PATIENT FORMS

Daniel J. Hudson, Lic Ac.

YAO Lander
785 Garfield Ave
Lander, WY 82520
307-205-6704
yaoclinic.com

YAO Denver
1705 SPearl St STE 2A
Denver, CO 80210
303-777-7891
yaoclinic.com

PLEASE PRINT LEGIBLY

GENERAL INFORMATION

Name: _____ Birthday: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation:_____ Cell ✆: _____Home ✆: _____

E-mail: _____ Who referred you? _____

Emergency Contact: _____ Emergency ✆: _____ Relationship:_____

Do we have permission to leave detailed messages regarding your health on voicemail? ☐ YES ☐ NO

FAMILY HISTORY if any blood relative has suffered any of the following – please indicate which relative

☐ Tuberculosis _____	☐ Epilepsy _____	☐ Arthritis _____	☐ Hypertension_____
☐ Stroke _____	☐ Diabetes _____	☐ Gout _____	☐ Alcoholism _____
☐ Migraine _____	☐ Cancer _____	☐ Kidney Disease_____	☐ Heart Attack _____
☐ Mental Illness _____	☐ Allergy_____	☐ Glaucoma _____	☐ Asthma _____

PRIOR SURGERY OR ILLNESS

Date:	Illness or operation:	Date:	Illness or operation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

_____

_____

_____

DRUG ALLERGIES

_____

_____

_____

MEDICAL HISTORY

Chief Complaint(s): _____

_____

Cause or how it started: _____

Is your condition due to an accident or an illness? _____

Have you ever had this condition before? ☐ YES ☐ NO

Have you received treatment for this condition before? ☐ YES ☐ NO

If you received treatment, when, by whom, and what was the diagnosis? _____

What were the results of the treatment? _____

What makes your condition better? _____

_____

What makes your condition worse? _____

_____

Additional Comments: _____

_____

_____

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MEDICAL HISTORY CONTINUED

Please read carefully the symptoms below. Check any and all that apply: ○ = past ☐ = present

Eye, Ear, Nose, and Throat
- ○ ☐ Decreased Hearing
- ○ ☐ Ringing in Ear
- ○ ☐ Ear Infections - Frequent
- ○ ☐ Dizzy Spells
- ○ ☐ Sensitive to Light
- ○ ☐ Eye Twitch
- ○ ☐ Eye Dryness
- ○ ☐ Failing Vision
- ○ ☐ Double or Blurred Vision
- ○ ☐ Eye Pain
- ○ ☐ Eye Infections - Frequent
- ○ ☐ Nose Bleeds - Recurrent
- ○ ☐ Sinus Trouble
- ○ ☐ Sore Throats - Frequent
- ○ ☐ Dry Mouth
- ○ ☐ Lump in Throat
- ○ ☐ Mouth/ Tongue Sores
- ○ ☐ Teeth Problems
- ○ ☐ Grind Teeth
- ○ ☐ Hayfever / Allergies
- ○ ☐ Hoarseness - Prolonged

Respiratory
- ○ ☐ Pneumonia / Pleurisy
- ○ ☐ Bronchitis / Chronic Cough
- ○ ☐ Asthma / Wheezing
- ○ ☐ Shortness of Breath: On Exertion ☐ Lying Flat ☐
- ○ ☐ Difficulty Inhaling
- ○ ☐ Sigh Often
- ○ ☐ Cough
- ○ ☐ Cough with Phlegm
- ○ ☐ Cough with Blood

Circulatory
- ○ ☐ Heart Problems
- ○ ☐ Chest Pain
- ○ ☐ Convulsions / Seizures
- ○ ☐ Stroke
- ○ ☐ High Blood Pressure
- ○ ☐ Low Blood Pressure
- ○ ☐ Slow Heart Beat Rate
- ○ ☐ Irregular Heart Beat
- ○ ☐ Heart Murmur
- ○ ☐ Palpitations
- ○ ☐ Irregular Pulse
- ○ ☐ Ankle Swelling
- ○ ☐ Facial Swelling
- ○ ☐ Hand Swelling
- ○ ☐ Fainting Spells
- ○ ☐ Numbness/ Tingling
- ○ ☐ Leg Pain when Walking
- ○ ☐ Varicose Veins / Phlebitis

Digestion
- ○ ☐ Recent Loss of Appetite
- ○ ☐ Bitter Taste in Mouth
- ○ ☐ Nausea / Vomiting
- ○ ☐ Foul Breath
- ○ ☐ Constant Hunger
- ○ ☐ Difficulty Swallowing
- ○ ☐ Indigestion or Heartburn
- ○ ☐ Persistent Nausea / Vomiting
- ○ ☐ Peptic Ulcers
- ○ ☐ Abdominal Pain - Chronic
- ○ ☐ Hemorrhoids
- ○ ☐ Gall Bladder Trouble
- ○ ☐ Jaundice / Hepatitis
- ○ ☐ Hernia

Stool
- ○ ☐ Change in Bowel Habits
- ○ ☐ Diarrhea ○ ☐ Constipation
- ○ ☐ Colon Problems
- ○ ☐ Diverticulosis
- ○ ☐ Bloody or Tarry Stools
- ○ ☐ Burning Anus
- ○ ☐ Pain / Cramping
- ○ ☐ Undigested Food in Stool
- ○ ☐ Intestinal Worms

Urination
- ○ ☐ Urine Infections - Frequent
- ○ ☐ Burning
- ○ ☐ Cloudy
- ○ ☐ Urgent
- ○ ☐ Strong Smell
- ○ ☐ Painful Urination
- ○ ☐ Blood in Urine
- ○ ☐ Overnight Urination
- ○ ☐ Incontinence
- ○ ☐ Decrease in force of Urination
- ○ ☐ Kidney Stones
- ○ ☐ Venereal Disease
- ○ ☐ Urethral Discharge

General Symptoms
- ○ ☐ Chronic Fatigue
- ○ ☐ Weight Loss
- ○ ☐ Anemia
- ○ ☐ Bruise Easily
- ○ ☐ Cancer
- ○ ☐ Diabetes
- ○ ☐ Thyroid Disease
- ○ ☐ Tremor / Hands Shaking
- ○ ☐ Muscle Weakness
- ○ ☐ Headaches - Frequent
- ○ ☐ Dizziness
- ○ ☐ Vertigo

General Symptoms Continued
- ○ ☐ Sleeping - Difficulty
- ○ ☐ Night Sweats
- ○ ☐ Perspire without Exertion
- ○ ☐ Cold Hands / Feet
- ○ ☐ Warm Palms / Soles
- ○ ☐ Hot Flashes
- ○ ☐ Alternate Chills and Fever

Pain
- ○ ☐ Arthritis / Rheumatism
- ○ ☐ Back Pain - Recurrent
- ○ ☐ Sciatica
- ○ ☐ Neck Pain
- ○ ☐ Hand/ Wrists
- ○ ☐ Hip
- ○ ☐ Knee
- ○ ☐ Foot/ Ankle
- ○ ☐ Muscle Cramp
- ○ ☐ Bone Fracture / Joint Injury
- ○ ☐ Gout
- ○ ☐ Foot Pain
- ○ ☐ Cold Numb Feet

Skin
- ○ ☐ Rashes
- ○ ☐ Hives
- ○ ☐ Psoriasis / Eczema
- ○ ☐ Dry Skin
- ○ ☐ Oily Skin
- ○ ☐ Itching
- ○ ☐ Boils
- ○ ☐ Moles / Warts

Psychological
- ○ ☐ Nervousness
- ○ ☐ Depression
- ○ ☐ Memory Loss
- ○ ☐ Excessive Moodiness
- ○ ☐ Phobias
- ○ ☐ Mental Illness

Disease
- ○ ☐ Chicken Pox
- ○ ☐ Polio
- ○ ☐ Measles / German Measles
- ○ ☐ Rheumatic
- ○ ☐ Scarlet Fever
- ○ ☐ Mumps
- ○ ☐ Tuberculosis
- ○ ☐ Hepatitis
- ○ ☐ Venereal Disease
- ○ ☐ Herpes
- ○ ☐ HIV-Positive
- ○ ☐ AIDS
- ○ ☐ Other _____

Habits
- ○ ☐ Alcohol _____ oz. / week
- ○ ☐ Smoking _____ cig. / day
- ○ ☐ Coffee / Tea _____cups / day
- ○ ☐ Soft Drinks _____cans / day
- ○ ☐ Recreational Drugs _____

Male - History
- ○ ☐ Reduced Sex Drive
- ○ ☐ Seminal Emission
- ○ ☐ Impotence
- ○ ☐ Discharge
- ○ ☐ Genital Pain
- ○ ☐ Prostate Problems
- ○ ☐ Pain/Burning during Urination
- ○ ☐ Dribbling Urine

Female - History

No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages_____
Birth Control Method_____
B.C. Pill Name _____
- ○ ☐ Reduced Sex Drive
- ○ ☐ Irregular PAP Test
- ○ ☐ Facial or Excessive Body Hair

Menses

___Age of Onset __ Days of Flow
- ☐ Age stopped
- ☐ Irregular
- ☐ Painful
- ☐ Heavy Flow
- ☐ Scanty Flow
- ☐ Dark Color
- ☐ Light Color
- ☐ Clotting
- ☐ Water Retention
- ☐ Abdominal Bloating
- ☐ Painful / Tender Breasts
- ☐ Emotional Changes
- ☐ Spotting between Periods
- ☐ Lump in Throat
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chest Tightness
- ☐ Hormonal Problems
- ☐ Backache
- ☐ Sigh Often
- ☐ Vaginal Discharge
- ☐ Flushing / Menopause
- ☐ Other _____

Allergies_____
_____
_____

Other important information _____
_____
_____

I certify that above information is true and accurate to the best of my knowledge.

*Patient Autograph:*_____ *Date:*_____

(Parent or Guardian if a minor)

The above signed has read the disclosed form.

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PART I

Name: _____ Age: _____ Sex: _____ Date: _____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.*

CATEGORY I	0	1	2	3
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard, dry, or small stool	☐	☐	☐	☐
Coated tongue of "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Use laxatives frequently	☐	☐	☐	☐

CATEGORY II	0	1	2	3
Excessive belching, burping, or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

CATEGORY III	0	1	2	3
Stomach pain, burning, or aching 1- 4 hours after eating	☐	☐	☐	☐
Use antacids	☐	☐	☐	☐
Feel hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	☐	☐	☐	☐

CATEGORY IV	0	1	2	3
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side	☐	☐	☐	☐
Under rib cage	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling,	☐	☐	☐	☐
Mucous-like, greasy, or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

CATEGORY V	0	1	2	3
Greasy or high-fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and or bloating several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates from clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed	YES ☐		NO	☐

CATEGORY VI	0	1	2	3
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, or have tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory/forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

CATEGORY VII	0	1	2	3
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal or larger than hip	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

CATEGORY VIII	0	1	2	3
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

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CATEGORY IX	0	1	2	3
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amounts of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 or more hours of sleep	☐	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

CATEGORY X	0	1	2	3
Tired, sluggish	☐	☐	☐	☐
Feel cold – hands, feet, all over	☐	☐	☐	☐
Require excessive amounts of sleep to function	☐	☐	☐	☐
Increase in weight gain even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression, lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face, or genitals or excessive falling hair	☐	☐	☐	☐
Dryness of skin and/or scalp	☐	☐	☐	☐
Mental sluggishness	☐	☐	☐	☐

CATEGORY XI	0	1	2	3
Heart palpitations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervous and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

CATEGORY XII	0	1	2	3
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders or lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

CATEGORY XIII	0	1	2	3
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
"Splitting" type headaches	☐	☐	☐	☐

CATEGORY XIV (MALES ONLY)	0	1	2	3
Urination difficulty or dribbling	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐

CATEGORY XIV (MALES ONLY)	0	1	2	3
Feeling of incomplete bowel evacuation	☐	☐	☐	☐
Leg nervousness at night	☐	☐	☐	☐

CATEGORY XV (MALES ONLY)	0	1	2	3
Decrease in libido	☐	☐	☐	☐
Decrease in spontaneous morning erections	☐	☐	☐	☐
Decrease in fullness of erections	☐	☐	☐	☐
Difficulty in maintaining morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decrease in physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increase in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional than in the past	☐	☐	☐	☐

CATEGORY XVI (MENSTURATING FEMALES ONLY)	0	1	2	3
Are you menopausal	☐	☐	☐	☐
Alternating menstrual cycle lengths	☐	☐	☐	☐
Extended menstrual cycle, greater than 32 days	☐	☐	☐	☐
Shortened menses, less than every 24 days	☐	☐	☐	☐
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne breakouts	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

CATEGORY XVII (MENOPAUSAL FEMALES ONLY)	0	1	2	3
How many years have you been menopausal?	☐	☐	☐	☐
Since menopause, do you ever have uterine bleeding?	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breasts	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal pain, dryness or itching	☐	☐	☐	☐

PART III

How many alcoholic beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions: _____

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Professional Disclosure, informed consent, Summaries of State and Federal Regulations

SUMMARY OF THE STATE OF COLORADO REGULATIONS

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies (DORA). Daniel J. Hudson complies with all rules and regulations specified by the Colorado Department of Health. He follows clean needle technique, using sterilized disposable needles, and follows state guidelines for sanitation and sterilization within the treatment room. Patients may seek a second opinion from any another health care professional or may terminate treatment at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the division of registrations in the department of regulatory agencies. Acupuncture is regulated by the Department of Regulatory Agencies. Any Complaints should be directed to: Department of Regulatory Agencies, Office of Acupuncturists Registration at 1560 Broadway, Suite 680, Denver, CO 80202, (303) 894-2464. Patients are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy.

INFORMED CONSENT TO TREATMENT

Daniel Hudson's training includes the recommendation and application of adjunctive therapies and herbs as defined by oriental medicine concepts, including Herbal medicine (internal and external use), electro-stimulation, cupping, auriculotherapy (ear acupuncture), moxibustion, acupressure, gua sha, bleeding techniques, as well as dietary, nutrition and lifestyle recommendations. I understand that I may be recommended or administered any of the above therapies.

SUMMARY OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT

The U.S. Dept of Health & Human Services had developed the Health Insurance Portability & Accountability Act (HIPPA). A policy that requires all health care providers to make reasonable efforts to protect your personal health information from being released to unauthorized persons. As your Oriental Medicine provider, I only share your health information with your referring physician, your insurance carrier, our billing dept or company and ANY other individuals or entities **specified by you**. All efforts are made by YAO Clinic /YAO Company (YAO) and each of these entities to protect your health information. If you feel your personal health information has been released to any unauthorized person, please notify us in writing (YAO Company PO Box 1399. Lander, WY 82520) and we will take the necessary steps to resolve the problem. For more information about HIPAA , contact the U.S. Department of Health and Human Services Office of Civil rights, 200 Independence Ave, S.W., Washington, D.C., 20201, 202-619-0257, Toll free 877-696-6775.

ACKNOWLEDGEMENT

By signing below, I acknowledge having read the above written notices, having received a copy of the Privacy Notice and having been provided an opportunity to receive/review the complete copy of the Notice of Privacy Practices for YAO Clinic. I give my permission and consent to treatment.

I certify that above information is true and accurate to the best of my knowledge.

Patient Autograph: _____ *Date:* _____

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EDUCATION

2010 – 2011	Golden Gate School of Feng Shui, San Francisco, CA
2009 – Active	Doctorate Fellow, 5 Branches Institute, San Jose, CA
2007 – 2011	Auricular Diagnosis and Treatment, Colorado
1999 – Active	Lotus Institute of Integrative Medicine, Continued Education: - Herbal Complements to Cancer treatment, Prescription Drugs and Herbal Alternatives, Recognition and Prevention Herb Drug Interactions, Herbal Alternatives for Pain Management, New Balance Method, Treating Gynecological Disorders, Science of Herbal Combinations.
2001 – 2005	Dynamis School for Advanced Homeopathy, Colorado
1999 – 2000	NAET, Allergy Elimination through Acupuncture Advanced BioSET, Allergy Elimination
2004 – Active	Dr. Datis Kharrazian, Continued Education: - Functional Endocrinology and Functional Blood Chemistry Analysis
1997	Colorado School of Acupuncture and Oriental Medicine, Colorado
1995	Colorado School of Traditional Chinese Medicine, Colorado (1960 hrs)
1994	Body Therapy Institute of Massage Therapy, Santa Barbara, California

PROFESSIONAL CERTIFICATION, LICENSURE, REGISTRATION

2021 – Current	Wyoming Board of Acupuncture (No. 40)
1998 – Current	National Certification Commission for Acupuncture and Oriental Medicine
1998 – Current	CO Dept of Regulatory Agencies, Registered Acupuncturist (No. 465)
1999	NAET Certification and Advanced BioSET
1996	Council of Colleges of Acup & Oriental Medicine, Clean Needle Certification

PROFESSIONAL AND CLINICAL EXPERIENCE

2021 – Current	Private Practice, Lander, Wyoming
1998 – Current	Private Practice, Denver, Colorado
2008 – Current	Colorado School of Traditional Chinese Medicine, Clinic Supervisor
1999 – 2002	Wild Oats Wellness Center, Resident Acupuncturist, Colorado
1998 & 2005	Dr. Yu Yun, Clinical Assistant, California and Spain
1998 – 1999	Mile High Council of Alcoholism & Drug Abuse, Resident Acupuncturist
1996 – 1998	Van Troung Acupuncture Clinic, Clinical Assistant, Colorado
1995 – 1996	Yan Jing Pharmacy Herbal Pharmacist, Colorado

FEES

New Patient Visit $460
1.5-2.5 hour appointment

Regular Patient Visit $209
1.5 hour appointment

Longtime Returning Patient..... $288
1.5 hour appointment

Consultation Visit (i.e. Consultations, Lab Review and Nutritional & Herbal Review, by case time) ..... $62 - $514
15 minute -1.5 hour

Late cancellation or No-show of appointment ..... full cost of scheduled visit

Prescribed items ..... Additional

Out of town patient management follows the same fee schedule.

Medical Records Reporting - All Records are recorded in Chinese medical diagnosis. We do not translate. We reserve the right to charge a fee for medical records copies & reporting to entities ..... $300-$2500

INTIAL VISIT

Our first office appointment is scheduled for 2 hours in length. Please complete the forms we send you **before** the visit so that we can spend our time addressing your current concerns, history, risk factors and perform an acupuncture treatment.

CANCELLATION POLICY

If you need to cancel an appointment, please give at least 24 hour notice, as it is a great inconvenience to both the office and other patients whom we could have seen at an earlier time.
You will be charged the arranged appointment time if less than a 24 hour notice is provided.

PAYMENT

The patient is responsible for payment at the time of service. We accept checks, cash and credit cards. If we are to send botanical items, vitamins or minerals to you between visits, we will use a charge card for that purpose. We do not process insurance. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I certify that above information is true and accurate to the best of my knowledge.

Patient Autograph: _____ *Date* _____