain, digestion, hormones, detoxification, sleep, energy, immune responses, emotions, relationships, support systems, lifestyle, diet and nutrition – what makes up "you". The goal is to preserve and restore the foundation.
    b. **What is your relationship with your environment** – this can be positive, negative or have no impact. Exposure to environmental stressors – chemicals, drugs, foods, geographical location, family, friends, work, etc. Cellular stress overtime can increase the potential for the development of chronic health problems and autoimmunity. The goal is to evaluate stressors and increase the positives and decrease the negatives – I know easier said then done, but critical for healing.
    c. **What is your biological terrain?** This may involve lab testing that can examine deficiencies and excesses of vitamins, minerals, pathways of detoxification, food testing, etc. Botanicals, diet choices, exercise and rest, etc. can improve treatment response and quality of life.

From this information I will provide you with a report that includes my assessment of your issues, additional testing that would be helpful, recommendations for nutritional and herbal supplements that can be used and information that you can incorporate into your health regime. This report is a starting point only. I think the saying "one man's food is another man's poison" describes how we are all unique and respond in different ways. We each have to find our own GPS! Healing involves the mind, body and spirit.

Your treatment may include modalities, such as:

Acupuncture

Moxa – an herb that is burned. It has many different forms – 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 – 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 – a form of bodywork often using a Chinese porcelain spoon that is massaged over specific body areas.

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

BioMat The BioMat delivers the highest vibrational resonance deeply into all body tissues. The combination of far infrared light, negative ions and amethyst quartz opens the channels for intelligent cellular communication to support DNA repair and total body wellness. (www.cameronclinic.thebiomatcompany.com)

ZYTO technology is based on the body's ability to respond to subtle stimuli (cellular consciousness). Using the body's natural energetic field, a communication link is established between the patient and the computer via the ZYTO hand cradle. Through this connection, ZYTO sends stimuli and then records the body's response. This conversation is called biocommunication, and it provides insights into health and wellness. (www.zyto.com)

EVOX, another component of the Zyto technology facilitates a process called Perception Reframing. Perception is the way you feel and think about something. Because we perceive more than we are aware of, perception is more often 'felt' rather than 'thought about.' EVOX uses the voice (VOX is Latin for voice) to map perception about specific topics like health, relationships, work or athletic performance; any aspect of life. It then analyses that map, called a Perception Index, and creates a playback information packet that the body uses to bring perception to the level of awareness and allow it to be reframed. EVOX is used to improve every aspect of human performance.

Life Vessel G2 is an FDA cleared, Class II medical device that has five US patents and employs the therapeutic modalities associated with vibration, sound and light. It utilizes an infrared light source to facilitate an increase in both blood circulation and oxygen levels to the cells, while the simultaneous combination of vibration, light and sound delivers the ultimate experience in relaxation therapy. Relaxation provides benefits to the body that include: higher energy levels, improved sleep, stronger cognitive abilities, an enhanced immune system and the ability for an individual to de-stress.

An additional benefit to stress reduction is the ability to balance an individual's autonomic nervous system (ANS). The ANS of the body is the part of the nervous system that controls bodily functions which we have little or no conscious control – functions such as digestion, blood pressure, heart rate, and the operation of major organs and glands. A balanced ANS is essential for an individual to maintain good health and allows your body to have optimal healing abilities.

Life Vessel treatments last for a period of one hour and are administered in a series of four sessions, typically over a three or four day period. Since every person is different, as are their conditions, the number of sessions required is dependent on the individual and the severity of their health challenge.

It is important to note the Life Vessel does not cure disease. Rather, through the modalities of vibration, light, sound and with the assistance of infrared light, the Life Vessel facilitates the body's ability to relax, de-stress and balance, thus enhancing an individual's natural ability to self-regulate and self-heal.

More information is available at lifevessel.com, Radical Remissions by Kelly Turner, p. 203-13 and Waking the Warrior Goddess by Christine Horner, MD p. 245.

Nutritional and Herbal Formulas

Herbal formulas are an important part of Oriental Medicine. Many different types of nutritional and herbal supplements are offered.

Chinese Herbal Formulas

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 ten and fifty dollars. I use products from Golden Flower, Health Concerns, Evergreen, Herbal Times, Blue Poppy, Mayway, etc. Chinese prepared 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

The granules are a freeze dried form of Chinese herbs that is formulated into a specific Chinese herbal formula for you. A weekly dose for one formula is approximately 42 – 64 gms. The weekly cost for each formula is about $15.00 - $35.00. 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

We have a wide selection of nutritional supplements including: probiotics, fish oil, vitamins, to name only a few products that are available in the office. We use product companies such as Allergy Research Group, Apex Energetics, Designs for Health, Narula Research, Innate Response, Integrative Therapeutics, Natura Products, Nordic Naturals, Pekana, Transformation Enzymes, etc.

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. If you only schedule your first visit it may be 4-6 weeks before we can schedule you for a return appointment. My schedule books quickly and it is often difficult to schedule an appointment if you wait until you come in for your first visit.

A minimum of 24 hours notice is required for cancellation of appointments, unless there is a true emergency e.g. hospitalization, death in the family. Failure to notify the office will result in a charge for the missed visit.

I look forward to working with you.

Sincerely,

Nan Cameron, MSN, RN, LAc

Rev.7/28/08, 1/29/10, 10/6/10, 5/17/11,5/29/13, 3/9/15

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Office Hours

Nan Cameron, MSN, RN, LAc
Tuesday, Wednesday, and Thursday 10a-5:30p
Two Fridays a month are scheduled for consults, zyto scans, EVOX sessions.
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	$190.00	Rife machine	$15.00
Acupuncture Follow up visits	$90.00	Consultation, 25 min.	$40.00
Initial consult, no acupuncture	$155.00	Consultation, 50 min.	$80.00
Consultation, each additional 10 minutes	$15.00	Biomat only	$25.00

Acupuncture follow up visits include only 10-15 minutes of consultation time, I want to get you on the table for your treatment. If you want more time to discuss issues please set up a consultation visit. If I have time to spend more than 10-15 minutes of consultation time during an acupuncture visit with you the invoice will reflect the acupuncture treatment and consultation time.

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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Child Health Questionnaire

(to be filled out by the parent)

Full Name_____ Parent's Name_____

Address_____City_____ State_____Zip_____

Emergency Contact_____ Phone number_____

Date of birth ____/____/____ Gender _____ Relationship to child _____

Parent's phone info: (home) _____ (work) _____ (cell) _____

Email address _____

Whom may we thank for referring you? _____ Relationship to you _____

Primary Concern

What is your child's primary health problem?_____
_____
_____
_____

Date of original problem:_____ Date of most recent recurrence:_____

Was there an event that created the problem?_____
_____

Has your child had this or similar conditions in the past? _____ Is the problem getting worse? _____

What makes it better?_____

Worse?_____

Is this problem interfering with school?_____ Sleep?_____ Activity?_____

Other:_____

What can your child not do now that he/she would like to do? _____
_____

What are your goals for your child's treatment? _____
_____

Health History

List all other CURRENT problems in their order of importance _____
_____
_____
_____
_____

List other practitioners seen, treatments, self care activities, and results_____

_____

_____

_____

_____

_____

Does your child have any spinal abnormalities that you are aware of?

_____

List ALL significant PAST illnesses

_____

_____

_____

_____

Please list ALL chronic infections (Epstein barr, herpes, chlamydia, hepatitis, HIV, bladder infections, respiratory infections, etc.)

_____

_____

List ALL surgeries your child has had, with dates and results

_____

_____

_____

Has your child ever been hospitalized other than for surgery?_____

Has your child ever been in an accident or seriously injured? List dates and describe_____

_____

_____

Has your child ever had: whiplash? Yes___ No___ // a hard fall on the tailbone? Yes___ No___ // a seizure? Yes___ No___

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health

_____

_____

_____

Describe any travel related illnesses

_____

Is there a time in your child's life when he or she began feeling significantly less healthy? Yes _____ No _____

If yes, please describe…

_____

_____

How many root canals does your child have? _____

How many doses of antibiotics (total lifetime)? _____

How many times per month does your child take aspirin? ____ Ibuprofen? ____ Tylenol? ____ Antacids? ____ Laxatives? _____

For what purpose are these taken? _____

Family History

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents), living or deceased, had any of the following problems? For each YES, state the age of the person when the problem occurred and their relationship with your child.

Condition Yes No Age Relationship

Alcoholism / Drug Addiction _____
Allergies / Asthma _____
Arthritis _____
Blood disorders _____
Cancer (type _____)_____
Diabetes _____
Digestive Disorders (type _____) _____
Heart attack before age 55 _____
Heart attack after age 55 _____
High blood pressure _____
Kidney or Liver disease _____
Lung disease / tuberculosis _____
Mental health problems/ depression _____
Seizure Disorder _____
Stroke _____
Thyroid disease _____
Uterine / Ovarian problems _____
List other problems that run in your family _____

Question	**Yes**	**No**	**Don't Know**	**Comment**
1. Was your child a full term baby?				
a. A preemie? How many weeks early?				
b. Breast fed?				
c. Bottle fed?				
2. Childhood illnesses a. Measles b. Mumps c. Chickenpox d. Other				
3. Vaccinations – list and note if any know reaction Tetanus/Diptheria (Td) Flu Pneumonia Polio Measles/Mumps/Rubella Hepatitis B Other_____				

Habits

Describe your child's exercise habits (activity / times per week)

_____

Describe your child's current sleeping pattern (bedtime, waking time, napping, difficulty with sleep)

_____

_____

Does your child have enough energy for normal activities? Yes____ No____ How long does your child watch TV each day?_____ How long does your child use the computer each day? _____

What does your child do for fun / pleasure / relaxation? _____

Preventive Measures and Screening

When did your child last receive the following (leave blank if it does not apply). Circle the test if you've had an abnormal result.

General physical exam_____ CBC/chemistry_____Dental exam_____

Eye exam_____ Hearing test_____

Other tests/scans (describe)

_____

Has your child ever had an X-RAY, MRI or CT (CAT) scan? Yes____ NO____ If so, what for?_____

Has your child received the following vaccines:

Allergies and Sensitivities

Please list any allergies you are aware of (foods / medications / other):

_____

_____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.)

_____

Is your child particularly sensitive to the effects of medications? Yes _____ No _____

Has your child ever reacted to a medication in an unexpected way? Yes ___ No ___ If yes, please describe

_____

Has your child had problems with damp or moldy places? Yes ___ No ___ Problems with new building materials? Yes ___ No ___

Nutrition

What does your child usually eat and drink on a typical weekday?

Place a check mark next to the food/drink that applies to your child's current diet. (List continues on next page.)

	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	

v.	Other: (List below		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

1. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m	Sodas without caffeine	

How many glasses of water per day? _____ Circle those that apply: tap water, distilled, bottled, well-water, other

How many servings per day of the following: Fruits & Vegetables___ Coffee___ Tea____ Soda___ Diet Soda___

If your child takes nutritional supplements, is there a specific improvement in the way he/she functions?_____

How many meals each week are:

At home_____ Alone_____ In restaurant_____ At fast food place_____ TV Dinners or “convenience” food _____ While watching TV_____ From deli_____ At "health food" restaurant or takeout _____

Does your child eat if he/she is not hungry but feels depressed, anxious or bored? Frequently / Occasionally / Rarely / Never (circle)

Does your child ever: a) binge eat? Yes__ No__ b) sneak or hide foods? Yes__ No__ c) make him/herself vomit? Yes __ No __ d) eat slowly and chew his/her food well? Yes __ No __ e) use extra salt on food at the table? Yes __ No __

List the oils or fats you use in cooking/preparing food:

_____

Does your child enjoy eating cheese? Yes____ No____ Drinking milk? Yes____ No____ If so, how much per day? _____

Does your child like sweets, pastries, cakes, donuts, etc.? Yes___ No___ How many servings per week? _____

Does your child eat sugarcoated cereal or add sugar to cereal? Yes___ No__ How many servings per week? __

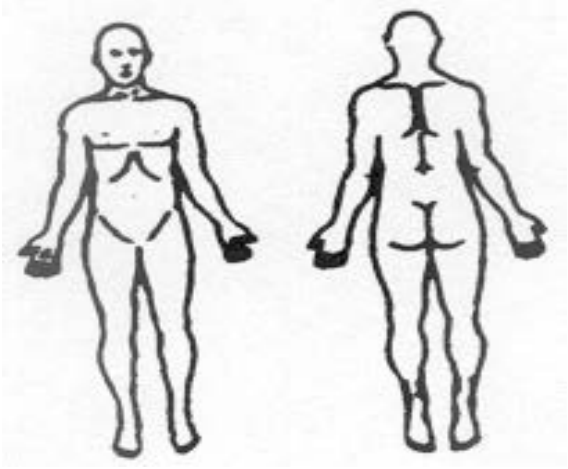
Does your child use artificial sweeteners (in diet soda or other foods)? Yes___ No___ How many servings per week? _____

When your child eats bread, is it white or whole wheat?_____ After eating, does he/she feel: Better / Worse / No different (circle)

Does your child usually eat breakfast? Yes__ No__ Does your child feel better if he/she skips breakfast? Yes____ No____
Does your child snack between meals? Yes__ No__ Does your child frequently skip meals? Yes _____ No ____
What is your child's preferred snack food? _____
Is there one food that your child likes the most, eats a lot of, and craves when he/she doesn't have it?
_____
Does your child have any reaction to eating food with MSG in it? Yes__ No__ If so, please describe:
_____
Does your child have trouble with gaining weight too easily? .....Yes_____ No _____
Does your child have trouble with losing weight too easily? .....Yes_____ No _____
If your child's weight has changed, please describe the circumstances involved
_____
Does your child have more than one meal a day that lacks a vegetable other than corn, potatoes, peas or beans? Yes_____No_____
Are there days when your child does not eat any raw vegetables? ..... Yes_____ No_____
List the three healthiest foods your child eats in the average week: _____, _____, _____
List the three un-healthiest foods your child eats in the average week: _____, _____, _____
Are there specific foods that irritate your child in any way? Yes ___ No ___ If yes, name the foods and describe the problem:
_____
_____
Please describe any ways in which you feel your child's diet is excessive:
_____
_____
Please describe any ways in which you feel your child's diet is deficient:
_____
_____
List all vitamins, herbs and other supplements your child is now taking
_____
_____
_____

Pain Questionnaire

(Skip to the next page if your child is not currently experiencing pain.)



Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)
0. . . . . |. . . . . |. . . . . |. . . . . |. . . . . |. . . . . |. . . . . |. . . . . |. . . . . |. 10

Mark the areas on your body where you feel the following sensations.
Use the appropriate symbol. Include all affected areas.
Ache ^ ^ ^ ^ , Burning x x x x , Numbness -----, Pins & Needles o o o o , Stabbing / / / / , Throbbing T T T T T

History of Injury
Please mark with an "X" all the places where your child has ever been injured (sprains, strains, burns, broken bones, scars from surgeries or accidents, severe bruises, concussions, hard blows to the head, falls, etc.).
Be sure to note any organs that have been operated on or removed. (tonsils, wisdom teeth, appendix, etc.).

About Medications
The treatment is intended to improve all aspects of your child's health. As your child's care progresses, his/her body may be better able to heal itself in all respects. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions may improve. If this occurs, it is possible that the doses of medications your child is taking will have to be modified, to account for this improvement. It is your responsibility to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that current doses do not become excessive or deficient in their effect on your child. These and any other changes to your child's regimen of medications must be made in coordination with and under the instructions of the physician who prescribed them.

Additional Information
Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans.
Please list the names of your child's pediatrician and other doctors.

_____ _____
_____ _____
_____ _____
_____ _____

Thank you for completing this questionnaire. The information that you have provided gives a more complete understanding of your child's health concerns and helps your child receive the highest quality care. If we left out an important question, please note below.

_____
_____

Signature_____ Date_____
Relationship to the patient _____

Cameron Clinic of Oriental Medicine
1928 South 16th Street
Wilmington, NC 28401
Tel: (910) 342-0999

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. We make an effort to place a reminder call, but it is your responsibility to remember appointments that you have scheduled. Cancellations should be made by calling 910-342-0999, we do not accept responsibility for cancellations sent by email. 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 CMS 1500 within 30 days of treatment so that your insurance company may reimburse you for the cost of treatment.

To be completed by patient — Date: _____

Patient's signature or guardian — Print patient's name

_____ _____

Cameron Clinic of Oriental Medicine, Inc.
1928 South 16th Street
Wilmington, NC 28401

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 that the 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: _____