CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: ______________________________/__________________________/_________
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____________ Age: ______Date of Birth: __________ S.S.#: _________________

Address:____/____________/___/ _______
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)__________/_(____)_______________/_(____)____________________
(home) (work) (cell phone or other)

E-mail address: ______________________________________Gender: female _____male _____

Are you (check one): ___Single__ Married ___ Other Partner's Name: ________________

Occupation:_____________________________ Full time Part time Student Retired

Employer / School: ____

Address: ________________________________/_________________/____/________________
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact ____
(Name) (Relationship)

_(_____)_____________________________________(_____)_______________________
(Cell Phone) (Home Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? ___________________

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May we send you educational/promotional materials such as newsletters via e-mail? Yes No
May we discuss your private medical information with you via e-mail? Yes No

Insurance Information – Please provide copy of front and back of Insurance card.

Group Insurance: Insurance Co: ____

Insured Full Legal Name: ______________________________________ Date of Birth: ___/___/___

Insured's Address:______________________/__________/_____/_________/(____)__________
(street / PO Box) (City) (State) (Zip Code) (Phone Number)

MVA: Date of MVA: __________ State MVA occurred: ______ Claim number: _____________

Insurance Co: ____________ Claim submitted Y N Adjuster: ________ Phone: (_____)________

Attorney's Name: ________________ Phone: (__) ___________ PIP Coverage: _____________

Do you have any secondary or additional Insurance plans? Yes No Name: ____________

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient ____ Today's Date____________

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________ Birthdate: ________ Date: ______

What are the concerns for which you are seeking care? (Primary concern first)

1. ______________________________Date of onset: __________
2. ______________________________Date of onset: __________
3. ______________________________Date of onset: __________
4. ______________________________Date of onset: __________

Who is your primary care physician? ______________________________
(Name) (Phone if known)

For what concern did you last receive health or medical care? ______________________

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? ______________________________

____

____

Check each that you currently use:

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Heart/Blood medication	Allergy Medication	Thyroid medication
Sleeping pills	Anti-depressants	Birth Control Pills	Hormones

Do you have any known contagious diseases at this time? Yes No If yes, what?__________

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer __________	Diabetes __________	Epilepsy __________
Heart Disease __________	High Blood Pressure __________	Stroke __________
Anemia __________	Kidney Disease __________	Glaucoma __________
Allergies __________	Asthma __________	Mental Illness __________
Arthritis __________	Tuberculosis __________	Alzheimer's Dz __________

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(360) 841-7558
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Name: ______________________________ Birthdate: ______________ Date: __________________

Have you have any of the following Childhood Illnesses (check if yes)

_____Scarlet fever _____Diphtheria ___Rheumatic fever ___Mumps __Measles ____German measles

Have you had any immunizations? Yes No Negative Reactions? ___________________________

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitalizations, surgeries, x-rays, or special studies have you had?

_____________________________year: _________ ____________________ year: __________

_____________________________year: ____________________________________year: __________

_____________________________year: _________ ____________________ year: __________

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

____

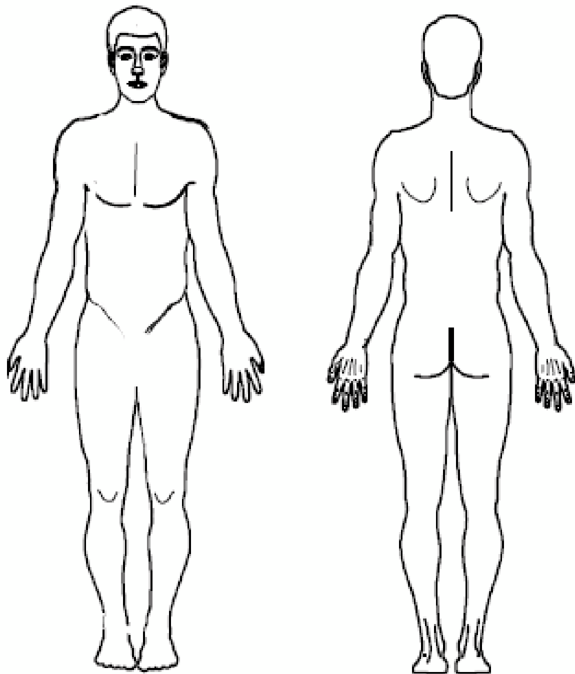
General

Weight _____________lbs. Height __________________Weight 1 year ago ___lbs.
Maximum (non pregnant) Weight _____________lbs. When ______________________

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? _______________
___Exercise, what kind? _________________
How often do you exercise? _______________
__Y __N Have a religious/spiritual practice
__Y __N Average 6-8 hrs. of sleep
__Y __N Have a supportive relationship
__Y __N History of abuse
__Y __N Major traumas
__Y __N Use recreational drugs
__Y __N Treated for drug dependence
__Y __N Drink coffee
__Y __N Drink black or green tea
__Y __N Drink cola or other sodas
__Y __N Add salt to your food
__Y __N Eat refined sugar
__Y __N Enjoy your work
__Y __N Take vacations
__Y __N Spend time outside
__Y __N Watch TV? How much? _______
__Y __N Read? How often? ___________
__Y __N Use alcoholic beverages
per week _____
__Y __N Treated for alcoholism
__Y __N Use tobacco currently
__Y __N Used tobacco in the past
How many years? ____How many packs per day?__

1) **Unless prior arrangement is made, full payment is due at the time of service.**

   Your payment options are: cash, check, or credit/debit cards.

2) Insurance Billing

   - If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
   - You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
   - **If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.**
   - Insurance companies may reimburse differently than the information they initially provide to us.
   - **You are responsible for and will be billed for any resulting unpaid balance.**

3) Missed Appointments/Late Cancellations
   All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged $75 for the missed appointment.**

4) The office provides reminder calls as a courtesy. You are responsible for remembering your appointment.

5) Past Due Accounts
   Accounts greater than 30 days past due will be charge a $10 administrative fee.
   Accounts greater than 90 days overdue will be sent to a collections agency.

6) The office provides non-emergency phone consultation. The fee is $75.00 for first 30 minutes. After hours consults incur an additional $35.00 fee.

These policies are subject to change without notice.
We also post our financial policy at www.Best-Acupuncture.com

I have read, understood and agree to the policies described above:

Print Name:________________________________Sign:________________________________Date:____________

Birthdate:

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Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Acupuncture Medical Clinic and www.Best-Acupuncture.com and you may obtain one at any time. This Notice goes into effect November 1, 2011.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Kim Blaufuss, L.Ac.. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.
Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact the clinic. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.
Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Kim Blaufuss, L.Ac. and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.
Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Kim Blaufuss, L.Ac. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.
Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.
Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.
Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Kim Blaufuss, L.Ac. to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Birthdate:
Patient Name (Please print)____

Patient/Guardian Signature_______________________________________Date_________________

Relationship to Patient (if other than self):____

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

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