Notice of Privacy Practices

This notice describes our office policy for how medical or financial information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share personal medical and/or financial information with your insurance company, third party payer, Worker's Compensation (and your employer in this instance), other healthcare practitioners, or with anyone that you authorize.

Types of information that we gather and use:

- Financial information includes your insurance coverage, out of pocket costs, or personal financial arrangement with Point of Healing Acupuncture.
- Medical information includes health history, treatment notes, test results, and any letters, emails or telephone conversations with other health care practitioners.
- From health care providers, insurance companies, workman's compensation and your employer, and other third party administrators (requests for medical records, claim payments information).

Types of disclosure:

The following are examples of the types of disclosures that Point of Healing Acupuncture is permitted to make without specific written consent:

- Medical emergency while at Point of Healing Acupuncture office.
- Mandated reporting by Massachusetts law.
- Judicial or administrative proceeding in response to a legal order or other lawful process, including subpoena.

Otherwise, your personal information will only be disclosed after the Authorization for Disclosure of Health/ Financial Information Form is signed by you, your guardian, or authorized agent. Upon request, Point of Healing Acupuncture will obtain personal information about you only after the Authorization to Obtain Health Information Form is signed by you, your guardian, or authorized agent.

You have the right to review and obtain a copy of your records at Point of Healing Acupuncture. You have the right to amend or modify your records if you believe they are inaccurate or incomplete. All requests must be in writing and will be granted if reasonable and appropriate.

Types of communication that we use:

- Telephone, voicemail messages, and texting
- Email
- Letters and fax

Safeguards in our office to protect your personal information include:

- Limited access to the office where information is stored.
- Secured network for credit/debit card processing.
- Computer password protection.
- Any business associate of Point of Healing Acupuncture that may have access to patient's personal information is required to sign a business agreement. Business associates include any legal firm, accountant, consultant, billing service, volunteers/assistants or other person that may have access to patient's personal information.
- All medical files and records (including telephone, letters, email, and faxes) are stored according to Massachusetts law.
- Telephone voicemail and texting messages will include as minimal information as possible.
- Each fax and email will include a confidentiality statement.

Point of Healing Acupuncture values our relationship and respects your right to privacy. If you have any questions about our privacy practices, please ask.

Consent to the Use & Disclosure of Health Information for Treatment, Payment and Health Care Operations Form

I consent to the use or disclosure of my identifiable health information by Point of Healing Acupuncture for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis and treatment of me at Point of Healing Acupuncture may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. If Point of Healing Acupuncture agrees to a restriction that I request, the restriction is binding upon Point of Healing Acupuncture.

I have the right to revoke this consent, in writing, at any time except to the extent that Point of Healing Acupuncture has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I received and reviewed Point of Healing Acupuncture Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Point of Healing Acupuncture. This Notice of Privacy Practices also describes my rights and the duties of my practitioner(s) with respect to my identifiable health information.

Point of Healing Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices during any office visit. If any changes are made to the Notice of Privacy Practices, the new version will be posted in the office for a period of at least one month.

By voluntarily signing below, I have carefully read or have had read to me, the above consent for purposes of treatment, payment, and health care operations. I understand my rights to change this consent at any time.

Patient Signature (or guardian):	Date:

Consent to Treatment Form

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 for whom I am legally responsible) by the licensed acupuncturists at Point of Healing Acupuncture who now or in the future treat me while employed by, working with, or serving as back-up at Point of Healing Acupuncture.

I understand that methods of treatment may include, but are not limited to acupuncture, dermal needling, moxibustion, heat lamp therapy, cupping, gwa sha, electrical stimulation, tui-na massage, and sotai exercises. I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body. I understand that acupuncture is generally a safe method of treatment but it may have side effects including, but are not limited to: bruising, numbness, tingling, minor bleeding, dizziness, fainting, pain, discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Bruising is a common side effect of cupping and gwa sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture including the lungs (pneumothorax), and infection. Unusual risks of electrical acupuncture include electrical shock, pain, discomfort, and the possible aggravation of symptoms existing prior to treatment. Burns and/or scarring are potential risks of moxibustion, heat lamps, cupping, and gwa sha.

I understand that Point of Healing Acupuncture staff may review my patient records and laboratory reports, but all my records will be kept confidential and will not be released without my written consent unless permitted to do so in the Notice of Privacy Practices Policy. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

By voluntarily signing below, I have carefully read or have had read to me, the above consent to treatment. I have been informed about the risks and benefits of acupuncture and other procedures. I had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I give my permission and consent to treatment.

Patient Signature (or guardian):	Date:

Office Procedures & Financial Policies

Financial Policies:

- Payment is required at the time of the visit unless other arrangements have been made in advance. Accepted forms of payment include cash, check, or credit card (MasterCard, Visa, Discover).
- For appointments in the office, the first visit is $150 (1 ½ hours) and each follow-up visit is $90 (1 ¼ hours).
- For home visits, the first visit is $200 (1 ½ hours) and each follow-up visit is $150 (1 ¼ hours).
- Returned checks will incur a $25.00 fee, payable immediately.

Cancellation Policies:

- 24 hour notice is required to cancel an appointment.
- Individuals are responsible for the full appointment fee if cancellation is made without 24 hours notice.

Late Policies:

- We respect your time and other patient's time. If you are late and treated, then the appointment will be shortened and end according to the original start time of the appointment.
- Late patients will be charged the full fee regardless of treatment time.

Dismissal Policies:

- Point of Healing Acupuncture reserves the right to dismiss patients for inappropriate conduct, non or late payment, medical reasons, and safety concerns.

Cell Phone Policies:

- Cell phones are to be turned off prior to entering the office.
- Talking on a cell phone is not permitted in the office.

Point of Healing Acupuncture reserves the right to change information contained in the Office Procedures & Financial Policies at any time. If any changes are made to the Office Procedures & Financial Policies, the new version will be posted in the office for a period of at least one month.

Patient Signature (or guardian):	Date:

Health History Questionnaire

Name (First & Last)	Referred By	Email
Day Phone	Evening Phone	Cell Phone
Street/PO Box	City	State & Zip Code
Date of Birth	Age	Sex
Height	Weight	Marital Status
Occupation	Emergency Contact Name & Phone Number	

Main Complaint	
How long ago did this problem begin?	Did this problem change over time (better, worse, same)?
Have you been given a diagnosis?	What other kinds of treatments have you tried?
Does anything make it better (heat, cold, humidity, dryness, pressure, season, movement, food, etc.)?	
Does anything make it worse (heat, cold, humidity, dryness, pressure, season, movement, food, stress, etc.)?	
How does this problem interfere with daily activities (work, sleep, diet, exercise, etc.)?	

Secondary Complaint	
How long ago did this problem begin?	Did this problem change over time (better, worse, same)?
Have you been given a diagnosis?	What other kinds of treatments have you tried?

Does anything make it better (heat, cold, humidity, dryness, pressure, season, movement, foods, etc.)?
Does anything make it worse (heat, cold, humidity, dryness, pressure, season, movement, food, stress, etc.)?
How does this problem interfere with daily activities (work, sleep, diet, exercise, etc.)?

Past Medical History

Please circle all that apply				
Asthma	Cancer	Diabetes	High/Low Blood Pressure	Heart Disease
Thyroid	Seizure	Stroke	Other (specify):	
Surgeries or Trauma (auto accidents, falls, etc.) including dates				
Infectious Diseases (HIV, hepatitis, etc.)				
Allergies (food, drug, chemical, latex, environmental)				

Diet and Exercise

Please describe your average daily diet		
Morning:		
Lunch:		
Dinner:		
Snacks:		
Do you smoke? If yes, how much?		
How many cups of caffeinated beverages do you drink per day (coffee, tea, cola)?	How many cups of water do you drink per day?	How many glasses of alcohol do you drink per day?
Exercise program		

Current Medications/Herbs/Vitamins/Supplements

Name	*Start Date*	*Dosage/Frequency*	*Reason for taking*

Please check the box if you had any of the following in the <u>past 3 months</u>.

General

□ Fevers	□ Difficulty falling asleep	□ Fatigue after eating
□ Chills	□ Difficulty staying asleep	□ Weight loss or gain
□ Sweat easily	□ Vivid dreams	□ Strong thirst (hot or cold)
□ Night sweats	□ Sudden energy drop	□ Peculiar taste or smell
□ Bleed or bruise easily	□ Fatigue	□ Cravings

Skin & Hair

□ Rashes	□ Pimples	□ Dandruff
□ Hives	□ Recent moles	□ Dry hair
□ Eczema	□ Dry or oily skin	□ Hair loss
□ Ulcerations	□ Itching	□ Other skin or hair problem

Head, Ears, Eyes, Nose, Throat

□ Headaches	□ Glasses or contact lenses	□ Sinus problems
□ Migraines	□ Poor vision	□ Congested nose
□ Concussion	□ Cataracts	□ Nose bleeds
□ Poor memory	□ Eye pain	□ Sore throat
□ Facial pain	□ Eye redness	□ Sores on lips or tongue
□ Dizziness	□ Eye itching	□ Teeth problems
□ Ringing in ears	□ Eye dryness	□ Jaw problems
□ Ear pain	□ Spots in front of eyes	□ Grind teeth
□ Hearing loss	□ Night blindness	□ Other head problem

Cardiovascular

□ Low blood pressure	□ Difficulty breathing	□ Poor circulation
□ High blood pressure	□ Fainting	□ Varicose veins
□ Chest pain	□ Cold hands	□ Blood clots
□ Heaviness in chest	□ Cold feet	□ Other heart problem
□ Irregular heart beat	□ Swelling of hands	□ Other blood vessel problem
□ Heart palpitations	□ Swelling of feet	□ Taking blood thinner

Respiratory

□ Asthma	□ Coughing phlegm	□ Difficulty inhaling
□ Dry cough	□ Bronchitis	□ Difficulty exhaling
□ Coughing blood	□ Pneumonia	□ Other lung/breathing problem

Gastrointestinal

□ Nausea	□ Abdominal bloating	□ Hemorrhoids
□ Vomiting	□ Bad breath	□ Rectal pain
□ Belching	□ Bleeding gums	□ Blood in stools
□ Indigestion	□ Gas	□ Chronic laxative use
□ Heartburn	□ Constipation	□ Other stomach problem

□ Abdominal pain or cramps	□ Loose stools or diarrhea	□ Other intestinal problem

Genito-Urinary

□ Pain upon urination	□ Urgent urination	□ Impotency
□ Blood in urine	□ Unable to hold urine	□ Sores on genitals
□ Cloudy urine	□ Wake up to urinate	□ Other urinary problem
□ Frequent urination	□ Kidney stones	□ Other genital problem

Reproductive & Gynecological

Are you pregnant?		Is it possible that you are pregnant?	
# of pregnancies	# of live births	# of miscarriages	# of abortions
Age of first menses	Age of menopause	# of days of flow	# of days between menses
Last menstrual period (1st day of period)	Last PAP Date	Birth control method	Other problem

□ Regular period	□ Light flow	□ Blood clots
□ Irregular period	□ Heavy flow	□ PMS symptoms
□ Painful period	□ Spotting between periods	□ Vaginal discharge

Psychological

Have you ever been treated for emotional problems?		Have you ever considered or attempted suicide?
□ Anger	□ Stress	□ Grief
□ Irritability	□ Depression	□ Sadness
□ Bad temper	□ Obsessing	□ Fear
□ Anxiety	□ Worrying	□ Other emotion

Musculoskeletal

□ Joint problem	□ Muscle pain	□ Numbness
□ Bone problem	□ Muscle weakness	□ Other musculoskeletal problem

Please mark any problem area(s) below with an X. **Please note any additional problems below.**