

# [ Alchemÿ ]

62 Clayton Street, Asheville NC 28801

828.575.9419

[www.alchemyasheville.com](http://www.alchemyasheville.com)

alchemyasheville@gmail.com

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## Fees

- Initial Acupuncture Treatment and Health History Consultation \$90
- Follow-up Acupuncture Treatment \$70
- Student Rate Acupuncture Treatment \$55
- Community-Style Acupuncture Treatment \$25-\$45 Sliding Scale
- Facial Rejuvenation Treatment \$140
- Ear Acupuncture Weekly Package \$50
- Children's Acupuncture Treatment for children under age fifteen \$35
- Herbal Consultation \$40
- Nutritional Consultation \$30
- Massage Therapy 60 min 65; 90 Min \$95; 120 Min \$120
- Herbal medicine varies in price and is a separate cost from treatments

## Scheduling and Payment Policies

- Office hours are by appointment.
- A 24 hour notice is required for cancellation or rescheduling, otherwise you will be billed for the full cost of the appointment time.
- If you are late to your appointment, that appointment will be shortened in order to complete the treatment at the scheduled time.
- Full payment is expected at time of service. We accept cash, check, and major credit cards. We are able to provide you with a receipt upon request. There is a \$25 fee for returned checks.
- Alchemy is not responsible for any billing associated with your insurance. A receipt for your office visit will be provided upon request; you have the option to check with your insurance carrier to see if reimbursement is possible.

**Your Arrival** We appreciate on time arrival for all appointments. If you arrive early, feel free to come in enjoy a cup of tea. Please silence your cell phone upon entering the building. Parking is available in our parking lot behind the building where our main entrance is located.

## Preparation

When possible, we ask patients to print out the Initial Health History Forms, and fill them out before coming to your first appointment. If you are unable to print the forms, please arrive 30 minutes in advance of your scheduled appointment time to fill out the forms. Also, please remember to provide a list of any and all medications and or supplements that you are currently taking (with dosage). We recommend wearing comfortable loose fitting clothes. We request that you eat a snack or a small meal with in two hours your scheduled treatment time.

## Your treatment

Treatments take place in a peaceful, private, comfortable environment. Your visit will begin by discussing health history and your specific goals for treatment, and in addition the intake will include pulse taking and tongue observation. Upon assessing your health condition, your practitioner may select from a variety of techniques to complement your acupuncture treatment. These techniques include: massage, cupping, gua sha, moxibustion heat therapy, electro acupuncture or qi gong rehabilitation. Your treatment may also include dietary and exercise planning that will complement your acupuncture. Treatments will range from 60-90 minutes. To get the most out of your treatment, please take time to relax and reflect both during and after. Following treatment, it is best to keep work or exercise to a minimum for several hours. Our goal is to provide you with the knowledge and tools to support your healing. We encourage patient participation with any questions and feedback.

## Herbal Medicine

Treatments at the clinic include herbal medicine, acupuncture nutrition and many other techniques. Chinese herbal medicine is tailored to the needs of each patient and used to treat both acute and chronic conditions. Primary options for herbal treatments are the use of teas, tinctured liquid extracts, teapills, and essential oils. Your practitioner may recommend herbal medicine, which the patient may choose to purchase for their treatment.

### ACKNOWLEDGEMENT OF RECEIPT OF CLINIC POLICIES

I have read, understood, and agree to the office policies for healthcare services at Alchemy

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Print

Signature

Date

We greatly appreciate your support and involvement in Alchemy. We look forward to providing you with an excellent healthcare experience. Suggestions, questions and concerns may be directed to your acupuncturist or the receptionist

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## INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists of Alchemy, LLC. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. I understand that I may refuse any of the following treatments at any time:

**Acupuncture:** I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

**Moxibustion:** Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin, intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa.

**Electro-Acupuncture:** I understand that I may receive electro-acupuncture, which involves the stimulation of acupuncture points with a mild electric current. This treatment is stimulating but not typically painful or shocking. I am aware that certain adverse side effects may result from this treatment., including, but not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

**Gua Sha/Cupping:** I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soup spoon. Cupping applies localized suction to the skin with glass cups, drawing the superficial muscle layer into the cup. Both are used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, soreness, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

**Acupressure/Massage:** I understand that I may receive acupressure or massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

**Chinese Herbs:** I understand that Chinese herbs may be recommended as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These may include, but are not limited to: changes in bowel movement, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. If I associate any concerns with the use of the herbal substances, I should stop use immediately and call my acupuncturist.

**Dietary & Exercise Advice:** In conjunction with my treatment, I may be given advice and suggestions concerning changes in diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Suggestions concerning physical activity and exercises may also be included in my treatment. I will communicate with my practitioner about any difficulties I may have with specific dietary or exercise recommendations.

***Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with acupuncture or herbal medicine.***

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature of Patient/Guardian/Personal Representative:

Date:

Printed Name of Patient/Guardian/Personal Representative:

Relationship to Patient:

Printed Name of Patient, if different from signer above:

Date:

**NOTICE OF PRIVACY POLICIES (HIPAA)**

The Clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

**We gather personal information and health information in several ways:**

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for the treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health or condition and related to health care services.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

**Marketing**

The Clinic will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

**Disclosure**

The Clinic may use or disclose your Protected Health Information when required by law.

**Patient Rights**

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information:

Contact: Alchemy  
Telephone: 828.575.9419  
Address: 62 Clayton Street, Asheville, NC  
28801

To send a written complaint to the U.S.  
Department of Health and Human Services:  
DHHS (Office of Civil Rights)  
200 Independence Ave S.W. Room 509 F  
HHH Building, Washington, DC 20201

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES**

I, \_\_\_\_\_, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Clinic.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. We will also discuss these questions on the first visit. Thank you for being here!

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by: \_\_\_\_\_  
Last, First

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Occupation (Current) \_\_\_\_\_ (Past) \_\_\_\_\_

Single / Married / Partnered / Separated / Divorced / Widowed

Emergency Contact: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Contact # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

How would you like to be reminded of your next appointment? phone call / email / no reminder necessary

Have you ever used Chinese medicine for your health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

## Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Western Medical Diagnosis (if you have one) \_\_\_\_\_

## With whom do you live?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Children who don't live with you

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What do you hope for and what are your expectations from this session today?

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On a long term basis?

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If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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Please list three things you would like to change about your health and well-being.

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Please list approximate dates and briefly describe any accidents, hospitalizations, surgeries, or major illnesses you have had.

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Please indicate areas of concern (pain, tension, numbness, tingling, swelling, etc.):

How long have you had this pain? \_\_\_\_\_

Describe the onset of your pain: \_\_\_\_\_

On a scale of 1-10 (10 worst), how strong is your pain? \_\_\_\_\_

What does your pain feel like?

- Dull  Sharp  Stabbing  Sore  Achy  Cramping
- Electrical  Burning  Constant  Comes and goes
- Fixed  Moves around  Other:

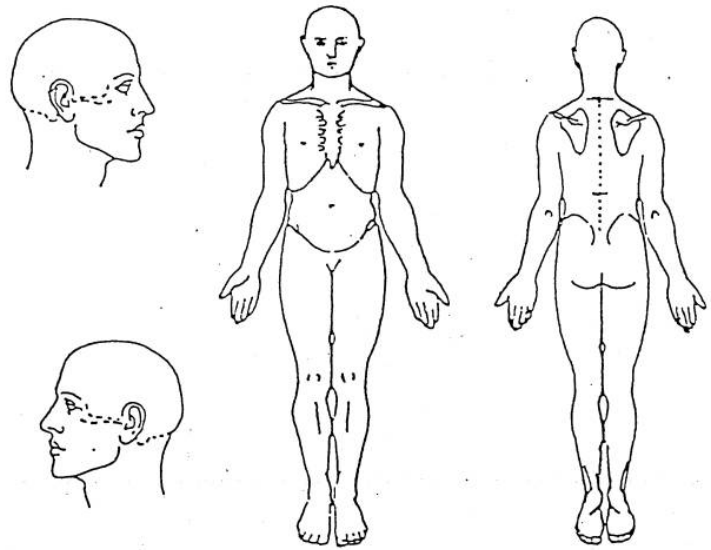
Does the pain radiate? Yes / No  
If yes, where? \_\_\_\_\_

What helps the pain? \_\_\_\_\_

- Ice  Heat  Rest  Movement  Pressure  Moisture  Massage  Nothing  Other:

What aggravates the pain? \_\_\_\_\_

- Ice  Heat  Rest  Movement  Pressure  Moisture  Massage  Nothing  Other:



What other treatments have you tried for this pain? \_\_\_\_\_

### Medications, Herbs, & Supplements

Please list all medications (prescription and over-the-counter) and supplements that you are taking or have taken in the past for longer than 3 months. Please also note the reason for which each is taken.

Dosage	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Diet and Lifestyle

Please list when and what you ate yesterday:

Breakfast \_\_\_\_\_ time: \_\_\_\_\_  
Lunch \_\_\_\_\_ time: \_\_\_\_\_  
Dinner \_\_\_\_\_ time: \_\_\_\_\_  
Snacks \_\_\_\_\_ time: \_\_\_\_\_

Alcohol \_\_\_\_\_ drinks per day/week    Tobacco \_\_\_\_\_ per day/week    Caffeine \_\_\_\_\_ per day/week

Are you recovering from any addictions? Please be specific. \_\_\_\_\_ If yes, how long have you been clean? \_\_\_\_

Exercise (type(s)) \_\_\_\_\_ # times per week

TV/Video/Computer \_\_\_\_\_ hours per day    Do you use recreational drugs? If yes, what type? \_\_\_\_\_

How many hours per night do you sleep on average? \_\_\_\_\_ Do you wake rested? \_\_\_\_\_

How would you describe the quality of your sleep? \_\_\_\_\_

What are the most important things to you \_\_\_\_\_

What are the major stressors in your life? \_\_\_\_\_

Have you experienced any major traumas? Y / N Explain: \_\_\_\_\_

What excites you in your life? \_\_\_\_\_

Do you enjoy work? Y / N Why/Why not? \_\_\_\_\_

What do you do to relax/relieve stress? \_\_\_\_\_

What hobbies or interests do you have? \_\_\_\_\_

Spiritual beliefs/religious affiliations, past, and present? \_\_\_\_\_

What are your sources of comfort, nurturing, and connection \_\_\_\_\_

If you could change one thing in your life, what would it be? \_\_\_\_\_

Favorite time of year and why? \_\_\_\_\_

## Medical History

Please circle any symptoms or conditions you are experiencing either currently or have experienced in the past. Please indicate when each symptom or condition first appeared and for how long it lasted, if known.

### Eyes

\_\_\_\_\_ Blurred vision  
\_\_\_\_\_ Dryness  
\_\_\_\_\_ Redness, itchiness, or pain  
\_\_\_\_\_ Excessive tearing  
\_\_\_\_\_ Poor night vision  
\_\_\_\_\_ Spots or floaters  
\_\_\_\_\_ Double vision  
\_\_\_\_\_ Glaucoma  
\_\_\_\_\_ Cataracts  
\_\_\_\_\_ Other (describe)

### Ears

\_\_\_\_\_ Hearing loss  
\_\_\_\_\_ Ringing  
\_\_\_\_\_ Earache  
\_\_\_\_\_ Discharge or fullness  
\_\_\_\_\_ Other (describe)

### Head and Neck

\_\_\_\_\_ Dizziness or fainting  
\_\_\_\_\_ Vertigo  
\_\_\_\_\_ Headache/migraines  
\_\_\_\_\_ Swellings  
\_\_\_\_\_ Tension/stiffness  
\_\_\_\_\_ Other (describe)

### Nose, Throat, and Mouth

\_\_\_\_\_ Nasal congestion  
\_\_\_\_\_ Phlegm or discharge  
\_\_\_\_\_ Allergies  
\_\_\_\_\_ Sinus infection  
\_\_\_\_\_ Postnasal drip  
\_\_\_\_\_ Frequent cold/flu  
\_\_\_\_\_ Nosebleed  
\_\_\_\_\_ Dry nose  
\_\_\_\_\_ Dry mouth  
\_\_\_\_\_ Sores or swellings  
\_\_\_\_\_ Dental/gum problems  
\_\_\_\_\_ Jaw tension/tightness  
\_\_\_\_\_ Teeth grinding  
\_\_\_\_\_ Facial pain  
\_\_\_\_\_ Dry or sore throat

\_\_\_\_\_ Strong thirst

\_\_\_\_\_ Difficulty swallowing

\_\_\_\_\_ Loss of voice

\_\_\_\_\_ Other (describe)

### Hot and Cold

\_\_\_\_\_ Feel hot or cold

\_\_\_\_\_ Cold hands or feet

\_\_\_\_\_ Desire hot or cold

### Skin

\_\_\_\_\_ Rashes or hives

\_\_\_\_\_ Acne

\_\_\_\_\_ Eczema/psoriasis

\_\_\_\_\_ Itching or redness

\_\_\_\_\_ Dry or oily skin

\_\_\_\_\_ Abnormal sweating

\_\_\_\_\_ Easy bruising

\_\_\_\_\_ Lumps or swellings

\_\_\_\_\_ Varicose veins

\_\_\_\_\_ Other (describe)

### Chest

\_\_\_\_\_ Difficulty breathing

\_\_\_\_\_ Frequent sighing

\_\_\_\_\_ Chronic cough

\_\_\_\_\_ Cough up mucous/blood

\_\_\_\_\_ Tight or stuffy chest

\_\_\_\_\_ Pneumonia or bronchitis

\_\_\_\_\_ Palpitations

\_\_\_\_\_ Rapid/irregular heartbeat

\_\_\_\_\_ Chest pain

\_\_\_\_\_ High or low blood pressure

\_\_\_\_\_ Heart murmur

\_\_\_\_\_ Heart disease

\_\_\_\_\_ Other (describe)

### Body and Limbs

\_\_\_\_\_ Heaviness or stiffness

\_\_\_\_\_ Limited range of motion

\_\_\_\_\_ Numbness or tingling

\_\_\_\_\_ Paralysis

\_\_\_\_\_ Seizures or tremors



Sleep

- \_\_\_\_\_ Difficulty staying asleep
- \_\_\_\_\_ Disturbing dreams
- \_\_\_\_\_ Waking due to pain
- \_\_\_\_\_ Night sweats
- \_\_\_\_\_ Fatigue or energy drops
- \_\_\_\_\_ Restlessness or hyper
- \_\_\_\_\_ Waking to urinate
- \_\_\_\_\_ Other (describe)

Urinary

- \_\_\_\_\_ Urinary/kidney infection
- \_\_\_\_\_ Burning/hot urination
- \_\_\_\_\_ Cloudy urine
- \_\_\_\_\_ Strong odor
- \_\_\_\_\_ Blood in urine
- \_\_\_\_\_ Disrupted flow
- \_\_\_\_\_ Incomplete emptying
- \_\_\_\_\_ Frequent or urgent
- \_\_\_\_\_ Difficult urination
- \_\_\_\_\_ Incontinence
- \_\_\_\_\_ Other (describe)

Gastrointestinal

- \_\_\_\_\_ Low or excessive appetite
- \_\_\_\_\_ Bloating/flatulence
- \_\_\_\_\_ Abdominal heaviness
- \_\_\_\_\_ Nausea or vomiting
- \_\_\_\_\_ Belching or hiccupping
- \_\_\_\_\_ Heartburn or reflux
- \_\_\_\_\_ Sluggish digestion
- \_\_\_\_\_ Abdominal pain
- \_\_\_\_\_ Change in weight
- \_\_\_\_\_ Altered taste
- \_\_\_\_\_ Bad taste in mouth
- \_\_\_\_\_ Bad breath
- \_\_\_\_\_ Diarrhea/loose stools
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Difficult bowel movements
- \_\_\_\_\_ Laxative dependence
- \_\_\_\_\_ Blood in stool
- \_\_\_\_\_ Other (describe)

Reproductive (male and female)

- \_\_\_\_\_ Low or high libido
- \_\_\_\_\_ Pain or itching of genitals
- \_\_\_\_\_ Genital discharge or lesions
- \_\_\_\_\_ Other (describe)

Male

- \_\_\_\_\_ Impotence
- \_\_\_\_\_ Premature ejaculation
- \_\_\_\_\_ Nocturnal emissions
- \_\_\_\_\_ Lumps in testicles
- \_\_\_\_\_ Hernia
- \_\_\_\_\_ Enlarged prostate
- \_\_\_\_\_ Other (describe)

Female

- \_\_\_\_\_ Pregnant (current or possible)
- \_\_\_\_\_ # of pregnancies
- \_\_\_\_\_ # of live births
- \_\_\_\_\_ # of miscarriages
- \_\_\_\_\_ # of abortions
- \_\_\_\_\_ Age at first period
- \_\_\_\_\_ Menopause
- \_\_\_\_\_ Painful periods
- \_\_\_\_\_ Irregular periods
- \_\_\_\_\_ Heavy or light blood flow
- \_\_\_\_\_ Menstrual blood clots
- \_\_\_\_\_ Vaginal discharge (describe)
- \_\_\_\_\_ Breast tenderness
- \_\_\_\_\_ Breast lumps
- \_\_\_\_\_ Painful intercourse
- \_\_\_\_\_ Abnormal pap smear
- \_\_\_\_\_ Vaginal infections
- \_\_\_\_\_ Uterine fibroids
- \_\_\_\_\_ Endometriosis
- \_\_\_\_\_ Other (describe)

Mental/Emotional

- \_\_\_\_\_ Poor memory
- \_\_\_\_\_ Foggy headedness
- \_\_\_\_\_ Difficulty focusing
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Mood swings
- \_\_\_\_\_ Irritable/frustration/anger
- \_\_\_\_\_ Difficulty relaxing
- \_\_\_\_\_ Loneliness
- \_\_\_\_\_ Sensitivity
- \_\_\_\_\_ Shyness
- \_\_\_\_\_ Frequent crying
- \_\_\_\_\_ Worry
- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Compulsive behaviors
- \_\_\_\_\_ Suicidal thoughts
- \_\_\_\_\_ Eating disorder
- \_\_\_\_\_ Other (describe)

*FAMILY HEALTH HISTORY*

*Age*

*Important Diseases/Illnesses*

*Deceased Y/N*

Father \_\_\_\_\_

Mother \_\_\_\_\_

Children \_\_\_\_\_

Siblings \_\_\_\_\_

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Do you have any info about your birth? \_\_\_\_\_

Your mother's pregnancy? \_\_\_\_\_

Is there anything else you would like me to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for taking the time to complete this form. We look forward to working with you!