Welcome

Welcome to Stonington Natural Health Center. We are so glad you made it here.

Here at Stonington Natural Health Center, we provide *Custom Holistic Healthcare for the Whole Family in a Tranquil Waterfront Setting*. We offer Acupuncture & Chinese Medicine Treatments, the SNHC Customized Massage which is a combination of Swedish and Deep Tissue Massage to your desired level of pressure, Chakra Balancing, Energy Work, Nutrition from a Chinese Medicine perspective, and Herbal Consultations.

Our treatments help you to feel better, breathe more deeply, rejuvenate, and let go of your worries. Your body, mind, and spirit will thank you. This is your time to relax and heal, initiate and speed up the healing process, to help you live a longer, healthier, and happier life.

For injuries, pain, and health problems, you will receive the most benefit when you come in before the effects of the previous treatment disappear. Your practitioner will give you a treatment protocol recommendation. It is often recommended to group your treatments close together, which can be daily, twice a week or three times per week for a series of weeks. During times of stress, anxiety, or depression, it is helpful to come in for Acupuncture and Massage treatments. Slow and steady wins the race, as we shift the energy over. Once you are feeling better, we slowly space the treatments apart as the positive effects hold. Our goal is to shift the pattern of your energy, with long lasting effects, to get you better and create long-term good health. Once you are feeling great, regular tune-ups are important.

If you have any questions, concerns, or feedback, please talk with us, call us at 860.536.3880, or email us at info@snhc.com.

We appreciate this opportunity to contribute to you on your path towards optimal health and happiness.

ALL OF US AT STONINGTON NATURAL HEALTH CENTER

The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.

THOMAS EDISON

All life is an experiment.
The more experiments you make the better.

RALPH WALDO EMERSON

Enjoy the journey.

DEEPAK CHOPRA

ACUPUNCTURE, CHINESE MEDICINE, AND MASSAGE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, phone consultations, telehealth, and telemedicine. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising, known as sha, is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Megan Marco, LAc, DAc

PATIENT NAME: _____

PATIENT SIGNATURE X _____Date_____
(Or Patient Representative -- Indicate relationship if signing for patient)

FINANCIAL POLICIES FOR TREATMENT AND CARE

Your treatment time is reserved for you. To change, reschedule, or cancel an appointment, please call **at least two business days, 48 business hours, before your appointment time.** This gives us time to fill your appointment. If no one answers, please leave a message. For Monday appointments, please call by Thursday. For Tuesday appointments, please call by Friday.

"Minimum 48 Hours Cancellation Policy": Because we have made preparations and staffing for your appointment, we ask for at least two business days, 48 business hours notice to reschedule or cancel your appointment. With LESS THAN 24 BUSINESS HOURS, your credit card will be charged for your appointment or treatment packages will have one treatment deducted.

We appreciate your cooperation as this is **vitally important for our mutual success.** We make reminder texts or calls as a courtesy; you are ultimately responsible, however, for coming to your appointments. It is also our courtesy that if you or we are able to fill your appointment, you will not be charged, and we encourage you to substitute a friend or family member.

If you are running late, please call or text to let us know. We would rather you come and have a shorter treatment than miss your appointment. Ideally, please arrive a few minutes before your appointment to use the restroom, make purchases, set up your next appointments, and unwind.

Payment: In an attempt to keep health care costs low, preferred methods of payment are cash or check. Payment is required at the time of your service. We also accept credit cards.

Treatment Plans: Dr. Marco and/or your Licensed Massage Therapist will develop your treatment plan to help you accomplish your goals and feel your best. Follow your Treatment Plan to achieve optimal results. If it has been over a year or if you would like more time to discuss your health history, it is recommended to come in for a ReActivation appointment to go over your health information.

Treatment Packages and Massage Memberships: (1) make check-out easier, (2) lower the price, and (3) help you complete your treatment goals. Treatment Packages and Massage Memberships are not refundable, can only be used for the services purchased, and expire one year after purchase.

Return Policy: Treatment Packages and Memberships, Gift Certificates, and products are non-refundable. We guarantee quality and cannot sell returned herbs, supplements, or products.

Your credit card number is encrypted in MindBodyOnline. Patients enjoy this convenience to pay for special orders, Gift Certificates, treatments, packages, herbs, missed or canceled appointments, and for guarantying personal checks. If you would like, you can type this information into the MindBody website before your appointment or hand us your credit card for us to input and not write it here. Upon receiving this form, we enter this information into an encrypted system and delete it from this form.

The following information is required to receive treatments printed here or encrypted in MindBody:

Visa/MasterCard/American Express/Discover (Please circle one)

_____ _____/_____ _____

Credit Card Number Expiration Month year 3 digit code on back

_____

Billing Address

I have read, understand, and agree to the above information:

_____ _____ _____

Signature **Printed Name** **Date**

All information within this document is considered privileged patient / provider communication by Dr. Marco, the Practitioners, and Staff of Stonington Natural Health Center, and is held as CONFIDENTIAL INFORMATION in accordance with federal HIPAA regulations.

MEGAN MARCO, DAc, LAc
STONINGTON NATURAL HEALTH CENTER
107 WILCOX ROAD, SUITE 103, STONINGTON, CT 06378

PATIENT NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (Health Insurance Portability and Accountability Act – "HIPAA")

Patient Rights and Uses and Disclosures of Health Information:

PERSONAL HEALTH INFORMATION DISCLOSURE:

In the course of your care as a patient at Stonington Natural Health Center, we may use or disclose personal or health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

2. Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

3. Your name and address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, Stonington Natural Health Center newsletters, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you, or the reimbursement avenues associated with your care.

PERMITTED OR REQUIRED TO USE OR DISCLOSE HEALTH INFORMATION WITHOUT YOUR CONSENT OR AUTHORIZATION:

UNDER federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.

2. If we provide health care services to you in an emergency.

3. If there are substantial barriers to communicating with you, but in our professional judgment believe that you intend for us to provide care.

4. If we are ordered by the courts or another appropriate agency.

ANY USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, OTHER THAN OUTLINED ABOVE WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION

We normally provide information about your health in person at the time you receive services or care from us. We also may mail information to you regarding your health care, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing

PRACTITIONER LEGAL DUTIES

We are required by state and federal law to maintain the privacy of your patient file and the protected health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

COMPLAINTS & QUESTIONS

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your questions to: Megan Marco, DAc, LAc, (860) 536-3880.

This notice is effective immediately. This notice, and any alteration or amendments made hereto, will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

Patient Name (printed) Signature

_____

DATE

Patient Health History Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate the best number to reach you and best number to leave messages:

Home Phone#: _____ Cell Phone#: _____

Preferred Reminders (circle) Text or Call Occupation: _____

Spouse or Significant Other: _____

Email (to receive newsletters & coupons): _____
Hobbies and Interests: _____

Emergency Contact: _____Phone#:_____ Relationship:_____

Primary Care Physician:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____
Specialist:_____Type:_____ Town, State:_____

What are your 4 primary health concerns / health goals in order of importance?
1. _____
2. _____
3. _____
4. _____

How long has each concern condition persisted?
1. _____
2. _____
3. _____
4. _____

What do you think is the cause?
1. _____
2. _____
3. _____
4. _____

How does it affect you?
1. _____
2. _____
3. _____
4. _____

What treatment have you received for this condition?
_____
Diagnosis given?
_____
What were the results of the treatment?
_____

Patient Health History

What are your hopes and expectations from treatments at Stonington Natural Health Center?

_____

_____

Blood Type_____ Height _____ Weight _____ Any recent (circle): weight loss or gain?

Do you have any reason to believe you are pregnant? Yes No

Do you have any chronic infectious diseases? Yes No

If yes, please explain: _____

Are you currently suffering from any chronic illnesses? Yes No

If yes, please explain: _____

Please list any hypersensitivities or allergies that you may have and your reaction: Allergies

to Foods: _____

Allergies to Environmental: _____

_____

Allergies to Medications: _____

Please list any medications, both prescription and over the counter, you are currently taking -- include dosages, what you are taking it for, and how long have you been taking it:

Please list any supplements or vitamins you are currently taking -- include dosages and brand names:

Please list any hospitalizations or major surgeries that you have had and the approximate dates they occurred:

Please list any significant traumas (i.e. car accidents, bone fractures, sprains, falls, etc.):

Have you experienced any significant emotional trauma? If so, what and when?

Patient Health History

Please circle any symptoms that you currently have and underline any symptoms you have had within the past year.

General:
Low energy or fatigue
Allergies
Insomnia
Spontaneous sweating
Night sweats
Aversion to heat
Aversion to cold
Chronic infections

Gastrointestinal:
Nausea/vomiting
Low appetite
Abdominal pain
Gas
Burping
Bloating
Indigestion
Acid reflux/heartburn
Heavy feeling after eating
Ulcers
Loose stools
Constipation
Blood in the stools
Black/tarry stools
Undigested food in stools
Hemorrhoids
Rectal pain/itching

Cardiovascular:
Heart disease
High blood pressure
Chest pain
Heart Attack
Heart palpitations/fluttering
Heart murmurs
Varicose veins
Swelling of legs/ankles
Stroke
Aneurism

Head and Neck:
Headaches
Red/swollen eyes
Dry/itchy eyes
Watery eyes
Mucus or discharge from eyes
Eye pain
Blurry vision
Night blindness
Glasses or contacts
Glaucoma or cataracts
Dizziness/vertigo
Recurrent phlegm
Sinus problems
Nosebleeds
Frequent sore throats
TMJ (jaw problems)
Earaches
Difficulty hearing
Hearing loss
Noises or Ringing in ears
Ear discharge
Excess earwax
Fever blisters
Sores on tongue or in mouth
Loss of smell
Change of taste
Dry throat/mouth
Excessive thirst
Bad Breath

Neurologic:
Paralysis
Numbness/tingling
Seizures
Loss of balance
Epilepsy
Tics
Lyme Disease
Bell's Palsy

Respiratory:
Pain in lungs
Asthma
Wheezing
Pneumonia
Chronic bronchitis
Persistent cough
Shortness of breath
Difficulty breathing
Frequent colds
Hay fever
Spitting or coughing up blood

Musculoskeletal: *(pain, numbness or weakness)*
Neck/shoulder Arms
Legs Feet
Joints Knees/elbows
Hands Whole body
Lower back
Mid/upper back
Muscle spasms/cramps (where?) _____
Broken bones (where?) _____
Sprains/strains (where?) _____
Tendonitis (where?) _____

Emotions:
Mood swings Stress
Nervousness Sad
Mental tension Angry
Irritability Frustrated
Anxiety Worried
Depression Afraid

Patient Health History

Please circle any symptoms that you currently have and underline any symptoms you have had within the past year.

Skin:
Acne or pimples
Hives
Stretch marks
Skin ulcers or sores
Cracks in corners of mouth
Dryness, roughness or scaling of skin
Dry or chapped lips
Hair loss or thinning
Dry course hair
Bruise easily
Cold sores or herpes
Nails weak, ridged or split easily
Brown spots or bronzing
Warts, moles, or skin tags
Sunburn easily
Cuts heal slowly or scar badly
Flush easily
Athlete's foot
Jock itch
Any other itchy areas

_____

Female Reproductive:
Breast lumps/tenderness
Nipple discharge
Irregular periods
Painful periods
PMS
Short cycle (less than 24 days)
Long cycle (more than 35 days)
Heavy periods
Bleeding between periods
Difficulty conceiving
Miscarriages
Endometriosis
Fibroids
Abnormal PAP smear:_____
Vaginal discharge
Vaginal itching
Vaginal pain
Pelvic Pain
Pain with intercourse
Hot flashes
Diminished or excessive sex drive
Difficulty reaching orgasm
Perimenopause
Menopause, age at last menses:_____

Genitourinary Tract:
Painful urination
Urinary urgency
Urinary frequency
Difficult urination
Incontinence
Kidney stones
Urinary tract infections
Frequent urination at night
Sexually Transmitted Disease
Blood in the urine
Dark urine

Male Reproductive:
Genital pain
Low sex drive
Difficulty conceiving
Low sperm count
Sexual difficulty / impotence
Enlarged prostate
Testicular pain or swelling
Genital discharge
Rashes or sores

Patient Health History

Family History:

	Mother	Father	Brothers	Sisters	Spouse/ Significant Other	Child	Child	Child	Child
Age (if living)									
Names									
Health (G=good P=poor)									
Age at death (if deceased)									
Check any of the following conditions that apply to your family members									
Cancer—where?									
Diabetes									
Heart Disease									
Heart Attack									
High Blood Pressure									
Stroke									
Mental Illness									
Other									

Nutrition: Please list what you usually eat at each meal.

Breakfast	
Lunch	
Dinner	
Snacks	

Patient Health History

Do you smoke cigarettes? Yes _____ No _____

If yes, how much? _____

Do you consume caffeine? Yes _____ No _____

If yes, what and how much? _____

Do you drink soda? Yes _____ No _____

If yes, what and how much? _____

Do you consume artificial sweeteners (aspartame, nutrasweet, splenda, saccharin)?
Yes _____ No _____

If yes, how much? _____

Do you drink alcohol? Yes _____ No _____

If yes, how much and how often? _____

What do you do for exercise and how often?

_____

Is there anything else about you or your condition that you would like me to know or address?

_____

_____

How did you hear about Stonington Natural Health Center?

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

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

Initial Below

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person- to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: _____

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature	_____	Parent/ Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name	_____
Date	_____	Date	_____	Date	_____