

## 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, Worker's Compensation (and your employer as well in this instance), other medical practitioners, or with anyone that you authorize. 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.

### ***Types of information that we gather and use:***

- Financial information includes your out of pocket costs or personal financial arrangement with Point of Healing Acupuncture.
- Medical information includes health history, treatment notes, test results, and appointment schedule.

### ***Types of communication that we use:***

- Telephone
- Letters
- Email
- Fax

### ***Safeguards in our office to protect your personal information include:***

- Telephone messages will include as minimal information as possible.
- Limited access to the office where information is stored.
- No personal information is shared (oral or written) without disclosure.
- 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.
- A fax log will be maintained for all faxes received and sent.
- Each fax and email will include a confidentiality statement.

### ***Fax/email confidentiality statement:***

The information contained in this facsimile/electronic message may contain protected health information confidential under applicable law, and is intended only for the use of the individual or entity named. If you are not the intended recipient, or the employee or agent responsible to deliver to the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying is strictly prohibited. If you have received this communication in error, please immediately notify Point of Healing Acupuncture via telephone at 774-217-0414.

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. 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, or Discover).
- For appointments in the office, the first visit is \$100 (1 ½ - 2 hours) and each follow-up visit is \$65 (1 - 1 ¼ hours). Discounts will be applied if applicable.
- For home visits, the first visit is \$120 (1 ½ - 2 hours) and each follow-up visit is \$85 (1 - 1 ¼ hours). Discounts will be applied if applicable.
- 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.

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?
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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 past 3 months.***

**General**

<input type="checkbox"/> Fevers	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Fatigue after eating
<input type="checkbox"/> Chills	<input type="checkbox"/> Difficulty staying asleep	<input type="checkbox"/> Weight loss or gain
<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Vivid dreams	<input type="checkbox"/> Strong thirst (hot or cold)
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sudden energy drop	<input type="checkbox"/> Peculiar taste or smell
<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cravings

**Skin & Hair**

<input type="checkbox"/> Rashes	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Hives	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Dry hair
<input type="checkbox"/> Eczema	<input type="checkbox"/> Dry or oily skin	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Itching	<input type="checkbox"/> Other skin or hair problem

**Head, Ears, Eyes, Nose, Throat**

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

**Cardiovascular**

<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Heaviness in chest	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Other heart problem
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Other blood vessel problem
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Swelling of feet	<input type="checkbox"/> Taking blood thinner (anticoagulant)

**Respiratory**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Coughing phlegm	<input type="checkbox"/> Difficulty inhaling
<input type="checkbox"/> Dry cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty exhaling
<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other lung/breathing problem

**Gastrointestinal**

<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Belching	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas	<input type="checkbox"/> Chronic laxative use
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other stomach problem
<input type="checkbox"/> Abdominal pain or cramps	<input type="checkbox"/> Loose stools or diarrhea	<input type="checkbox"/> Other intestinal problem

**Genito-Urinary**

<input type="checkbox"/> Pain upon urination	<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Impotency
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Sores on genitals
<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Wake up to urinate	<input type="checkbox"/> Other urinary problem
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> 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 (1 <sup>st</sup> day of period)	Last PAP Date	Birth control method	Other problem
<input type="checkbox"/> Regular period	<input type="checkbox"/> Light flow	<input type="checkbox"/> Blood clots	
<input type="checkbox"/> Irregular period	<input type="checkbox"/> Heavy flow	<input type="checkbox"/> PMS symptoms	
<input type="checkbox"/> Painful period	<input type="checkbox"/> Spotting between periods	<input type="checkbox"/> Vaginal discharge	

**Psychological**

Have you ever been treated for emotional problems?	Have you ever considered or attempted suicide?
<input type="checkbox"/> Anger	<input type="checkbox"/> Stress
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Bad temper	<input type="checkbox"/> Obsessing
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Worrying
	<input type="checkbox"/> Grief
	<input type="checkbox"/> Sadness
	<input type="checkbox"/> Fear
	<input type="checkbox"/> Other emotion

**Musculoskeletal**

<input type="checkbox"/> Joint problem	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Numbness
<input type="checkbox"/> Bone problem	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Other musculoskeletal problem

Please mark any problem area(s) below with an X.

Please note any additional problems below.

