

**The Chi Farm Acupuncture Clinic, Publications and Seminars**

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Hello and welcome to the Chi Farm.

I want to personally thank you for including me in your healthcare team and I look forward to helping you achieve the state of wellness you deserve. You are a unique individual and deserve to have your acupuncture treatments tailored to your individual needs.

Acupuncture treatments at The Chi Farm can help you attain relief from physical and emotional pain, reproductive, digestive, and respiratory disorders, learning disabilities or addictions and mental health issues while at the same time offering stress relief and a general sense of well-being. Treatment may also serve as an adjunct to physical, occupational and behavioral health therapy sessions.

In addition to acupuncture treatment, I also offer counseling in whole-foods nutritional supplementation and herbs. I have found over the years that the root cause of many physical, emotional and spiritual maladies can be linked to nutritional deficiencies and/or the need for herbal remedies. As part of your overall wellness program, I may recommend supplements and herbs to speed along your healing.

Before coming in for your first appointment I ask that you fill out the following forms and bring them with you. That way we can look at not just the big-ticket issue for which you scheduled an appointment, but also all the other symptoms that make up the whole picture of your wellness level.

Plan on being here about 1 1/2 – 2 hours for your first appointment and about an hour for follow up appointments. Generally I will want to see you once per week for the first 3 – 6 weeks. Continued wellness care is recommended after the initial phase.

Please feel free to call with any questions and once again thank you for scheduling an appointment at the CHI Farm.

Sincerely,



David R Wurzel, PE, MAc, LAc  
Proprietor

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**The Chi Farm Acupuncture Clinic**

David R Wurzel, PE, MAc, LAc

**Patient Information**

Name \_\_\_\_\_

Nickname \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ email: \_\_\_\_\_

Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ By Whom? \_\_\_\_\_

Date of Last Glaucoma Screening \_\_\_\_\_ By Whom? \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_

Please List All Medications You Are Taking:

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

\_\_\_\_\_ Amount \_\_\_\_\_ Prescribed? \_\_\_\_\_

For Women:

Date of Last PAP Smear \_\_\_\_\_ Do You Perform Monthly Breast Exams? \_\_\_\_\_

For Men:

If over 40, Have You Had Annual Prostate Exam? \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

**1. Health History:** Have you ever been diagnosed with any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Tension Headaches          | <input type="checkbox"/> Coronary Disorder or Heart Attack    | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Migraine Headaches         | <input type="checkbox"/> Lung or Respiratory Disorder         | <input type="checkbox"/> Low Blood Pressure         |
| <input type="checkbox"/> TMJ Disorder               | <input type="checkbox"/> Liver Disease or Hepatitis           | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Pain or Sciatica      | <input type="checkbox"/> Urinary or Bladder Infection         | <input type="checkbox"/> Seizures or Epilepsy       |
| <input type="checkbox"/> Chest Pain or Angina Pain  | <input type="checkbox"/> Kidney Disorder or Kidney Stones     | <input type="checkbox"/> Concussion                 |
| <input type="checkbox"/> Abdominal Pain             | <input type="checkbox"/> Gall Bladder Disorder of Gall Stones | <input type="checkbox"/> Cancer or Tumors           |
| <input type="checkbox"/> Pelvic or Genital Pain     | <input type="checkbox"/> Spleen or Lymphatic Disorder         | <input type="checkbox"/> HIV+ or AIDS               |
| <input type="checkbox"/> Rheumatoid Arthritis       | <input type="checkbox"/> Gastric or Peptic Ulcer              | <input type="checkbox"/> Multiple Sclerosis         |
| <input type="checkbox"/> Osteoarthritis             | <input type="checkbox"/> Irritable Bowel Syndrome or Colitis  | <input type="checkbox"/> Polio or Mononucleosis     |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Diabetes Mellitus                    | <input type="checkbox"/> Allergies or Hayfever      |
| <input type="checkbox"/> Chronic Fatigue Syndrome   | <input type="checkbox"/> Hypoglycemia                         | <input type="checkbox"/> Asthma or Bronchitis       |
| <input type="checkbox"/> Bone Fracture/Joint Sprain | <input type="checkbox"/> Thyroid Disorder                     | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Muscle Spasm or Tremor     | <input type="checkbox"/> Dysmenorrhea (Painful Menstruation)  | <input type="checkbox"/> Pneumonia                  |
| <input type="checkbox"/> Carpal Tunnel Syndrome     | <input type="checkbox"/> Pre-Menstrual Syndrome               | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Tennis Elbow               | <input type="checkbox"/> Prostate or Vaginal Disorder         | <input type="checkbox"/> Obsessive-Compulsive       |
| <input type="checkbox"/> Frozen Shoulder            | <input type="checkbox"/> Skin Disorder, Eczema, Psoriasis     | <input type="checkbox"/> Panic Attacks or Phobias   |
| <input type="checkbox"/> Peripheral Neuropathy      | <input type="checkbox"/> Raynaud's Disease                    | <input type="checkbox"/> Major Depression           |
| <input type="checkbox"/> Shingles (Herpes Zoster)   | <input type="checkbox"/> Deafness or Tinnitus                 | <input type="checkbox"/> Schizophrenia              |

**2. Accidents:** Have you ever been injured in any of the following types of accidents?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Work Related Accident | <input type="checkbox"/> Accident at Home |
| <input type="checkbox"/> Athletic Injury     | <input type="checkbox"/> Surgical Complication | <input type="checkbox"/> Other Accident   |

**3. Current Conditions:** In the past year, have you noticeably experienced any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain in Legs or Feet       | <input type="checkbox"/> Large Weight Gain or Weight Loss | <input type="checkbox"/> Sinus Congestion      |
| <input type="checkbox"/> Pain in Arms, Wrist, Hands | <input type="checkbox"/> Overeating or Binge Eating       | <input type="checkbox"/> Colds, Flu or Chills  |
| <input type="checkbox"/> Cold Hands or Cold Feet    | <input type="checkbox"/> Undereating or Poor Appetite     | <input type="checkbox"/> Sore Throats          |
| <input type="checkbox"/> Swollen Ankles or Feet     | <input type="checkbox"/> Craving for Sweets or Chocolate  | <input type="checkbox"/> Nausea or Vomiting    |
| <input type="checkbox"/> Stiff, Aching Joints       | <input type="checkbox"/> Craving for Drugs or Alcohol     | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Neck or Shoulder Tension   | <input type="checkbox"/> Dissatisfaction with Job         | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Grinding Your Teeth        | <input type="checkbox"/> Bored or Uninterested in Things  | <input type="checkbox"/> Blurred Vision        |
| <input type="checkbox"/> Rapid Heart Beat           | <input type="checkbox"/> Loneliness or Lack of Affection  | <input type="checkbox"/> Lethargy, Fatigue     |
| <input type="checkbox"/> Excessive Sweating         | <input type="checkbox"/> Sex Life Not Satisfying          | <input type="checkbox"/> Difficulty Sleeping   |
| <input type="checkbox"/> Hyperventilation           | <input type="checkbox"/> Thoughts of Killing Yourself     | <input type="checkbox"/> Disturbing Dreams     |
| <input type="checkbox"/> Dizziness or Fainting      | <input type="checkbox"/> Worried About Finances           | <input type="checkbox"/> Relationship Problems |

**4. Substances or Medications:** In the past several months, did you regularly take any of these?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cigarettes or Cigars       | <input type="checkbox"/> Aspirin or Tylenol                  | <input type="checkbox"/> Sleeping Pills        |
| <input type="checkbox"/> Several Cups of Coffee/Day | <input type="checkbox"/> Prescribed Pain Reliever Medication | <input type="checkbox"/> Anti-Anxiety Pills    |
| <input type="checkbox"/> Glass of Beer or Wine      | <input type="checkbox"/> Recreational Drugs/Marijuana        | <input type="checkbox"/> Anti-Depressant Pills |
| <input type="checkbox"/> Liquor or Mixed Drinks     | <input type="checkbox"/> Several Cans of Soda/Day            | <input type="checkbox"/> Blood Pressure Pills  |

**5. Other conditions not listed here with which you have experienced symptoms:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Nutritional Supplement Needs Analysis: Symptom Survey**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_

**INSTRUCTIONS:** Fill in the circles if you experience a particular symptom. Leave blank otherwise.

- Fill in the circle marked 1 for MILD symptoms (occur once or twice a year). ●○○
- Fill in the circle marked 2 for MODERATE symptoms (occur several times a month). ○●○
- Fill in the circle marked 3 for SEVERE symptoms (you are aware of it almost constantly). ○○●

Remember to leave the circles blank for symptoms that do not apply to you. ○○○

**GROUP ONE**

- |                               |  |                               |
|-------------------------------|--|-------------------------------|
| 1 ○○○ Acid foods upset        | 8 ○○○ Gag easily                       | 15 ○○○ Appetite reduced       |
| 2 ○○○ Get chilled often       | 9 ○○○ Unable to relax; startles easily | 16 ○○○ Cold sweats often      |
| 3 ○○○ "Lump" in throat        | 10 ○○○ Extremities cold, clammy        | 17 ○○○ Fever easily raised    |
| 4 ○○○ Dry mouth-eyes-nose     | 11 ○○○ Strong light irritates          | 18 ○○○ Neuralgia-like pains   |
| 5 ○○○ Pulse speeds after meal | 12 ○○○ Urine amount reduced            | 19 ○○○ Staring, blinks little |
| 6 ○○○ Keyed up - fail to calm | 13 ○○○ Heart pounds after retiring     | 20 ○○○ Sour stomach often     |
| 7 ○○○ Cut heals slowly        | 14 ○○○ "Nervous" stomach               |                               |

**GROUP TWO**

- |   |   |   |
|---|---|---|
| 21 ○○○ Joint stiffness on arising                     | 29 ○○○ Digestion rapid                    | 37 ○○○ "Slow starter"                       |
| 22 ○○○ Muscle-leg-toe cramps at night                 | 30 ○○○ Vomiting frequent                  | 38 ○○○ Get "chilled" infrequently           |
| 23 ○○○ "Butterfly" stomach, cramps                    | 31 ○○○ Hoarseness frequent                | 39 ○○○ Perspire easily                      |
| 24 ○○○ Eyes or nose watery                            | 32 ○○○ Breathing irregular                | 40 ○○○ Circulation poor, sensitive to cold  |
| 25 ○○○ Eyes blink often                               | 33 ○○○ Pulse slow; feels "irregular"      | 41 ○○○ Subject to colds, asthma, bronchitis |
| 26 ○○○ Eyelids swollen, puffy                         | 34 ○○○ Gagging reflex slow                |   |
| 27 ○○○ Indigestion soon after meals                   | 35 ○○○ Difficulty swallowing              |   |
| 28 ○○○ Always seems hungry; feels "lightheaded" often | 36 ○○○ Constipation, diarrhea alternating |   |

**GROUP THREE**

- |                                       |   |  |
|---------------------------------------|---|--|
| 42 ○○○ Eat when nervous               | 49 ○○○ Heart palpitates if meals missed or delayed              | 53 ○○○ Crave candy or coffee in afternoons         |
| 43 ○○○ Excessive appetite             | 50 ○○○ Afternoon headaches                                      | 54 ○○○ Moods of depression - "blues" or melancholy |
| 44 ○○○ Hungry between meals           | 51 ○○○ Overeating sweets upsets                                 | 55 ○○○ Abnormal craving for sweets or snacks       |
| 45 ○○○ Irritable before meals         | 52 ○○○ Awaken after few hours sleep - hard to get back to sleep |  |
| 46 ○○○ Get "shaky" if hungry          |   |  |
| 47 ○○○ Fatigue, eating relieves       |   |  |
| 48 ○○○ "Lightheaded" if meals delayed |   |  |

**GROUP FOUR**

- |  |   |   |
|--|---|---|
| 56 ○○○ Hands and feet go to sleep easily, numbness | 63 ○○○ Get "drowsy" often   | 68 ○○○ Bruise easily, "black and blue" spots                                      |
| 57 ○○○ Sigh frequently, "air hunger"               | 64 ○○○ Swollen ankles, worse at night                                   | 69 ○○○ Tendency to anemia   |
| 58 ○○○ Aware of "breathing heavily"                | 65 ○○○ Muscle cramps, worse during exercise; get "charley horses"       | 70 ○○○ "Nose bleeds" frequent   |
| 59 ○○○ High altitude discomfort                    | 66 ○○○ Shortness of breath on exertion                                  | 71 ○○○ Noises in head, or "ringing in ears"                                       |
| 60 ○○○ Opens windows in closed rooms               | 67 ○○○ Dull pain in chest or radiating into left arm, worse on exertion | 72 ○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion |
| 61 ○○○ Susceptible to colds and fevers             |   |   |
| 62 ○○○ Afternoon "yawner"                          |   |   |

## Nutritional Supplement Needs Analysis: Symptom Survey – Page 2

### GROUP FIVE

- 1 2 3  
73 ○○○ Dizziness  
74 ○○○ Dry skin  
75 ○○○ Burning feet  
76 ○○○ Blurred vision  
77 ○○○ Itching skin and feet  
78 ○○○ Excessive falling hair  
79 ○○○ Frequent skin rashes  
80 ○○○ Bitter, metallic taste in mouth  
in mornings  
81 ○○○ Bowel movements painful or  
difficult  
82 ○○○ Worrier, feels insecure

- 1 2 3  
83 ○○○ Feeling queasy; headache  
over eyes  
84 ○○○ Greasy foods upset  
85 ○○○ Stools light colored  
86 ○○○ Skin peels on foot soles  
87 ○○○ Pain between shoulder blades  
88 ○○○ Use laxatives  
89 ○○○ Stools alternate from soft to  
watery  
90 ○○○ History of gallbladder attacks or  
gallstones

- 1 2 3  
91 ○○○ Sneezing attacks  
92 ○○○ Dreaming, nightmare type bad  
dreams  
93 ○○○ Bad breath (halitosis)  
94 ○○○ Milk products cause distress  
95 ○○○ Sensitive to hot weather  
96 ○○○ Burning or itching anus  
97 ○○○ Crave sweets

### GROUP SIX

- 1 2 3  
98 ○○○ Loss of taste for meat  
99 ○○○ Lower bowel gas several hours  
after eating  
100 ○○○ Burning stomach sensations,  
eating relieves

- 1 2 3  
101 ○○○ Coated tongue  
102 ○○○ Pass large amounts of  
foul-smelling gas  
103 ○○○ Indigestion 1/2 - 1 hour after  
eating; may be up to 3-4 hrs.

- 1 2 3  
104 ○○○ Mucous colitis or "irritable  
bowel"  
105 ○○○ Gas shortly after eating  
106 ○○○ Stomach "bloating" after  
eating

### GROUP SEVEN

- (A)  
1 2 3  
107 ○○○ Insomnia  
108 ○○○ Nervousness  
109 ○○○ Can't gain weight  
110 ○○○ Intolerance to heat  
111 ○○○ Highly emotional  
112 ○○○ Flush easily  
113 ○○○ Night sweats  
114 ○○○ Thin, moist skin  
115 ○○○ Inward trembling  
116 ○○○ Heart palpitates  
117 ○○○ Increased appetite without  
weight gain  
118 ○○○ Pulse fast at rest  
119 ○○○ Eyelids and face twitch  
120 ○○○ Irritable and restless  
121 ○○○ Can't work under pressure

- (C)  
1 2 3  
137 ○○○ Failing memory  
138 ○○○ Low blood pressure  
139 ○○○ Increased sex drive  
140 ○○○ Headaches, "splitting or  
rending" type  
141 ○○○ Decreased sugar tolerance

- (E)  
1 2 3  
150 ○○○ Dizziness  
151 ○○○ Headaches  
152 ○○○ Hot flashes  
153 ○○○ Increased blood pressure  
154 ○○○ Hair growth on face or body  
(female)  
155 ○○○ Sugar in urine  
(not diabetes)  
156 ○○○ Masculine tendencies  
(female)

- (B)  
1 2 3  
122 ○○○ Increase in weight  
123 ○○○ Decrease in appetite  
124 ○○○ Fatigue easily  
125 ○○○ Ringing in ears  
126 ○○○ Sleepy during day  
127 ○○○ Sensitive to cold  
128 ○○○ Dry or scaly skin  
129 ○○○ Constipation  
130 ○○○ Mental sluggishness  
131 ○○○ Hair coarse, falls out  
132 ○○○ Headaches upon arising, wear  
off during day  
133 ○○○ Slow pulse, below 65  
134 ○○○ Frequency of urination  
135 ○○○ Impaired hearing  
136 ○○○ Reduced initiative

- (D)  
1 2 3  
142 ○○○ Abnormal thirst  
143 ○○○ Bloating of abdomen  
144 ○○○ Weight gain around hips or  
waist  
145 ○○○ Sex drive reduced or lacking  
146 ○○○ Tendency to ulcers, colitis  
147 ○○○ Increased sugar tolerance  
148 ○○○ Women: menstrual disorders  
149 ○○○ Young girls: lack of menstrual  
function

- (F)  
1 2 3  
157 ○○○ Weakness, dizziness  
158 ○○○ Chronic fatigue  
159 ○○○ Low blood pressure  
160 ○○○ Nails weak, ridged  
161 ○○○ Tendency to hives  
162 ○○○ Arthritic tendencies  
163 ○○○ Perspiration increase  
164 ○○○ Bowel disorders  
165 ○○○ Poor circulation  
166 ○○○ Swollen ankles  
167 ○○○ Crave salt  
168 ○○○ Brown spots or bronzing of  
skin  
169 ○○○ Allergies - tendency to  
asthma  
170 ○○○ Weakness after colds,  
influenza  
171 ○○○ Exhaustion - muscular and  
nervous  
172 ○○○ Respiratory disorders



## ***The Chi Farm Acupuncture Clinic***

David R Wurzel, PE, MAc, LAc

### **Notice of Privacy Practices**

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.

#### Use and Disclosure of Health Information

I may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for the purposes of providing you treatment, obtaining payment for your care and conducting health care operations.

Treatment – Your health information will be recorded and used to determine the course of treatment that should work best for you. The sharing of your health information may include other health care providers involved in your care.

Payment – Your health care information will be used in order to receive payment for services. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – Your health care information will be used as necessary in order to improve the quality and effectiveness of the care and services I provide. For example, I may discuss your case with another health care provider to increase my understanding of your unique situation.

Appointment reminders – I may contact you with appointment reminders.

Treatment alternatives – I may contact you with information about treatment alternatives and other health-related activities that may be of interest to you.

Marketing - I may contact you to inform you of new services that I offer or of events that I am hosting or attending.

Communications with Family - In an urgent situation, a family member, or close personal friend, identified by you, may be given information relevant to your care.

Research/Education – Your information will be disclosed to researchers or educators upon the assurance that protocols have been established to assure the privacy of your health information.

Law Enforcement – Your health information will be disclosed when it is required under Federal, State, or Local law.

Other than so stated, I agree not to use or disclose your health information without your written authorization. Other than activity that has already occurred, you may revoke this authorization in writing at any time.

**Notice of Privacy Practices, continued**

Your Rights with Respect to Your Health Information

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information (a copy fee may be requested), and to receive an accounting of the disclosures that have been made of your health information (after the effective date of this Notice) for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your care. You may also request communications of your health information be made by reasonable alternative means or to reasonable alternative locations. All requests must be submitted to me in writing (The Chi Farm Acupuncture Clinic, 8370 Court Avenue, Ellicott City, MD 21043). You have the right to a paper copy of this Notice and may request one at any time by contacting me at 443-812-1665). You have the right to file a complaint with me or with the Secretary of Health and Human Services, with no fear of retaliation.

My Responsibilities

I am required by law to maintain the privacy of your health information and to provide you this Notice of duties and privacy practices. I am required to abide by the terms of this Notice and to notify you if I am unable to grant your requested restrictions or desires. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that I maintain. If I change this Notice, you will be informed at your next office visit.

Client Comments and Requests to Restrict Disclosures

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By my signature below I am indicating and have read and understand the forgoing Notice of Privacy Information:

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(Client's Signature)

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(Date)

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## **The Chi Farm Acupuncture Clinic**

David R Wurzel, PE, MAC, LAc

### **Patient Consent and Agreement**

#### **Voluntary**

I hereby voluntarily consent to be treated by acupuncture. The procedures involved in this treatment have been explained to me. I understand I may be treated with needles and/or with the application of heat and/or vacuum to the skin.

I have not been guaranteed any success concerning the uses and effects of acupuncture and/or nutritional supplementation. I understand I am free to discontinue treatment at any time.

#### **Possible Side Effects/Healing Reactions**

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms that existed prior to treatment. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

#### **Medical Referral**

I understand if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by David Wurzel at the beginning of treatment, or if a new ailment or condition arises, that I should consult a licensed physician. I also understand that if I am currently under a physician's care I should continue as long as my physician and I deem it necessary and that David Wurzel does not recommend altering medications or other therapies without first consulting my personal physician or provider.

I further understand that if I have not had a physical exam performed in the last year that it is recommended I have one as soon as possible.

#### **Infectious Disease/Clean Needle Procedures**

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand David Wurzel follows universally prescribed precautions to guard against the spread of infection.

In the case of airborne infectious disease, such as colds and influenza, I understand that practitioners and clinicians are urged not to see patients until they are well.

In the case of infectious disease spread by physical contact, such as smallpox, I understand that clinicians and practitioners wash their hands before seeing each new patient to guard against contagion by contact.

In the case of blood-borne infections, such as hepatitis or HIV, I understand David Wurzel follows strict precautions and uses only sterilized, prepackaged, disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards.

I understand that my questions about the safety of acupuncture and the precautions take by David Wurzel are most welcome and will be answered as fully as possible.

#### **Treatment Fees and Payment**

Unless other arrangements have been made, I understand the fees for my treatments are \$100 for the first session and \$70 for each subsequent appointment and agree to pay these amounts at the time of service. I further understand that I may be charged \$25 for any missed appointments that I did not cancel at least 24 hours prior unless an emergency arises.

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Patient Name (Printed)

---

Patient/Guardian Signature

---

Date