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**_____

Kim Blaufuss, EAMP, Dipl Ac
(360) 841-7558
Woodland, WA 98674

www.Best-Acupuncture.com Kblaufuss@Best-Acupuncture.com

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

Kim Blaufuss, EAMP, Dipl Ac
(360) 841-7558
PO Box 976, Woodland, WA 98674

www.Best-Acupuncture.com
Kblaufuss@Best-Acupuncture.com

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:

_____

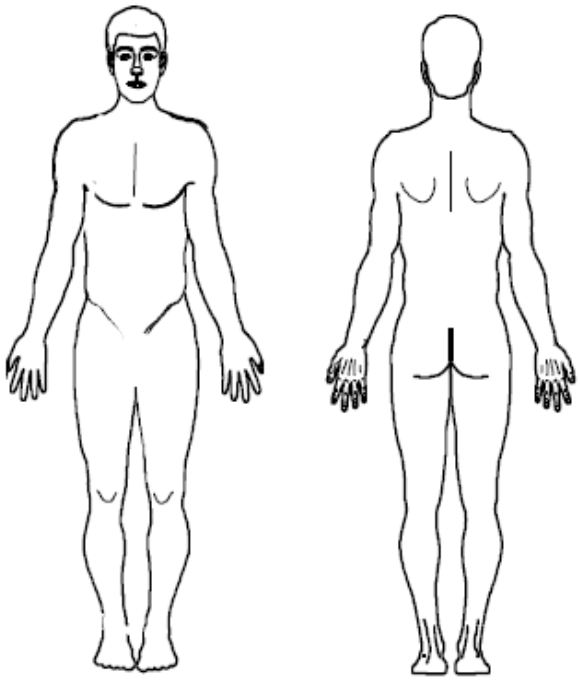
General

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?__

Kim Blaufuss, EAMP, Dipl Ac
(360) 841-7558
Woodland, WA 98674

www.Best-Acupuncture.com
Kblaufuss@Best-Acupuncture.com

FINANCIAL POLICIES

1) **Payments**

   - 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 $55 for the missed appointment.** *(this policy is inline with the Vancouver Clinic and other healthcare providers in the area).*
   - *Clients who receive three late cancellations (less than 24 hours' notice) or no-shows will no longer be scheduled for future appointments.*
   - Services are provided with the understanding that a credit card is kept on file for all incurred charges.

4) 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 may be sent to a collections agency.

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:

Kim Blaufuss, EAMP, Dipl Ac
(360) 841-7558
Woodland, WA 98674

www.Best-Acupuncture.com
Kblaufuss@Best-Acupuncture.com

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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.

Kim Blaufuss, EAMP, Dipl Ac
(360) 841-7558
Woodland, WA 98674

www.Best-Acupuncture.com
Kblaufuss@Best-Acupuncture.com

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.

Patient Name (Please print)_____ Birthdate:

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.

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

.

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

ASSIGNMENT OF BENEFITS FORM

DATE:

PATIENT:

INSURANCE COMPANY:

MEMBER ID:

I hereby instruct and direct the above insurance company to pay be check made out and mailed to or electronic transfer of funds with electronic EOB sent to:

Best Acupuncture, llc
566 Goerig St.
Woodland, WA 98674

For the professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney on my behalf.

DATE:

Signed:

Printed Name:

Witness