PranaTonic
Yoga and Wellness

1224 Washington Ave. #210, CO 80401
303-274-5733

Name _____ Date _____

How did you hear about us? _____

Would you like appointment reminders via text? Y N

Street _____ E-Mail _____

City/State _____ Cell Phone _____

Zip _____ Other Phone _____

Occupation _____ Employer _____

Birth date/age _____ Marital Status _____ Sex _____

Emergency Contact (Name & Phone) _____

Please state your major health concerns:

1 _____ Date appeared _____

2 _____ Date appeared _____

3 _____ Date appeared _____

Related to employment? Y N Related to accident? Y (Date _____) N

Other professionals consulted? _____

Diagnosis received? _____

Have you received any treatment? What? _____

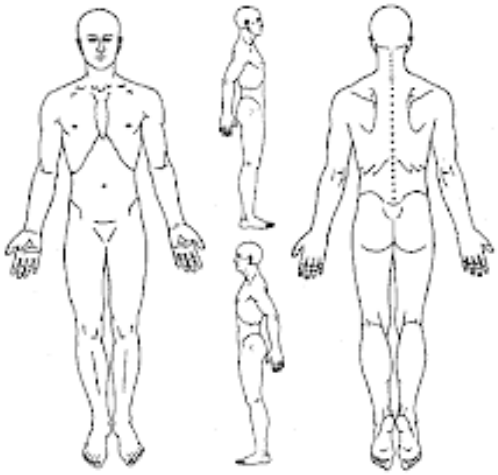
What makes it better? _____

What makes it worse? _____

Please rate your pain on 1-10 scale (1 = very little pain, 10 = worst pain of your life):

Now _____ At its worst _____

Please mark area(s) of pain on the figure(s):



Please describe your pain:

- ○ Sharp
- ○ Dull
- ○ Aching
- ○ Burning
- ○ Numbness/tingling
- ○ Other

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. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. 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:	_____

PranaTonic
Life Enhancing Products & Services

Office Policies

Payment: We accept Cash, Personal Checks, Master Card, Visa and Discover as forms of payment. All returned checks are subject to a $30 fee. (Please note that if two or more checks have been returned from the same party, then we will no longer be able to accept checks from that party.) All services and products must be paid for at the time of purchase.

Discounts: We offer a 10% discount on Services and Product for Students, Yoga Teachers, and Acupuncturists with a valid/current ID/License. These discounts are not to be combined with any other discounts or promotional offers.

Late Arrival Policy: If you find that you cannot be on time, please notify our office as soon as possible. We will do our best to accommodate our patients who come late to their scheduled treatment time. If you are more than **fifteen (15) minutes late** for your appointment, we may reschedule your appointment for a later date.

24 - Hour Cancellation Policy: If you need to cancel an appointment, we require 24 hours advance notice. You may leave a message on our after-hours voicemail.

Confirmation E-mails: You will receive a reminder about your appointment via e-mail. If you do not receive your appointment reminders, please call to confirm that we have your correct e-mail address.

Insurance Responsibility: PranaTonic will contact your insurance company to see if Acupuncture services our covered under your policy. **Payment** is expected at time of services. You will be responsible for co-payments and any charges that are not covered by your policy.

Herbs: We are pleased to offer herbal formulas in raw, tincture and pill form. PranaTonic does not accept returns on raw, or bottled herbal formulas, including sealed packages of herbs. This policy is in keeping with industry standards and legal guidelines.

Cell Phone Use: We try to keep the center area free of noise and other distractions. In consideration of our patients, please turn off your cell phone in the clinic area.

Pets: No pets are allowed at PranaTonic with exception of service dogs.

I have read, fully understand, and agree to all terms in the above Office Policy.

Responsible Party (Please print name)_____

Responsible Party Signature _____ Date: _____

Thank you,

PranaTonic Staff

COLORADO MANDATORY DISCLOSURE STATEMENT
PRACTITIONER EDUCATION & EXPERIENCE

Kimball Cicciu, L.Ac., E-RYT, Certified Group Exercise Instructor (AFAA)

Kimball Cicciu graduated from Florida Institute of Traditional Chinese Medicine and was awarded a diploma in 1999. Following this three-year program including 2082 didactic hours and more than 800 clinical training hours, Kimball was certified as a Licensed Acupuncturist by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), February 1999 and has been practicing ever since. She has successfully completed the Clean Needle Technique course offered by NCCAOM. Kimball Cicciu is trained in and qualified to prescribe Chinese Herbs. She is also trained in Chinese diagnostic technique, acupuncture treatments, cupping, moxibustion therapy, auricular therapy, electrical stimulation, and massage (tui-na). Kimball has been teaching fitness and yoga since 1990 and is a Certified Group Exercise Instructor (AFAA) and an Experienced Registered Yoga Teacher (Yoga Alliance).

Greg Cicciu, L.Ac

Greg graduated from Florida Institute of Traditional Chinese Medicine and was awarded a diploma in 1998. Following this three-year program including 2082 didactic hours and more than 800 clinical training hours, Greg was certified as a Licensed Acupuncturist by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), September 1998 and has been practicing ever since. He has successfully completed the Clean Needle Technique course offered by NCCAOM. Greg Cicciu is trained in and qualified to prescribe Chinese Herbs. He is also trained in Chinese diagnostic technique, acupuncture treatments, cupping, moxibustion therapy, auricular therapy, electrical stimulation, and massage (tui-na).

Shanti Pitschka

Shanti Pitschka graduated from the Institute of Integrative Nutrition in 2018 and became an Ayurvedic Health Practitoner in 2019 at the New World Ayurvedic School (NWA). Shanti is a teacher at NWA and has been teaching yoga since 2011. She is a registered EYRT500 yoga and meditation teacher. She works with clients one on one in a 6 month Ayurvedic Lifestyle Coaching Program, Ayurvedic Consults, and private yoga sessions.

FEE SCHEDULE

Initial Acupuncture Treatment and Examination	$130
Acupuncture Follow-up includes Chinese medical modalities and herbal recommendations	$90
Massage	$55 Per 30 Minutes, $90 Per 60 Minutes, $130 Per 90 Minutes
Cupping Therapy	$45
Auricular Therapy	$35
Herbal Consultation	$60 Per 60 Minutes
Follow Up Herbal Consultation	$30 Per 30 Minutes
Kinesio Taping	$10
Lifestyle Coaching First Visit and Follow Up	$200
Ayurvedic Lifestyle Coaching	$150
Ayurvedic Consult	$90

PATIENT'S RIGHTS

The patient has the right to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy 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.

PranaTonic LLC and its agents all comply with the rules and regulations promulgated by the Colorado Department of Health and Environment, including the proper cleaning and sterilization of needles, and the sanitation of equipment the acupuncture offices. Only single-use, factory-sterilized, disposable needles are utilized. The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, CO, 80202. Or at (303) 894-7800. This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5.

I have been informed that acupuncture and it's auxiliary treatments are safe methods of treatment but that they may have side effects including discomfort, pain, dizziness, bruising, burning, or numbness at site of procedure. Unusual and rare risks include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the health care provider.

I will inform my providers of any medications I am using or treatments I am undergoing from another healthcare provider.

I understand that there are no guarantees regarding cure or improvement of my condition. I do not expect the acupuncturist to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I declare that I have read or have had read to me and understand this document. I have had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition for which I seek treatment.

Patient or Guardian's Signature_____ Date _____

Print Name_____

PranaTonic
1224 Washington Ave. #210
Golden, CO 80401

Patient Acknowledgement Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a patient Rights section describing you rights under the law. You have the right to review our notice before signing this form. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting this office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent, PranaTonic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient acknowledges that: (please initial each line)

___ PranaTonic has a Notice of Privacy Practices and that the patient has received a copy of this notice and opportunity to review this notice.
___ Protected Health Information may be disclosed or used for treatment, payment or healthcare operations.
___ PranaTonic reserves the right to change the Notice of Privacy Practices.
___ The patient has the right to restrict the uses of their protected health information, however PranaTonic does not have to agree to those restrictions.
___ The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.

_____ _____
Name of Patient or Patient Representative (Print) Date

_____
Signature of Patient or Patient Representative

_____
Relationship to Patient (if other than patient)