

ELEMENT Acupuncture Health Center

PATIENT INFORMATION (Please Print and complete in full) New Patient Established Patient

Name: _____ Today's Date: _____

Address: _____

_____ ZIP _____

Home Telephone #: _____ Work Telephone #: _____

Cell# _____

Would you like to be contacted by email with informational newsletters and special clinic offers?

If Yes Email Address: _____ No

Patient Status: Married Single Divorced Widowed Other _____

Birth Date: _____ Age: _____

Referred to our Clinic By: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #: _____

Employment/School Status:

Full Time Part Time Retired Unemployed Student

Occupation: _____

Employer's Name: _____ Telephone #: _____

Employer's Address: _____

Primary Health care source

Physician's Name: _____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

Date of Injury or Onset of Illness: _____

Medical Insurance status:

Self Private Insurance Medi -Cal Worker's Comp Other _____

ELEMENT Acupuncture Health Center - Initial Health History Form

Patient Name: _____ date: _____

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for a medical condition? Please describe

Please briefly describe any chronic pain:

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue?

Do you have other health concerns?

Please describe the type of foods you eat regularly:

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

Do you exercise regularly? Yes No

What type of exercise do you do?

ELEMENT Acupuncture Health Center - Initial Health History Form

Patient Name: _____ date: _____

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box:

	self	mother	father	sister	brother	spouse	child
allergies							
blood disorder							
diabetes							
cancers or tumors							
seizures							
high blood pressure							
kidney or bladder disorder							
stomach or intestinal disorder							
drug abuse							
tuberculosis							
heart disease							
stroke							
depression							
mental illness							

MAJOR HOSPITALIZATIONS - If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

year	operation or illness	name of hospital	city & state

PREVIOUS PREGNANCIES:

Total Pregnancies ___ Living ___ Ectopic ___ Miscariages ___ Induced Abortions ___

MEDICINES - Mark an X in the box next to any of the following that you are now taking:

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Diet pills |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Fiber supplements |
| <input type="checkbox"/> Insulin, diabetic pills | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Hay fever tablets |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Blood pressure pills |
| <input type="checkbox"/> Cold tablets | <input type="checkbox"/> Blood thinning pills |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> OTHER: _____ |

vitamins (please list) _____

herbs (please list) _____

DRUG ALLERGIES _____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Coffee yes no cups per day/week ___ age started ___ age quit ___

Tobacco yes no # cigarettes per day ___ age started ___ age quit ___

Marijuana yes no use per day/week ___ age started ___ age quit ___

Alcohol yes no use per day/week ___ age started ___ age quit ___

Other _____

ELEMENT Acupuncture Health Center

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ Give Consent to ELEMENT Acupuncture Health Center the use and disclosure of my individual identifiable health information or Protected Health Information for the specific purposes:

- A. Providing treatment to me;
- B. Relating to the payment of the services this office has rendered to me; and
- C. The general administrative operation this practice provides to me

The purpose of this consent:

Protected Health Information is any information that includes:

- A. Demographic information
- B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition.
- C. Information gathered by this office for past, present or future payments for providing the healthcare services.
- D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my protected Health Information for the purposes of treatment; payment of healthcare operation of the Acupuncture practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time except to the extent that ELEMENT Acupuncture Health Center has acted in reliance on this consent.

_____ Date _____
Signature of Patient or Personal Representative

_____ Date _____
Description of Personal Representative's Authority

ELEMENT Acupuncture Health Center

Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$15 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature _____ Date _____