

Annapolis Community Acupuncture, LLC
Patient Registration and Health History Form

Name _____ "Nickname" _____ Veteran Active Duty
Address _____ City _____ State _____ Zip _____
Email: _____ Phone: _____ - _____ - _____
Date of Birth ____/____/____ Occupation: _____ @ _____
Emergency Contact Name: _____ Phone: _____ - _____ - _____
Who told you about us? _____ I have had acupuncture before

The more we know about you, the better we can provide high quality acupuncture designed specifically for your needs. Thank you for completing the information on this form!

Problem 1) _____ Started: _____ Other Treatments: _____
Right Now: (10 = severe): _____/10. Describe: _____
How bad can it get? (10 = severe): _____/10. Describe: _____
I have it _____ hours / day. It interferes with: _____
Gets worse from: _____ Gets better from: _____

Problem 2) _____ Started: _____ Other Treatments: _____
Right Now: (10 = severe): _____/10. Describe: _____
How bad can it get? (10 = severe): _____/10. Describe: _____
I have it _____ hours / day. It interferes with: _____
Gets worse from: _____ Gets better from: _____

Problem 3) _____ Started: _____ Other Treatments: _____
Right Now: (10 = severe): _____/10. Describe: _____
How bad can it get? (10 = severe): _____/10. Describe: _____
I have it _____ hours / day. It interferes with: _____
Gets worse from: _____ Gets better from: _____

Medical Information

Ebola screening: Been to West Africa in last 30 days? Exposed to anyone from there who is sick?
 Flu symptoms? Fever? Unexplained Bleeding? Comments: _____
 Latex Allergy Silicone Allergy Implanted Medical Devices: _____
 Seizures: _____ Doctor (for seizures): _____
 Cancer/Tumor: _____ Doctor (for cancer): _____
 Restrictions on needling arms/legs Lymphedema Fatigue ER/Hospital Visit: _____
 Sleep Apnea/CPAP Insomnia Anxiety ADD ADHD Depression Bi-Polar OCD PTSD
 Diabetes Hypoglycemia Thyroid High Blood Pressure Hepatitis A/B/C HIV/AIDS
Chronic Pain(s): _____ Muscle tightness Cramps/Spasms Restless Legs
Concerned about: Alcohol use Medicine use Smoking Caffeine use Cravings: _____

Please check all that apply to you in the last 30 days:

Pregnant: due: _____ Trying to get pregnant NOT Pregnant PMS Menstrual Menopausal
 Stress Low Energy Level Trouble falling asleep Wake up often Disturbing Dreams
 Sad Worried Grieving Fearful Irritable Overwhelmed Trouble focusing/concentrating
 GERD/Reflux Nausea Vomiting Bloating Gas Constipation Diarrhea Urine problems
 Often sick Weak voice Sore throat Lump in throat Short of Breath Chest tight Wheezing
 Palpitations Chest pain Weakness Fainting Dizziness Night Sweats Hot Flashes
 Allergies Sinus congestion Itching Rash Numbness Tingling Burning
 Medicines: _____

MD: _____ Chiropractor: _____ PT: _____ Massage: _____

*Signature: _____ Date: _____

Annapolis Community Acupuncture, LLC
Acupuncture Information and Informed Consent for Treatment

I, _____, voluntarily consent to acupuncture services provided by Annapolis Community Acupuncture, LLC. Acupuncture involves the insertion of sterile, single-use, disposable needles through the skin in specific locations. I may also be treated with heat applied to the skin. While side effects are rare, they may include local bruising, slight bleeding, temporary pain or discomfort, fainting, infection, burns, broken needles, pneumothorax (collapsed lung) and spontaneous miscarriage. **About 15% of people experience a temporary worsening of their condition or a flare-up of old conditions following their first few treatments. This is known as a “healing reaction” and it is a normal part of getting better.** Infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my acupuncturist follows universally prescribed precautions and procedures to prevent the spread of infectious disease.

I understand that each person is unique and each has ultimate responsibility for his/her own healthcare. **I agree to inform my acupuncturist about my medical conditions, medications, and any changes that occur during the course of treatment (including pregnancy and suspected pregnancy). I agree to contact my acupuncturist immediately if I experience any problem which I associate with the acupuncture services provided.** If I experience a medical emergency, a worsening of my health condition, or a new condition arises, I will consult a licensed physician, or seek medical treatment.

I understand that my practitioner is a Licensed Acupuncturist in Maryland, not a licensed physician, and does not provide primary medical care. My acupuncturist will not suggest that I discontinue medical treatment, and may request that I have a consultation with and/or physical examination by a licensed physician.

I have had the opportunity to ask my acupuncturist questions regarding the proposed acupuncture services, this consent form, and other pertinent information, including any questions about my practitioner’s education and experience, and I have received a satisfactory explanation.

I understand the acupuncture services provided at Annapolis Community Acupuncture, LLC, and the fees. Annapolis Community Acupuncture, LLC does not bill insurance. Upon request, they will provide me with a receipt which I can submit to my insurance.

Community Acupuncture Services are treatments designed specifically for my needs provided in a group setting. The fee is a sliding scale of \$15.00 to \$40.00 per treatment, plus a one-time additional fee of \$10.00 for the initial evaluation. **I decide what I can afford, and no income verification is performed. I understand that what I pay never affects the care I receive.** Appointments strongly recommended. I understand that all appointments that are cancelled with less than 24 hours advance notice and appointments missed without notice will be charged the cancellation fee of \$15.00.

I understand that when I select Community Acupuncture provided in a group setting, conversations in the group room may be overheard. If I wish to discuss a sensitive issue, a private room is available for discussion. I understand that if I need to have a detailed discussion about my medical history, we may need to schedule this separately by phone.

I understand that Annapolis Community Acupuncture, LLC will not contact my physician without my written consent. I give my consent to inform my physician _____ that I am receiving acupuncture.

I understand that Annapolis Community Acupuncture, LLC will record medical & other information concerning my treatment, and that my health information will be used & disclosed consistent with the Notice of Privacy Practices. I permit a copy of this authorization to be used in place of the original. This authorization is not intended to allow the release of my treatment records, which require a restricted release under State or Federal Law.

I have read and understand all the information on this form. I acknowledge that I have not received any guarantees or promises of results from these services, and I understand that I am free to discontinue services at any time.

I have received a copy of the Notice of Privacy Practices (attached to the Patient Registration / Health History form). I am aware that this form is also displayed on the waiting room desk and may be accessed in the FAQ section on the clinic’s website.

*Patient’s Printed Name _____

*Patient’s Signature _____ Date _____

The undersigned represents that he or she is the parent or legal guardian of the minor named above, and represents that he or she has the legal authority to sign this consent and authorize acupuncture treatment.

*Parent’s Signature _____ Date _____

*Witness Signature _____ Date _____

Annapolis Community Acupuncture, LLC

17 N. Southwood Avenue, Annapolis, MD 21401

AnnapolisCommunityAcupuncture.com

443-951-1575

NOTICE OF PRIVACY PRACTICES

We are dedicated to providing service with respect to human dignity and to your privacy. This notice describes how health information about you may be used and disclosed, and how you can get access to your health information.

I. Understanding your Health Record / Information

Each time you visit us, a record of your visit is made. This record may include your health history, symptoms, examination, diagnoses, plan of care, treatments, advice provided, and referrals made to other healthcare providers. This information is maintained in your health record, and it serves as a:

- a) basis for planning your care and treatment;
- b) means of communication among health professionals who contribute to your care;
- c) legal document describing the care you received;
- d) means by which you or another person can verify that services billed were actually provided;
- e) source of information for program planning and community education;
- f) tool for educating our acupuncturists and continually improving the care we provide and the outcomes we achieve; and
- g) source of information for medical research and for public health officials charged with improving the nation's health.

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

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

II. Your Health Information Rights

Although your health record is the property of Annapolis Community Acupuncture LLC, the information in it belongs to you. You have the right to:

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

III. Our Responsibilities

Annapolis Community Acupuncture, LLC is required to:

- a) maintain the privacy of your health information;
- b) provide you with a notice of our 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; and
- e) accommodate reasonable requests by you to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization, except as described in this notice. 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 email a revised notice to the e-mail address you supply to us, or mail a copy to the address supplied.

IV. For More Information or to Report a Problem

If you have questions and would like additional information, ask your practitioner for clarification. If your questions require lengthy answers, it may be necessary for your practitioner to call you later that day to answer your questions. If you believe your privacy rights have been violated, you can file a complaint with us and/or the U.S. Secretary of Health and Human Services' Office for Civil Rights, with no fear of retaliation by this clinic or its staff.

Annapolis Community Acupuncture, LLC

17 N. Southwood Avenue

Annapolis, MD 21401 443-951-1575

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201 OCR Hotlines – Voice: 1-800-368-1019

V. Examples of Disclosures

Needless to say, we will disclose your protected health information with you. For example, we may contact you as a reminder that you have an appointment, to recommend possible treatment options, or share other health-related information that might be of interest to you.

Your health record will be used:

- a) to provide treatment to you;
- b) to make referrals for other recommended services;
- c) for documentation of services rendered to you, for you to obtain reimbursement of payments to Annapolis Community Acupuncture, LLC; and for
- d) quality monitoring.

Your consent, or the opportunity to agree or object, is not required in these instances:

- a) **Treatment and Referrals:** Your acupuncturist will obtain and enter health information into your health record, and use that information to develop your plan of care. Your acupuncturist will document your response to treatment, and any referrals to other health care providers.
- b) **Payment for Services Provided:** Your health record will be used to receive payment for services provided by us. Payment is expected at the time of service, by cash, check, or major credit card. While we do not bill insurance, we will (upon request) provide you with a receipt that you can submit to insurance or a health savings / flexible spending account. The information on the receipt may include information that identifies you, your symptoms, and diagnoses.
- c) **Quality Monitoring:** We will use your health information to assess the care you received, the outcome of your care, and compare the outcomes of your care to others' outcomes. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law, and do not require your consent:

- a) **Food and Drug Administration (FDA):** This clinic is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- b) **Worker's Compensation:** This clinic will release information to the extent authorized by law in matters of worker's compensation, or other similar programs, as required by law.
- c) **Public Health:** This clinic is required by law to disclose health information to public health and / or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury or disability, or to comply with mandated reporting requirements for tracking of birth or morbidity.
- d) **Law Enforcement:** As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: 1) in response to a valid subpoena; 2) in the event that a staff member or business associate of this clinic believes in good faith that a patient, staff member, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; 3) when a patient is a suspected victim of abuse, neglect, or domestic violence.

It is this clinic's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, this clinic will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- ❖ **Professional Associates:** Some or all of your health information may be subject to disclosure through contracts for professional services (Acupuncture services for Hospice of the Chesapeake patients only) to assist this clinic in providing health care to you. To protect your health information, we require these Professional Associates to appropriately safeguard your health information, by following the same standards held by this clinic, through terms detailed in a written agreement.
- ❖ **Communications with Family:** We may use or disclose information by notifying the person identified by you on your Health History Questionnaire or other paperwork as your emergency contact. They may be given information to confirm your whereabouts, or general information to enhance your well-being in case of an emergency.
- ❖ **Educational Materials:** The clinic may send information to you about treatment alternatives and other health-related information that you may find helpful. Persons contacting you will know only that you have been a patient, but they have no access to your health records.