ACUPUNCTURE REGISTRATION & HEALTH HISTORY

Date of Visit: ___ /____/ _____

1 PATIENT INFORMATION

Last Name	
First Name	
Sex ☐ Male ☐ Female	Birthdate
Marital Status ☐ Married ☐ Single ☐Divorced ☐ Widowed ☐ Partnered	
Address:	
Occupation	

2 CONTACT INFORMATION

Home Phone:	
Cell Phone:	
Work Phone:	
Email:	
EMERGENCY CONTACT	
Name	Relationship
Work Phone	Cell Phone

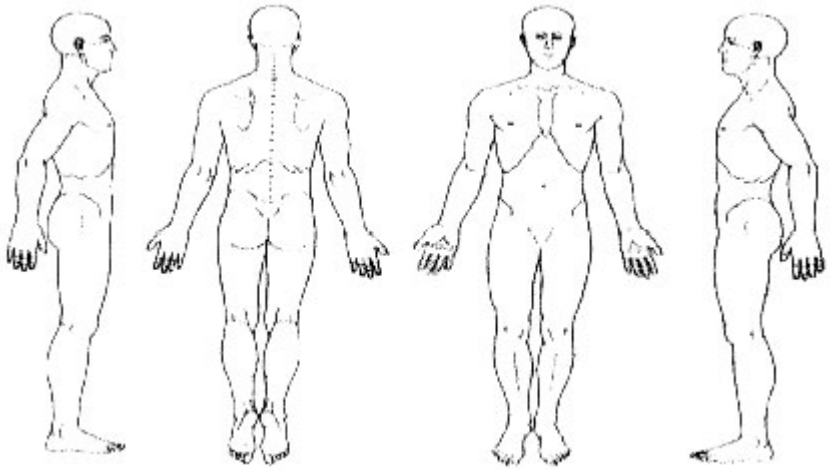
3 PATIENT CONDITION

1. Reason for Visit

2. When did your symptoms appear?

_____

3. How did your symptoms begin? _____



4. Mark an **X** on the picture where your symptoms appear (if applicable).

5. How are your symptoms changing?
☐ Getting Better ☐ Not Changing
☐ Getting Worse ☐ Not Sure

6. What tests have been performed for your condition?

☐ X-Rays *date*: _____

☐ CT Scan *date*: _____

☐ MRI *date*: _____

☐ Other *date*: _____

7. Do symptoms interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

8. What treatment have you already received for your condition? ☐ None ☐ Medications ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture ☐ Surgery ☐ Other: _____

9. Secondary Complaints _____

10. Treatment for Other Conditions: ☐ No ☐ Yes (Please, explain) _____

11. In general, would you say your overall health right now is : ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4 HEALTH HISTORY

- Place check to indicate if you have had any of the following:

☐ AIDS / HIV	☐ Cancer	☐ Hypertension	☐ Sexually transmitted diseases _____
☐ Allergies _____	☐ Diabetes	☐ Miscarriage	
☐ Anemia	☐ Epilepsy	☐ Nervous Breakdown	☐ Pacemaker
☐ Asthma	☐ Hepatitis A , B or C	☐ Stroke	☐ Artificial Joints
☐ Bleeding Disorder	☐ Heart Disease	☐ Tuberculosis	☐ Other_____

- **Past surgeries** (indicate type/year) ☐ None ☐ Yes

_____

- **Have you been advised to have surgery which was not done?** ☐ No ☐ Yes _____

- **Any familial disease tendency of which you are aware? (ie. Diabetes, cancer)** ☐ No ☐ Yes

_____

- **For women only** Check to indicate, if you are: ☐ Pregnant ☐ Nursing Child ☐ Have Uterine Fibroids

LIFESTYLE HABITS

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	(# packs / day _____)
☐ Moderate	☐ Standing	☐ Alcohol	(# drinks / day _____)
☐ Daily	☐ Light Labor	☐ Coffee / Caffeine Drinks	(# cups / day _____)
☐ Heavy	☐ Heavy Labor	☐ High Stress Levels	(# reason _____)
		☐ Non-medical drugs	(# type _____)

MEDICATIONS / VITAMINS / HERBAL SUPPLEMENTS (Taken with last 2 months including over-the-counter drugs)

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

5 SIGNATURE

PATIENT AFFIRMATION

I,the patient, have been advised by the acupuncturist, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

PRIVACY POLICY

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. **I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.**

CANCELLATION POLICY: I agree to provide at least 24 hours notice of appointment cancellations and am subject to late cancellation / no show penalties.

CHECK PAYMENTS: I understand that personal check payments returned due to insufficient funds are subject to penalty charges.

I have read, understood and agree to the terms detailed in the above patient affirmation, privacy policy and financial agreement. To the best of my knowledge, the information I've provided on this form is complete and correct.

X _____ _____

Signature Date

Relationship to patient:
☐ Self
☐ Parent
☐ Guardian

Acupuncture: Informed Consent to Treat

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 named 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 may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, guasha and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Redness of the skin is a normal effect of guasha. Unusual risks of acupuncture include spontaneous miscarriage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify a clinical staff member who is caring for me if I am pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 that then known is in my best interest. I understand that results are not guaranteed.

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.

By voluntarily signing below, I show 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 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.

X
Patient Signature (Or Patient Representative) (Date) *If signing for patient, please indicate relationship*

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.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Individual Rights. You have certain rights under the federal privacy standards.

These include:

the right to request restrictions on the use and disclosure of your protected health information
the right to receive confidential communications concerning your medical condition and treatment
the right to inspect and copy your protected health information
the right to amend or submit corrections to your protected health information
the right to receive an accounting of how and to whom your protected health information has been disclosed
the right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or the Privacy Officer/Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the office. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the office. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on January 4, 2010.