

6405 NE 116th Ave. Suite 104

Vancouver, WA 98662

Premier Acupuncture

Ph: (360) 892-4355

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so

Patient Information Form

Name: _____ Date of Birth: ____/____/____
(first) (middle initial) (last)

Circle one: Male / Female

Marital Status: _____ Spouse's Name: _____

Address: _____

Phone Number (circle type): _____ (Cell / Home / Work)

Email: _____

Occupation: _____

Emergency Contact: _____ Ph. #: _____

Referred By/How did you hear about Premier Acupuncture?: _____

Name of Primary Insurance Company (if paying with insurance):

_____ ID#: _____ Group# _____

Name of Insured: _____ D.O.B.: _____

Insurance Company phone number: _____

Relationship to Patient(circle one): Self / Spouse / Parent / Other (specify) _____

Secondary Insurance: _____

Name of insured: _____ D.O.B.: _____

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understanding that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).



Patient Health History Form

Please identify any health issues or concerns that you wish to have addressed:

Primary Condition:

1: _____

Please circle the severity of your primary issue: (0 = no problems/pain, 10 = very severe)

0 1 2 3 4 5 6 7 8 9 10

Secondary Condition:

2: _____

Please circle the severity of your secondary issue:

0 1 2 3 4 5 6 7 8 9 10

Do you have any reason to believe that you are, or may be pregnant: **Yes / No**

If yes, how far along: _____

Do you currently have a pacemaker or a history of seizures?: **Yes / No**

If yes, Please identify: _____

Do you have any communicable infectious diseases? **Yes / No**

If yes, Please identify: _____

Do you have any other medical issues of note (ex: High Blood Pressure, Diabetes, Cancer, Etc)

If yes, Please identify: _____

Please list any medications you are taking and the dosages (including supplements):

(continue listing medications/supplements on back if necessary)

PREMIER ACUPUNCTURE LLC

CONSENT TO TREATMENT & FINANCIAL AGREEMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, herbal therapy, Tuina massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxabustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include, but are not limited to, dizziness, pneumothorax, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable one time use needles and maintains a safe and clean environment. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours' notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee may be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

If my insurance covers acupuncture I can elect to have Premier Acupuncture LLC submit claims for me. I am responsible for my deductible, co-pay and co-insurance amounts. If my insurance denies payment of a claim I am responsible for the billed charges. I understand that if insurance is not billed, full payment is due at the time of service, and MasterCard and Visa are accepted as well as cash and checks.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred, or carried out at Premier Acupuncture LLC.

Signature

Date

Premier Acupuncture, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **IMPORTANT NOTE:** This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative

Date

Print patient name

Patient Birth Date



NOTICE OF PRIVACY PRACTICES

I. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- a) basis for planning your care and treatment
- b) means of communication among the many health professionals who contribute to your care
- c) legal document describing the care you received
- d) means by which you or a third-party payer can verify that services billed were actually provided
- e) a tool for educating health professionals
- f) a source of data for medical research
- g) a source of information for public health officials charged with improving the health of the nation
- h) a source of data for facility planning and marketing
- i) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- a) ensure its accuracy
- b) better understand who, what, when, where, and why others may access your health information
- c) make more informed decisions when authorizing disclosure to others

II. Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- a) request a restriction on certain uses and disclosures of your information
- b) obtain a paper copy of this Notice of Privacy Practices upon request
- c) inspect and obtain a copy of your health record
- d) amend your health record under certain circumstances
- e) obtain an accounting of disclosures of your health information
- f) request communications of your health information by alternative means or at alternative locations
- g) revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities

This organization is required to:

- a) maintain the privacy of your health information
- b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

- c) abide by the terms of this notice
- d) notify you if we are unable to agree to a requested restriction
- e) 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 protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you supply to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

IV. For More Information or to Report a Problem

If have questions and would like additional information, ask your provider for clarification. If you believe your privacy rights have been violated, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. You can find the Office for Civil Rights for your state at: <http://www.hhs.gov/ocr/regmail.html>. There will be no retaliation for filing a complaint.

V. Examples of Disclosures for Treatment, Payment and Health Operations

Needless-to-say, we will disclose your protected health information in communications with you. For example, we may use and disclose health information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefits or services that might be of interest to you. Other reasons to disclose your health information include the following.

1) We will use your health information for treatment.

For example: Information obtained by your practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his or her expectations of any other members of your healthcare team. Those team members will then record the actions they take and their observations. In that way, the practitioner will know how you are responding to treatment.

2) We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular clinic operations.

For example: Members of the clinic staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the service we provide.

3) Business associates

There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party

payer for services rendered, if appropriate. To protect your health information, however, we require the business associate to appropriately safeguard your information.

4) Notification

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

5) Patient Directory

Unless you notify us that you object, we may use your name, general condition for the clinic directory purposes. This information will not be given out to outside interests.

5) Communication with family

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

6) Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

7) Coroners, medical examiners and funeral directors

We may disclose health information to coroners, medical examiners and funeral directors consistent with applicable law to carry out their duties.

8) Organ procurement organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

9) Marketing

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

10) Food and Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

11) Workers compensation

We may disclose 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.

12) Public health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

13) Correctional institution

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

14) Law enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

15) Health oversight

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct, or have otherwise violated professional or clinical standards, and are potentially endangering one or more patients, workers or the public.

16) As required by law

We will disclose health information about you when required to do so by federal, state, or local law. For example, information may need to be disclosed to the Department of Health and Human Services to make sure that your rights have not been violated.

17) Suspicion of abuse or neglect

We will disclose your health information to appropriate agencies if relevant to a suspicion of child abuse or neglect, or, if you are not a minor, if you are a victim of abuse, neglect or domestic violence and either you agree to the disclosure or we are authorized by law to disclose this and it is believed that disclosure is necessary to prevent serious harm to you or others.

18) To avert a serious threat to health or safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone who we believe would be able to prevent the threat or harm from happening.

19) For special government functions

We may use or disclose your health information to assist the government in its performance of functions that relate to you. For example, if you are a member of the armed forces, this might include sharing your information with appropriate military authorities to assist in military command.

Effective Date: January 01, 2010