First name_____M.I. _____Last Name_____

Address_____

City_____ State_____ Zip_____

Phone (please check primary contact)

☐ home (____)_____ ☐ mobile (____)_____

☐ work (____)_____ ☐ other (____)_____ specify_____

Email _____@_____

Date of Birth month_____ day_____ year_____ ☐male ☐female ☐single ☐married

height _____ weight_____Physician_____

occupation_____☐employed ☐part time student ☐full time student

emergency contact (____) _____ name_____ relationship_____

Reason for visit_____

Major medical events/ pregnancies by year:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

medications

_____

_____

_____

_____

_____

_____

_____

supplements

_____

_____

_____

_____

_____

_____

_____

Informed consent for treatment

I understand that the scope of practice of Traditional Chinese medicine (TCM) utilizes Chinese Medical theory to diagnose and formulate a treatment plan.

I understand that I am advised to consult a Physician regarding the condition for which I am seeking treatment, if I have not already done so.

I understand that treatment within the scope of TCM theory may include but is not limited to the following therapies:
Insertion of sterile acupuncture needles into the skin
Warming the skin by moxibustion (burning herbs), or other methods
Stimulation of points on the skin by electric current, magnets, or finger pressure
Application of vacuum cups (cupping) to the skin
Application of dermal friction
Utilization of massage techniques
Internal and/or external application of medicinal foods, herbs, mineral and animal products
Counseling on lifestyle issues such as exercise and diet

I understand that treatments may have adverse effects which may include but are not limited to:
Acupuncture needles inserted into the skin can cause pain and discomfort, bruising, infection, feeling of weakness, nausea, fainting, bleeding or complications due to broken needles
Moxibustion can cause burns
Electric stimulation can cause some conditions to worsen
Acupressure, cupping, massage may cause bruising and/ or soreness
Medicinal herbs, (plant, mineral, animal products) may have adverse reactions

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued treatment. I agree to release the below named practitioner from all legal responsibility for practices done here except in the case of negligence or unsafe practice on the part of said practitioner.

I **have/ have not** (circle one) been examined by a physician or other licensed health care provider with regards to the condition for which I seek treatment.

I **do/ do not** (circle one) have a bleeding disorder

I **do/ do not** (circle one) have a pacemaker or other cardiac condition

Patient signature_____Date_____

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please ask for and read the NOTICE OF PRIVACY PRACTICES.

I. How we may use and share health data about you:
- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patient.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of this office. In accordance with the Notice of Privacy Practices, this office, via this authorization form, requests that the patient indicated below authorize the release of his/her health information.

I, the undersigned, understand that I have the right to:
- refuse to sign this authorization
- receive a copy of this authorization
- restrict what is disclosed by this authorization
- inspect or request an amendment of the health information to be disclosed
- revoke this authorization, by written notice
- know about any compensation the practitioner/facility will receive resulting from the release of my health information

I recognize that once disclosed my health information is no longer under the control of this practitioner/facility. While I understand that the practitioner/facility will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document will not effect my treatment at this practice, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: http://www.hhs.gov/ocr/regmail.html.

Signature of patient or representative	Date	Print Patient Name	Patient birth date

Optional-- Authorization for disclosure of health Information

Describe in detail the health information you are authorizing to be used and/or disclosed.

[ ] patient notes and file [ ] financial information Other_____

Form of disclosure: [ ] all [ ] personal contact [ ]phone [ ]email [ ]copies [ ] other_____

Name the people and/or organizations (or the kinds of people and organizations) that you are authorizing Bock Acupuncture and Herbal Medicine to receive the protected health information described above.

_____

I voluntarily give my authorization to use or disclose my protected health information as described above.

Patient signature_____ date_____

Optional : This authorization is:

effective until _____ [ ] revoked; Patient signature_____ date_____