Acupuncture Patient Intake Form

Name:____ **Date**:__________

Address:____
City/State:____ **Zip**:________________
Phone: Home(   )________________ Cell(   )_______________ Work(   )_____________
Email:____ **Date of Birth**:______________
Height: __________ **Weight**:___ **Career**:___________________________________

Reason for visit:____
Referred by:____
Have you had acupuncture before?___ With whom?_________________________________
Single:__ Married:__ Divorced: __ Widowed:__ Sig. Other:____

Family History:	Self	Mother	Father	Sibling
Cancer or tumors				
Diabetes				
Bleeding disorders or anemia				
Seizures				
High Blood Pressure/Heart Disease				
Allergies				
Stroke				
Drug Abuse				
Depression or Mental Illness				
Age of Death				
Hepatitis				
Kidney Disorder				
Thyroid Disorder				
Musculoskeletal Disorder				

List Current Medicines:	Dose:	Reason taking:

Major Hospitalizations: Please list only serious medical illness or operation/s

Year	Operation/Illness

Date of last physical exam:____________________

Name & phone number of physician:______________________________

____

Describe Current Diet:

____

____

____

Please Check Off All That Applies:

Emotions:

__sadness __joy __anger __worry __ fear

__ highly stressed __moderately stressed __ low stress

____

____

Temperature:

__neither hot nor cold

__alternating hot/cold

Cold: __hands __feet __nose __center __all over

Hot: __palms __feet __whole face __cheeks __all over

____

Sweat:

___no ___yes: __day ____# of times ___profuse sweat ___mild perspiration

__night ___# of times ___profuse sweat ___mild perspiration

____

Energy:

__ high __ low __ moderate __up and down

____

Sleep:

___# of hours on average __wake throughout the night __# of times

__difficulty falling asleep __vivid dreams __nightmares __talking in sleep

____

____

Digestion:
__gas __bloating __acid reflux __bitter taste in mouth __stomach upset
_____# of bowel movements a day: __well formed __constipation __diarrhea

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Cravings:
__sweet __sour __salt __spicy How frequent? ________________________

Thirst:
__dry mouth __drink water just because you know its healthy __crave cold drinks

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Urination:
__no problems with urination __problems with urination
__times per day __wake to urinate __# of times at night __incontinence
__burning urination __pain with urination __frequent urination
__feelings of incompletely emptying the bladder

Lifestyle/Exercise:
__alcohol __cigarettes __coffee __tea; frequency________________________
__cardio; how many hours per week________________________
__weights; how many hours per week________________________

Pain:________________________

Menstruation: ___Age of first period ________date of your last menstrual period
_____number of days bleed ___clots ___PMS __breast tenderness __cramps
___regular cycle ___irregular cycle _____number of days cycles are

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Menopause:
________date began________________________

Office Policy

We will be open and honest with you when answering any questions during your exam and treatments in our office. Our personalized treatment plans are recommendations for your care, which you have the option of following. Inability to follow our recommendations or failure to commit to the plan by missing appointments may jeopardize the expected results we are trying to achieve. Everybody responds differently to care, so treatment plans will progress as you do. With your dedication to care, we can accomplish our goals and restore your health at a greater pace. We advise you to ask any questions regarding your treatment plan and be patient while this restructuring process occurs.

We ask you read and adhere to the following policies. Should you have any questions regarding these policies please address them to the office manager.

Initial _______ 1. Patients are required to complete all necessary paperwork prior to treatment.

Initial _______2. **Changes or cancellations of appointments require 24 hour advance notice to avoid being charged 100% of the services scheduled.** This includes appointments for the doctor, Physical Therapy, Acupuncture, Nutrition or Massage Therapy Departments. Please notify the office as soon as possible to reschedule any appointments.

Initial _______3. **Insurance:**
Patients with insurance will be asked to pay their deductible and/or Co-payments, if they are due, at the time of their visits.

We inform our patients of insurance coverage's as we know them, but it is the patients' responsibility to confirm their own coverage and to know what their insurance plan provides. Our office will submit your insurance for you as a complementary service.

Initial _______ 4. **Patient account balances:**
Patients will be responsible for payment of all charges incurred. This includes payment for all treatments rendered without regard to coverage's under their insurance plans or Medicare coverage. If patient has insurance, they are responsible for all balances remaining after payments have been made by their insurance company.

Initial _______ 5. **Return Policy:**
Any and all products or services purchased from this office, Pure Health and Wellnesses, or Hunter Family Chiropractic, are non-refundable. All Sales are final. No refunds, credits, or exchanges will be issued.

With my initials above I confirm I have read and fully understand each item and by my signature below I agree to the terms as stated above.

____Signature _____________Date

The Process of Therapeutic Activities

Participating in therapeutic activities can result ina number of benefits to you, including neurological, musculoskeletal, visceral, and emotional changes. Working towards these benefits, however, requires effort and can result in discomfort. Change will sometimes be easy and quick, and sometimes will be slow and frustrating. It is also possible that there may be times when treatment produces no discernable benefits or change.

- *Bruising, tenderness, and discoloration may occur in some cases. Post treatment stiffness, tenderness, or numbness at the needle location can be present, but typically abates within hours of treatment to a few days at most.*

- *One out of five or six patients will have emotional reactions. These are sometimes associated with remembering the feelings from the time of the traumas that are being moved out of the tissues. This can simply be exact memories about the details of the trauma incidents, to the more rare (and severe) reactions that are reliving some traumatic event (less than one out of fifty emotional reactions). Remember that these emotional reactions may happen with any treatment.*

Consent for treatment

I, ______________________________________, agree to enter therapeutic treatment with Anna Nazos Licensed Acupuncturist, Certified Herbalist, and I authorize and request that Anna Nazos LAc CH carry out an oriental medical examination and treatment procedures which now or during the course of my care as a patient, are explained to me. My signature here attests to the fact that I have read, understand, asked any relevant questions and agree to abide by the points presented above.

Patient Signature ________________________________Date__________

Practitioner Signature ____________________________Date__________

Request Amendment

You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate, as provided for in 45 CFR 164.524. You must make this request in writing to our office, stating exactly what information is inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy
- The information is not part of the designated record kept by this practice.
- If it is the opinion of the doctor or provider that the information is accurate or complete.

Request Restrictions

You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations.

For example – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care. Your request must be made in writing to our office.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures

You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications

You have the right to request how we communicate with you to preserve your privacy. *For example* - you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manger, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our office c/o Justin T. Hunter D.C., 3540 Seven Bridges Dr., Suite 130, Woodridge, IL. 60517. You should know there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

Please Sign Below

X____________________________________

Your Signature indicates you have read and fully understand this document. If you have questions or would like additional information, you may contact us at (630) 435-0100.

NOTICE OF PRIVACY PRACTICES

Justin T. Hunter, D.C.

Pure Health & Wellness
Div. Hunter Family Chiropractic
3540 Seven Bridges Drive, Suite 130
Woodridge, IL. 60517

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we ay use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Information:

Pure Health and Wellness a Division of Hunter Family Chiropractic is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes your rights as they relate to your protected health information. This Notice is effective April 2003, and applied to all protected health information as defined by federal regulations.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For Example* – we would disclose your health information to a specialist to whom we have referred you to for additional treatment.

Payment

We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed and supplies used in rendering the service.

Health Care Operations

We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associate that perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders

We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatments

Laboratory Results

We will use and disclose your protected health information to contact you either by phone or mail to notify you of findings.

Others Involved In Your Care

We will use and disclose your protected health information to a family member, relative, close personal friend, or any other person you identify, that is involved in your medical care or payment related to your care.

Research

We will use and disclose your protected health information to researches provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law

We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Public Health and Safety

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Worker's Compensation

We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Law Enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Food and Drug Administration (FDA)

We may disclose to the FDA health information related to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

Marketing and Fund Raising

We may contact you to relay information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you as part of a fund-raising effort.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice

You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy

You have the right to inspect and copy the protected health information that we maintain in our designated record for as long as we maintain that information. This designated record includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to Dr. Justin Hunter, Pure Health and Wellness, 3540 Seven Bridges Dr., Suite 130, Woodridge, IL. 60517. We will have 30 days to respond to your request for information we maintain at our site and we are allowed 60 days to respond should information be stored off-site, but we must inform you of this delay.