Marinwood Community Acupuncture 7 Mt. Lassen Drive Suite B136 San Rafael, CA 94903 415.518.6191

PATIENT INFORMATION

E-mail: _____ Date: / / (mm/dd/yy)

Patient: _____

Address: _____

_____

City State ZIP

Sex: ☐ M ☐ F Age: _____ Birth Date: / / (mm/dd/yy)

Patient SS# _____ - _____ - _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: ( ) -

Referral Source: _____

CONTACT INFORMATION

Home Phone: ( ) -

Work Phone: ( ) - ext.

Mobile Phone: ( ) -

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home Phone: ( ) -

Work Phone: ( ) - ext.

INSURANCE INFORMATION

Who is responsible for this account: _____

Relationship to Patient: _____

Insurance Company: _____

Group # _____

Member # _____

Is Patient covered by additional insurance: ☐ Yes ☐ No

Subscriber Name: _____

Birth Date: / / (mm/dd/yy) SS# _____ - _____ - _____

Relationship to Patient: _____

Insurance Company: _____

Group # _____

Member # _____

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No Date: / / (mm/dd/yy)

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

Attorney Phone: ( ) - ext.

May we contact your Attorney? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Name: _____ Signature: _____ Date: / / (mm/dd/yy)

PATIENT CONDITION

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

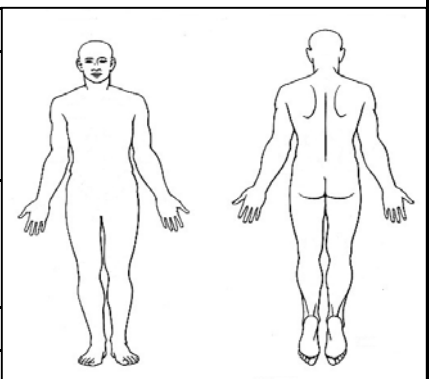
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation



Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Lying on side

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other (specify): _____

DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION:

Name: _____ Address: _____ Phone: ( ) -

City State ZIP

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI / CT-Scan / Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS / HIV	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Other:		
Glaucoma	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No			

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: / / (mm/dd/yy)

Injuries/Surgeries you have had			Description	Date (mm/dd/yy)
Falls	☐ Yes	☐ No		/ /
Head Injuries	☐ Yes	☐ No		/ /
Broken Bones	☐ Yes	☐ No		/ /
Dislocations	☐ Yes	☐ No		/ /
Surgeries	☐ Yes	☐ No		/ /

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name:		
Pharmacy Phone: ( ) -		

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a

family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority