New Patient information

China Acupuncture Health Center

175 Littleton Rd. Unit 6, Westford, MA 01886. Phone: (978) 692-8889

NAME: _____D.O.B._____ / _____ / _____
First middle initial last

AGE: _____ SEX: _____ MARITAL STATUS: _____HOME PHONE: _____

HOME ADD: _____
Street city state zip code

EMPLOYER:_____ OCCUPATION: _____ WORK PHONE: _____

WHERE COULD WE LEAVE A MESSAGE IN CASE WE NEED TO CONTACT YOU: HOME _____ OFFIC_____

OR CELLPHONE: _____ YOUR CELL PHONE NUMBER: _____

YOUR PCP NAME: _____ PHONE: _____

REFERED BY: _____FROM YELLOW PAGE:_____ FROM INTERNET: _____AD:_____

IN CASE OF EMERGENCY CONTACT: _____PHONE:_____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. You may release any information you deem appropriate, concerning my physical condition, to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at this office.
2. In the event an insurance company, obligated by contractual agreement to make payment to me or to your office refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. It is understood, however, that you will refrain from attempts and efforts to collect the amounts owed directly from me until all reasonable efforts have been made to collect payment due from the insurance company. I understand that I personally owe you whatever amounts, whether they be all or part of what is due, you do not collect from insurance proceeds.

Signed: _____ **Date:** _____ / _____ / _____
Type your name here as signature

CLIENT RESPONSIBILITY

I understand that Acupuncture Is a system of medicine based on Traditional Oriental Principles, and is not meant to replace Western medical treatment, should the case warrant it. I further understand that any Western medical diagnosis of my condition must be performed by a licensed physician, and that I shall be advised to seek more appropriate treatment when it indicated. I assume full responsibility for consulting with the appropriate physician, if this is necessary. I understand that no claims are being made about curing my condition. I hereby certify that the information I have provided is true and complete to the best of my knowledge, In addition I will advise my acupuncturist of any changes in my medical condition, address, work status, and I realize that it is my responsibility to pay for all services rendered.

24 hour cancellation notice required otherwise I will be charged $30 for late cancellation, $95 for a missed appointment.

Signed: _____ Date: _____ / _____ / _____
Type your name here as signature

Name:_____ Wt.:_____ Ht:_____ Today's Date: _____

Your chief medical problem (the reason for your coming to clinic):

_____

_____

How long ago did this problem begin (be specific)? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

_____

Have you seen your physician for this problem? Yes _____ No _____

Have you been given a diagnosis for this problem? If so what? _____

What kinds of treatment have you tried? _____

Have you used acupuncture treatment or Chinese medicine before? Yes ___ No ___

Names of all drugs or medicines you are now taking: _____

_____

Allergies:(drugs, chemicals, food, other)_____

_____

Significant illness: Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever Thyroid Disease Seizures Venereal Disease AIDS Other Illness (specify):

_____

Significant trauma:(auto accidents, falls, etc.): _____

_____

Your blood pressure:_____

Past medical history (please include date): _____

Hospitalization, Surgeries (include date): _____

Do you smoke? Yes___ No___ Estimated amount: _____

Do you drink alcoholic? Yes___ No___ Estimated amount:_____

Family medical history: Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma Allergies: _____

Notice of Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Understanding your acupuncture health record information

Each time you visit China Acupuncture Health Center, a record is made of your visit. The records are kept safely, only the acupuncturists have the access to them. Typically this record contains your health history, current symptoms, examination results, oriental medicine diagnosis and treatment plans. This information serves as:

1. A basis for planning your care and treatment.
2. A legal document describing the care you received, written in a format appropriate to Acupuncture and Chinese Herbal Medicine.
3. A tool to assess the appropriateness and quality of the care you received.

Your rights under the Federal Privacy Standard

Although your health record is the physical property of China Acupuncture Health Center, you have certain rights with regard to the information contained therein. You have the right to:

1. Request restrictions on the use and disclosure of your health information for treatment, payment, and health care operations. Health care operations consists of activities necessary to carry out the operations of our clinic such as quality assurance, peer review, and education. This right does not include those required by law, for example mandatory reporting of communicable diseases like tuberculosis.
2. You may ask us to communicate with you by alternative means and, if the method is reasonable, we must grant the request.
3. You have a right to receive and keep a copy of this notice of information practices. If you do request a copy, the law requires us to ask you to acknowledge receipt of your copy.
4. You have the right to inspect and copy your health information upon request.
5. You have the right to request a correction of your health information unless we did not create the record or if the record is accurate and complete.
6. You have the right to revoke authorization to use or disclose your health information at any time.

With the regulatory consent granted by the Health and Human Services Department we may use or disclose your health information for treatment, payment and operations. For example:

1. China Acupuncture Health Center can use your personal health information to diagnose, plan and implement the best course of treatment for you. China Acupuncture Health Center may also use you health information to receive payment from a third party payer, for example Workers Compensation, if applicable and appropriate.

Our responsibility under the Federal Privacy Standard

In addition to providing you your rights, the federal privacy standard requires us to:

1. Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
2. Provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
3. Abide by the terms of this notice.
4. Lessen the harm of any breach of privacy or confidentiality.

If you feel your rights as outlined in this notice have been violated, you have the right to file a complaint with Security and Privacy Officer.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF INFORMATION PRACTICES

I, _____, have read the China Acupuncture Health Center's Notice of Information Practices

Patient's signature _____
Type your name here as signature

Date _____

INFORMED CONSENT

China Acupuncture Health Center
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1. I hereby authorize Joy Yue Zhang, Lic.Ac. to perform acupuncture today. The nature, extent and purpose of the procedure has been fully explained to me. I understand the treatment may involve some risk, which includes slight bleeding, bruising, and localized pain. Any prior questions have been answered to my satisfaction.

2. In addition to the Insertion of needles, acupuncture therapy may consist of another method of treatment which is called “cupping”. With this type of treatment, suction is applied to the skin surface causing a local congestion. The suction draws up the underlying tissues and forms blood stasis. During the treatment, you may feel a pulling sensation. Cupping often leaves a purplish mark that will disappear in several days.

3. A Chinese massage technique called "gwa sha" may be used in certain cases. This procedure produces a deep redness of the skin which usually remains for approximately 3 - 5 days. For some people, a slight bruising and tenderness may persist for few hours following treatment.

4. In some cases, electrical stimulation of the needles may be indicated. This procedure involves the use of a small, battery powered electrical stimulator, which is attached with wires to the ends of the needles after they have been inserted. A slight vibratory sensation may be felt during stimulation.

I hereby certify that I have read the above information, and have discussed all questions related to my treatment and the above procedures with the attending staff.

NAME:_____
Type your name here as signature

DATE:_____