

**Acupuncture Clinic of Richmond
Initial Health Status**

General Information

Date: _____

Patient Full Name: _____ Date of Birth: _____

Address: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Employer _____ Occupation: _____

Email: _____ Emergency Contact: _____

Primary Care Physician: _____ Phone: _____

Date of Last Physical Exam: _____ By Whom: _____

How did you hear about the clinic? _____

Reason for Visit

Please describe in detail why you are here today and your primary health goal:

Date of onset: _____ Sudden Gradual Severity (1-10, 10 worse) _____

Have you had this in the past? No Yes When: _____

What makes it better? _____

What makes it worse? _____

Is the condition: Getting worse Improving Constant Comes and goes

How often are your symptoms present? Constant Frequent Sporadic

Are your symptoms preventing you from daily activity: All activity Some activity Not at all

Have you seen a physician or other practitioner for this condition? No Yes

Please describe any treatments you have taken for the condition and the results (surgery, chiropractic, medications, injections, herbal...)

Family Medical History:

Please check any illness or condition that a family member may have had in the past.

- | | | | | |
|--|---|--|--|--|
| AIDS <input type="checkbox"/> | Asthma <input type="checkbox"/> | Allergies <input type="checkbox"/> | Alcoholism <input type="checkbox"/> | Antibiotic Use <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Artificial Joint <input type="checkbox"/> | Bleeding Tendencies <input type="checkbox"/> | Blood Disorder <input type="checkbox"/> | Breast Lumps <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Chicken Pox <input type="checkbox"/> | Convulsions or Seizures <input type="checkbox"/> | Depression <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Glaucoma <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| HIV <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Lupus <input type="checkbox"/> | Meningitis <input type="checkbox"/> |
| Mononucleosis <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> | Measles <input type="checkbox"/> | Mental Illness <input type="checkbox"/> | |
| Polio <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Stroke <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> | |
- Other: _____

Personal Medical History:

Please check any illness or condition that a family member may have had in the past.

- | | | | | |
|--|---|--|--|--|
| AIDS <input type="checkbox"/> | Asthma <input type="checkbox"/> | Allergies <input type="checkbox"/> | Alcoholism <input type="checkbox"/> | Antibiotic Use <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Artificial Joint <input type="checkbox"/> | Bleeding Tendencies <input type="checkbox"/> | Blood Disorder <input type="checkbox"/> | Breast Lumps <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Chicken Pox <input type="checkbox"/> | Convulsions or Seizures <input type="checkbox"/> | Depression <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Glaucoma <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| HIV <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Lupus <input type="checkbox"/> | Meningitis <input type="checkbox"/> |
| Mononucleosis <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> | Measles <input type="checkbox"/> | Mental Illness <input type="checkbox"/> | |
| Polio <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Stroke <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> | |
- Other: _____

Please list any surgeries including date and physician:

Please list any traumas, injuries,... and the dates they occurred:

Prescription Medications and Supplements

Please list any medications, supplements, and herbs that you are taking including dose and frequency:

Lifestyle/Habits

Alcohol Consumption: Yes No How many times per week: _____

Coffee / Sodas: Yes No Type: _____ How often? _____

Exercise: Yes No Sometimes Type: _____

_____ How often? _____

Recreational Drug Use: Now Past Type: _____ How often? _____

Tobacco Use: Yes No Past Type: _____ How often? _____

Meditate / Pray: Yes No Sometimes How often? _____

What activities do you do to relax/unwind (example: exercise, yoga, music, shopping...)

Have you had acupuncture in the past? Yes No When and for what reason?

Do you have any concerns about acupuncture, herbal medicine or afraid of needles?

I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature

Informed Consent and Disclosure

I hereby request and consent to acupuncture treatment and other procedures within the scope of the practice of acupuncture, and/or herbal supplement recommendations for me (or legal charge) provided by the acupuncturist named below.

I have read the information below and understand the possible risks involved. I have had an opportunity to discuss these risks with the acupuncturist or clinic office staff named below and I understand that the results are not guaranteed.

- Acupuncture is a safe and effective method of treatment. Slight bleeding may occur and is typically resolved when pressing dry cotton to the area. Slight bruising may also occur. The risk of infection is small when using sterile needles. It is the practice of this clinic to use pre-packaged, sterile, one-time-use only needles as required by law.
- Acupressure/TuiNa involves rubbing, kneading, pressing and stroking of an area and may result in minor muscle soreness at the massage site that may last up to several days.
- Indirect Moxibustion requires the burning of an herbal material at a site near the skin or acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of contact burns does exist.
- Cupping involves localized suction produced by heating a small glass cup. There is a possibility of bruising from the suction as well as slight burning or blistering from the heat involved in the procedure.
- Gu sha involves scraping over a small area by using a smooth edge instrument. There is a possibility of local bruising at the Gu Sha site.
- Tapping, Plum Blossom, Bleeding, Pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment may occur. Only single use needles are used in this procedure.
- Electrical Stimulation / TENS uses microcurrent electricity to stimulate acupuncture points. A mild tingling of electricity may be felt.

Payment and Cancellation Agreement

I understand that payment is expected at the time of visit and I agree to make full payment at the time of my appointment.

I understand that when I schedule an appointment, I am agreeing to pay for the time set aside, as well as any treatment that I may receive during that designated time. I agree to provide this office with at least 24 hours notice when cancelling an appointment. I understand that if I cancel an appointment without a 24 hours notice, that I may be required to pay a charge which may include the cost of the appointment.

Patient Signature

Date

Office/Practitioner Signature

Date

Recommendation for Examination by a Physician

Virginia law requires that the Clinic provides this recommendation to you if we do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).

I, Deborah Farley, L.Ac. (VA), recommend to you, _____, that you be examined by a licensed Physician regarding the condition for which you are seeking acupuncture treatment. I have read and understand this recommendation.

Patient Signature

Date

Acupuncturist Signature

Date

Patient Consent Use & Disclosure of Protected Health Information

Our **Notice of Privacy Practices** contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If our Notice changes, you may obtain a revised copy by contacting the clinic.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. Acupuncture Clinic of Richmond is not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Acupuncture Clinic of Richmond has a Notice of Privacy Practices and the patient may review this Notice
- Acupuncture Clinic of Richmond reserves the right to change the Notice of Privacy Policies
- Patient has the right to restrict use of their information, but the Practice is not required to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Acupuncture Clinic of Richmond may condition treatment upon the execution of this Consent.

I have received, read and understand the **Notice of Privacy Practices** and I authorize and consent to the use and disclosure of protected health information in manner described.

Patient Signature

Date

Acupuncturist Signature

Date

PRIVACY POLICY

This notice describes how health and medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Section I. Uses & Disclosures for Treatment, Payment & Health Care Operations

A. We may use or disclose your protected health information (PHI) for treatment, payment, or health care operations purposed with your consent. To help clarify these terms here are some definitions:

a. "PHI" refers to information in your health record that could identify you.

b. "Treatment, Payment and Health Care Operations"

i. *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or a specializing physician.

ii. *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

iii. *Health Care Operations* are activities, business-related matters such as audits and administrative services, and case management and care coordination.

c. "Use" applies only to activities with our office/clinic/practice group, such as releasing, transferring or providing access to information about to other parties.

d. "Disclosure" applies to activities outside our office/clinic/practice group/etc, such as releasing, transferring or providing access to information about you to other parties.

Section II. Uses and Disclosures Requiring Authorization

B. We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and healthcare operations, we will obtain an authorization from you before releasing this information. We must obtain an authorization before releasing your medical records.

C. You may revoke all such authorization at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Section III. Uses & Disclosures with Neither Consent nor Authorization

D. We may use or disclose PHI without your consent or authorization in the following circumstances:

a. Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.

b. Adult and Domestic Abuse: If we have reason to suspect that an adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare and Social Services.

c. Health Oversight: The Virginia Board of Medicine has the power, when necessary, to subpoena relevant records should we the focus of an inquiry.

d. Judicial or Administrative Proceedings: If you are involved in a court proceeding and request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether

the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

e. **Serious Threat to Health or Safety:** If we are engaged in our professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death, to an identified or to an unidentified person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

f. **Worker's Compensation:** If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant health information to you, your employer, insurer, or certified rehabilitation provider.

Section IV. Patients Rights & Provider's Duties

E. Patient's Rights

a. **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

b. **Right to Receive Confidential Communication by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (Example: you may request your bill be sent to an alternate address.)

c. **Right to Inspect and Copy** – You have the right to inspect and obtain a copy (or both) of PHI and bill records used to make decisions about you for as long as the PHI is maintained in the record (service charges and copy fees may apply.)

d. **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request.

e. **Right to Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On request, we will discuss with you the detail of the accounting process.

f. **Right to a Paper Copy** – You have the right to obtain a paper copy of this notice from our office/clinic, even if you have agreed to receive the notice electronically.

F. Health Provider's Duties:

a. We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy policies and practices with respect to PHI.

b. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

c. If our policies or procedures are revised, these changes will be posted in the waiting room.

Section V. Questions and Complaints

G. If you have questions about this notice or other concerns about your privacy rights, or if you have a complaint please contact Deborah Farley, 5700 Old Richmond Avenue, Suite D18, Richmond, VA 23226.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Clinic can provide you with the appropriate address upon request.

H. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

Section VI. Effective Date, Restrictions and Changes to Privacy Policy

I. This notice will go into effect November 1, 2010.

J. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by posting this information in the waiting room of the office.