ACUPUNCTURE PATIENT INFORMATION

PATIENT INFORMATION

Date_____

Name_____

Mailing Address_____

_____
City State Zip

Sex:☐M ☐F Age_____ Birthdate_____

☐Single ☐Married ☐Significant Other
☐Widowed ☐Separated ☐Divorced

Patient SS#_____

Occupation_____

Employer_____

Emp. Address_____

Emp. Phone_____

Spouse/Partner's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse/Partner's Employer_____

Whom may we thank for referring you?_____

CONTACT INFORMATION

H_____W_____Cell_____

Your email: _____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home ph_____ Cell_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I(or my dependent) have insurance coverage with _____and assign directly to _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident?☐Yes ☐No

Date_____
Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐ Worker Comp. ☐Other

Attorney Name (if applicable)_____

GENERAL INFORMATION

Have you had acupuncture before? ☐Yes ☐No Have you used Chinese herbal medicine? ☐Yes ☐No

Are you currently under the care of a physician? ☐Yes ☐No If Yes, for what?_____

Physician's name:_____ Physician's phone:_____

ORIENTAL MEDICINE INTAKE FORM

Name:_____ **Date:**_____

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

2. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

3. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list **allergies** that you have to any of the following:

Drugs:_____ Foods:_____

Other (i.e. pollen, paint, etc.):_____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

_____

_____

Personal Habits:

☐Tobacco packs/day_____
☐Alcohol drinks/wk_____
☐Coffee/tea/cola cups/day_____
☐Recreational drugs times/wk_____

☐High Stress Level Reason_____

Do you follow any diet regimens/restrictions?
☐Yes ☐No
If Yes, describe:_____

Work Activity:

☐Sitting % of time_____
☐Standing % of time_____
☐Light labor % of time_____
☐Heavy labor % of time_____

Exercise:

Do you exercise regularly? ☐Yes ☐No
If Yes, describe & tell how often:_____

_____

FAMILY INFORMATION

Do you have children? ☐Yes ☐No If Yes, how many? _____ Ages _____

Are you, or could you be currently pregnant? ☐Yes ☐No Due date _____

Please check if you have had (in the **last three months**)

GENERAL

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Changes in appetite
- ❑ Weight loss/gain
- ❑ Cravings
- ❑ Peculiar tastes
- ❑ Strong thirst
- ❑ Fevers/Chills
- ❑ Sweat easily
- ❑ Localized weakness
- ❑ Bleed / bruise easily
- ❑ Sudden energy drop (time?)
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor sleeping
- ❑ Heavy sleeping
- ❑ Dream disturbed sleep
- ❑ Night sweats
- ❑ Dizziness

SKIN AND HAIR

- ❑ Rashes/Hives
- ❑ Itching
- ❑ Dry skin
- ❑ Dandruff
- ❑ Ulcerations
- ❑ Eczema/Psoriasis
- ❑ Loss of hair
- ❑ Pimples/Acne
- ❑ Fungal infections
- ❑ Recent moles
- ❑ Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Concussions
- ❑ Glasses/Contacts
- ❑ Eye strain/pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Excessive tearing
- ❑ Poor/blurry vision
- ❑ Night blindness
- ❑ Cataracts/Glaucoma
- ❑ Spots in front of eyes
- ❑ Earaches/Infections
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Excessive phlegm – color_____
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Swollen glands
- ❑ Sores on lips/tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Teeth problems
- ❑ Gum problems
- ❑ TMJ disorder
- ❑ Grinding teeth
- ❑ **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Fainting
- ❑ Cold hands/feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

- ❑ Cough
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Production of phlegm - color?_____
  Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Hiccups
- ❑ Belching
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Mucus in stools
- ❑ Acid Regurgitation
- ❑ Abdominal pain
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Bedwetting
- ❑ Kidney stones
- ❑ Impotency
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Sores on genitals
- ❑ Frequent urinary tract infections
- ❑ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Cramps/spasms
- ❑ General joint pain/stiffness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Joint with limited range of motion_____

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Tics
- ❑ Lack of coordination
- ❑ Memory loss
- ❑ Concussion
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily susceptible to stress
- ❑ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses_____ If no longer menstruating, approximate date ceased_____

First day of last menses_____ Length between menses:_____days Duration of period:_____days

- ❑ Unusual flow (☐heavy or ☐light)
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots in flow
- ❑ Vaginal discharge – color_____
- ❑ Vaginal odor
- ❑ Vaginal dryness
- ❑ Vaginal sores
- ❑ Hot flashes
- ❑ Breast lumps/soreness

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP:_____ Results were: normal abnormal unsure
If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation? (i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies_____ Births_____ Miscarriages_____ Abortions____
Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Wurtsboro Acupuncture, Chiropractic & PT, PLLC
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture by a licensed acupuncturist at Wurtsboro Acupuncture, Chiropractic and Physical Therapy, PLLC. I understand that acupuncturists practicing in the state of New York 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 practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. 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 effect may result from taking these substances. These could 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. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the practitioner as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment 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 could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Cupping/Gua Sha: I understand that I may also be given cupping/guasha as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that superficial bruising will result from this treatment. Other adverse side effects could include, but are not limited to: deep bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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

Signature: _____ **Date:**_____

Printed Name: _____ **Date of Birth:** _____

Address: _____ **Email:**_____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

<u>SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION</u>

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*_____ *X*_____

Patient's Signature Date Explained by me and signed in my presence Date

General Pain Index Questionnaire

We would like to know how much your pain presently ***prevents*** you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. Family/at -home responsibilities such as yard work, chores around the house or driving the kids to school -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

3. Social activities including parties, theater, concerts, dining –out and attending other social functions with friends -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

4. Employment including volunteer work and homemaking tasks -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

5. Self -care such as taking a shower, driving or getting dressed -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

6. Life -support activities such as eating and sleeping -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

PATIENT NAME _____ DATE _____

Score _____ [60] Benchmark -5 = _____

NOTICE OF PRIVACY PRACTICES

Wurtsboro Acupuncture, Chiropractic and Physical Therapy PLLC

Jacek Kura MSPT, DC, MSA

P.O. Box 490 ~ 80 Sullivan Street

Wurtsboro, NY 12790

Phone: (845) 644-4426 ~ Fax: (845) 644-4428

Email: healingtouchalternative@gmail.com

Effective Date: 10/01/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the equest. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____ Date_____

Print Name: _____

Summary of Rights and Obligations Concerning Health Information

(Patient's copy)

Wurtsboro Acupuncture, Chiropractic and Physical Therapy, PLLC is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law, as well as by ethics of the medical profession. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by [name of practice]. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have certain rights to your health information. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices.* In the following pages, we explain our privacy practices and your rights to your health information in more detail.

Chiropractic or Physical Therapy Residents and Chiropractic or Physical Therapy Students. Medical residents or medical students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

Business Associates. Healing Touch Alternative Care Center sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

Appointment Reminders. We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment at Healing Touch Alternative Care Center. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

Treatment Options. We may use and disclose your health information in order to inform you of alternative treatments.

Release to Family/Friends. Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Health-Related Benefits and Services. **The following sentence is required only if the practice intends to send information to patients concerning health-related benefits or services.** We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest you.

Newsletters and Other Communications. We may use your personal information in order to communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Disaster Relief. We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement. We may release your health information:

- in response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
- to identify or locate a suspect, fugitive, material witness, or similar person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at [name of provider];
- to coroners or medical examiners;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
- to authorized federal officials for intelligence, counterintelligence, and other
- national security authorized by law; and
- to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

De-identified Information. We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative

Acupuncture Initial Intake Form

Patient Name_____ Age_____ Sex_____ Date _____

CHIEF COMPLAINT(S)

Illness History [onset, frequency, severity, better/worse, previous dx, other tx, medications]

Energy /10 Comments: Stress /10 Comments:

- Hot/Cold
- Perspiration
- Head & Body
- Chest & Abdomen
- Appetite/thirst
- Urination/stools
- Sleep & dreams
- Eyes & Ears
- Pain, Numbness
- Menses/Repro fxn
- Sexual activity/libido
- Emotions
- Lifestyle, habits & work

PALPATION / INSPECTION

PULSE

HR _____ BP _____/_____

TONGUE

Body (color, shape, motion)
Coating (color, thickness, moisture, location)
Vessel distention, color

Quality:

Force:

Width:

Depth:

PATTERN DISCRIMINATION(S)

TREATMENT PRINCIPLE(S)

TREATMENT PLAN [modality, objective, freq. of fx, duration]

TREATMENT [points, moxa, herbs, lifestyle rec's] # of Needles _____ Time _____

Practitioner's Signature_____ Date_____

Acupuncture Progress Form

Patient Name_____ Date _____ Visit # ____

TONGUE: Body (color, shape, motion)
Coating (color, thickness, moisture, location)
Vessel distention and color

CHIEF COMPLAINTS(S):

RESPONSE TO LAST TX:

ADDITIONAL NOTES:

PULSE: HR_____BP_____/_____

_____*Left*_____*Right*_____

Cun
_____

Guan
_____

Chi
_____

PATTERN DISCRIMINATION(S) **TREATMENT PRINCIPAL(S)**

TREATMENT **# of Needles _____ Time _____**
[pts, moxa, other, herbs, lifestyle recs]

Practitioner's Signature _____ Date _____