Nurse Practitioner Form

Name: ____ Sex: M F Date: __________________________

Mailing Address: ____________________________________ City: _____________________ State: ________ Zip: _______

H. Phone: _______________________ W. Phone: __________________________ Cell phone: ______________________

Email: _____________________________ Date of Birth: ________________ Age: _____ Social Security #: ______________

Occupation: __________________________ Employer: ____

In Case of Emergency, Contact:

Name: ______________________ Relationship: _______________ Phone numbers: _________________________________

1. Chief Complaint: ____

____

2. Secondary reason for seeking care: ____

Complaint began when? And how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Grade Intensity/Severity: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint)

Does this complaint/pain travel or radiate to any areas of your body? _____ Where? ___________________________________

Do you have any numbness or tingling in your body? ______ Where? ____

How frequent is the complaint present, how long does it last?

____

Does anything aggravate the complaint?

____

Does anything make the complaint better?

____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

____

4. Past Health History:
A. Previous Illnesses you've had in your life:____

____

B. Previous Injury or trauma: ____

____

Have you ever broken any bones? _______ Which? ____

C. Allergies and reactions: ____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of surgery

F. Females / Pregnancies and outcomes:

Pregnancies/ date of delivery	Outcome

What was the date of the beginning of your last menstrual period? ____________________

5. Family Health History:

Significant health problems of relatives: ____________________

____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

D. Recreational activities / Level of Exercise:____________________

____

E. Lifestyle:

Hobbies: ____________________

Tobacco Use**:** ____________________ Alcohol Use: ____________________

Illicit Drug Use: ____________________

Diet: ____________________

7. Activities of Daily Living:

A. Do you live alone? Yes No **B. Do you need any help with your daily activities? Yes No**

I have read the all of the above information and certify it to be true and correct to the best of my knowledge.

.

Patient Signature ____________________Date ____________________

Doctor's signature ____________________ 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 & Physical Therapy, PLLC

Barbara Kura, FNP

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 request. 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)

Healing Touch Alternative Care Center 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.

Wurtsboro Acupuncture, Chiropractic & Physical Therapy, PLLC
Barbara Kura, FNP
P.O. Box 490 ● 80 Sullivan Street
Wurtsboro, NY 12790
Phone: (845) 644-4426 Fax: (845) 644-4428
Email: healingtouchalternative@gmail.com

CONSENT TO TREATMENT WITH MARIJUANA FOR MEDICAL PURPOSES

I am/have been evaluated for a Health Care Providers recommendation for Medicinal Marijuana. The Health Care Provider has/will make this recommendation based, in part on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use medical marijuana only as needed for the treatment of my medical condition and not for recreation or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale / purchase and or distribution of marijuana. I have been informed of and understand the following: **(please initial each item)**

1. _____ The Federal Government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states which have modified their state laws to treat marijuana as a medicine.

2._____ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the “manufacture” of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, (i.e., may vary in) potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

3._____ I understand that the Health Care providers may not be knowledgeable of all associated risks involved in the use of a non-FDA approved substance such as marijuana. I acknowledge that there is a controversy in the medical/scientific literature available regarding the usage of marijuana for medical purposes and that more research needs to be conducted.

4._____ I understand that although New York State has approved the limited use of medical marijuana for medical purposes, its use is not approved under federal law and the current and future enforcement action of federal law enforcement officials is uncertain.

5._____ I understand that each state has their own rules and regulations regarding Medical marijuana and the use of medical marijuana outside of New York State cannot be recommended.

6._____ I understand that use of medical marijuana on Federal properties or associations is not allowed.

7._____The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I DRIVE WHILE UNDER THE INFLUENCE OF MARIJUANA, I CAN BE ARRESTED FOR “DRIVING UNDER THE INFLUENCE.”

8. _____Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, a tendency to drug abuse, and schizophrenia.

9. _____ I understand that using medical marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

10. _____ I agree to contact Barbara Kura, FNP if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. Additionally, I will contact Barbara Kura if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

11._____ The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating health care provider(s) before using medical marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating health care provider.

12. _____ Individuals may develop a tolerance to, and/or dependence on marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I will contact Barbara Kura, FNP.

13. _____ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

14. _____ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Barbara Kura, FNP immediately or go to the nearest emergency room.

15._____ If Barbara Kura, FNP subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with Barbara Kura, FNP and provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

16. _____ I have had the opportunity to discuss these matters with the health care provider and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Barbara Kura, FNP has informed me of the nature of a recommended treatment, including but not limited to, any recommendations regarding medical marijuana. Barbara Kura has also informed me of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Barbara Kura, FNP has informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

17._____ In order to stay in compliance with New York State's medical marijuana program it is required that you return for a review of your medical condition.

18._____ I understand that New York State has approved medical marijuana for only certain medical problems. To be qualified for the medical marijuana program the patient must have one or more of the serious conditions set forth in Public Health Law 3360(7). The law currently identifies the following severe, debilitating or life threatening conditions: cancer, HIV infection or AIDS, amyotrophic lateral sclerosis (ALS), Parkinson's disease, multiple sclerosis, spinal cord injury with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathy, chronic pain as defined by 10 NYCRR 1004.2(a)(8)(xi), and Huntington's disease. Patients must also have one of the following associated or complicating conditions: cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms.

19._____The Dept. of Financial Services (DFS) has stated that all insurers authorized to write accident and health insurance in New York State, including health maintenance organizations, student health plans and municipal cooperative health benefit plans, must provide coverage for office visits for covered services, including those that may result in a medical marijuana certification. However, if the sole purpose of the visit is to obtain a certification for the medical marijuana program, then the visit may not be billed to the insurance carrier.

20._____ I understand that I may not give the medical marijuana I have obtained to another individual or sell the medical marijuana as this is illegal and considered as drug trafficking.

21._____ I agree to lock and safely store my medical marijuana so that others may not obtain it or accidently ingest the medical marijuana.

____

Signature of Patient Date

____

Signature of Witness Date