22481 El Toro Rd, Ste D, Lake Forest, CA 92630
Tel : 949-273-3294 / Fax : 949-522-9522 / contact@affinityacucare.com

Instructions

AS USED IN THIS DOCUMENT, THE TERMS "WE", "OUR" AND/OR "US" REFERS TO THE LEGAL OWNER AND OPERATOR OF AFFINITY ACUPUNCTURE CLINIC.

Welcome to *Affinity Acupuncture*. This document aims to serve every new patient more completely. Please take enough time to read every question and answer in detail. We do recommend that you download and complete this form.

We request that you email the completed paperwork prior to 24 hours ahead of your first appointment. This will save you time when you get to the clinic, and help us to serve you to the best results in the shortest amount of time.

PATIENT INFORMATION

Name | Gender

Street | City | State | Zip

Date of Birth | Age | Marital Status

Home Phone | Cell Phone

Occupation | Height | Weight

Emergency Contact Name | Relation | Phone

INSURED PERSON'S INFORMATION

Name | Date of Birth

Street | City | State | Zip

Employer | Relationship to patient

Insurance Co | Policy # | Group #

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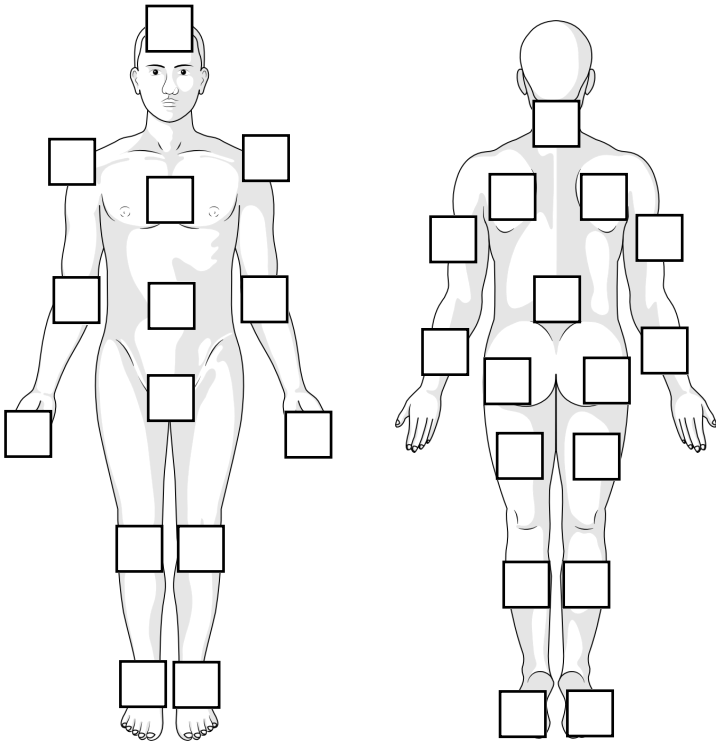
COMPLAINTS

Chief Complaint Pain Level / 10

*** Please mark any pain/symptom on the chart** and describe if needed



When did the pain/symptom start? What is the date of injury?

Have you ever been diagnosed with a doctor? If so, what was it?

What kinds of treatment have you ever tried?

What alleviates your discomfort? Please check all that apply.

☐ Morning ☐ Afternoon ☐ Standing ☐ Sitting ☐ Bending forward

☐ Bending backward ☐ Twisting left ☐ Twisting right ☐ Walking ☐ Driving

☐ Lifting ☐ Lying down ☐ Heat ☐ Cold

What aggravates your discomfort? Please check all that apply.

☐ Exercising ☐ Resting ☐ Heat ☐ Cold ☐ Massage

☐ Medications _____ ☐ Others _____

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Review of Systems

Please mark the following conditions/diseases/symptoms that you have been treated for :

General

☐ Chills	☐ Fevers	☐ Insomnia	☐ Fatigue	☐ Poor appetite
☐ Weight loss	☐ Weight gain	☐ Easily sweats	☐ Easily bruise	☐ Tremors
☐ AIDS/HIV	☐ Alcoholism	☐ Arthritis	☐ Cancer	☐ Diabetes

Head/Eyes/Ears/Nose/Throat

☐ Poor vision	☐ Blurry vision	☐ Cataracts	☐ Eye pain	☐ Headache
☐ Dizziness	☐ Hearing problems	☐ Earaches	☐ Nosebleeds	☐ Sinus problems
☐ Ringing in ears	☐ Dental problems	☐ Bleeding gums	☐ Jaw pain	☐ Grinding teeth

Cardiovascular

☐ Chest pain	☐ Hypertension	☐ Blood clots	☐ Fainting	☐ Palpitations

Respiratory

☐ Cough	☐ Asthma	☐ Penumonia	☐ Bronchitis	☐ Shortness of breath

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Indigestion
☐ Abdominal pain	☐ Acid reflux	☐ Bad breath	☐ Belching	☐ Hemorrhoids

Genitourinary/Nephrology

☐ Prostate problems	☐ Impotence	☐ Kidney stones	☐ Blood in urine	☐ Frequent urination

Musculoskeletal

☐ Lower back pain	☐ Neck pain	☐ Knee pain	☐ Hand/wrist pain	☐ Shoulder pain
☐ Muscle pain	☐ Foot/ankle pain	☐ Muscle spasm	☐ Hip problems	☐ Joint problems

Psychiatric

☐ Suicidal thoughts	☐ Depression	☐ Excessive stress	☐ Anxious	☐ Poor memory

Reproductive and Genecologic

☐ Painful menses	☐ Abortions	☐ Miscarriages	☐ Irregular menses	☐ Unusual menses

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MEDICAL HISTORY

Past Medical History

☐ Cancer ☐ Arthritis ☐ Diabetes ☐ Hepatitis ☐ Thyroid disease

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Others _____

Surgeries

_____ Year _____

_____ Year _____

_____ Year _____

Current Medications

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

Allergies

_____

Family History (Please check all that apply)

☐ Cancer ☐ Arthritis ☐ Diabetes ☐ Hepatitis ☐ Osteoporosis

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Others _____

SOCIAL HISTORY

Tobacco use :

☐ Never used ☐ Current user (_____ pack(s) per day) ☐ Former user (Quit date _____)

Alcohol use :

☐ Never used ☐ Social use ☐ History of alcoholism ☐ Current alcoholism ☐ Daily use of alcohol

Illegal Drugs use :

☐ Never used ☐ current illegal drug use ☐ Formerly used illegal drugs (not currently using)

I certify that I have read and understand the above informations. To the best of my knowledge, above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____ _____ _____

Patient/Guardian's Signature *Date* *Reviewer* *Date*

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ACUPUNCTURE INFORMED CONSENT

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 on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or on the future treat while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are limited to, acupuncture, moxibustion, cupping electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed by the acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Guardian's Signature *Date*

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FINANCIAL AGREEMENT

Check In

When you arrive in the office, please check in with the front office manager. You will be assisted to an assigned treatment room and the doctor will be in as soon as possible.

Cancellation Policy

We require 24 hour notice if you are unable to keep your appointment to allow time to offer your appointment to another patient. If 24 hour notice is not given, you will be charged $50 as a missed appointment fee.

Payment of Bills

We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. We do not bill patients. Our policy is that patients not have a personal owing. If there is a balance due upon discontinuation of services, we will contact you to inform you that your credit card will be charged for the full amount.

Insurance companies will be billed as a courtesy for services rendered. You will be responsible at the time of service for payment of the Annual deductible, Co-payments or Co-insurance amounts for your plan. Most insurance plans have a "co-insurance" amount which you will be responsible. Most insurance companies do not pay 100% of the contracted/allowed amounts leaving a co-insurance balance to be paid by the patient. We recommend you to contact the Member Services Department of your insurance company if you have questions about what is covered and amounts you will be responsible for.

Any checks sent to your home by the insurance company should be brought or sent to our office. Please also bring or send us any attached documents indicating which services were paid. If your insurance company denies coverage for a charge you thought was covered by your plan, you will be responsible for that charge after we obtain a denial from your insurance carrier. Patient due balances over 30 days will be assessed a 1.5% monthly (18% annual) service charge, unless other payment arrangements have previously been made with our office.

I have read and understand the Affinity Acupuncture Financial Agreement. By signing below, I understand my responsibility regarding charges incurred in this office.

_____

Print Patient's Name or Guardian

_____ _____

Patient/Guardian's Signature *Date*

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NOTICE OF PRIAVACY PRACTICES

We understand that health information about you is personal and we are committed to protecting this information. When you receive treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any test result that you provide to us, and billing record. We are required by law to:

1. Maintain the privacy and security of your health information;
2. Provide you with notice of our legal duties and privacy practices with respect to information;
3. Abide by the terms of this notice; and
4. Notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your health information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment**. We will use and disclose your health information to provide, coordinate, or manage your treatment at this clinic. For example, we may share your information with your primary care physician or other specialists upon request.
2. **For Payment**. We will use and disclose health information about you so that payment for the treatment you receive may be collected from you or another party.
3. **For Health Care Operations**. We may use and disclose health information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your health records may be used in the evaluation of services, and the appropriateness and quality of treatment we provide. Treatment services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected health information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devises will have a notice posted at the clinic informing you of the use of such devices.
4. **For Contacting You**. We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.
5. **Appointment Reminders**. We may use and disclose health information to remind you of an appointment, if applicable.
6. **As Required by Law**. We will disclose health information about you when required to do so by federal or state laws or regulations.
7. **Health Oversight Activities**. We may disclose health information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health related civil rights and criminal laws.
8. **Lawsuits and Disputes**. If you are involved in certain lawsuits or administrative disputes, we may disclose health information about you in response to a court or administrative order.
9. **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order or subpoena.
10. **Electronic Disclosure**. We may use and disclose your health information electronically. For example, your health information is maintained on an electronic health record. If another provider requests a copy of your health record for treatment purposes, we may forward such record electronically.

DISCLOSURES REQUIRING AUTHORIZATION

1. **Marketing**. Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

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1. **Right to Inspect and Copy**. The right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to us. You can also ask to see or get an electronic copy of health information we have about you. Ask us how to do this.
2. **Right to Amend**. If you feel that health information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us. To request an amendment, your request must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by us;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
3. **Right to an Accounting of Disclosures**. To request an "accounting of disclosures." This is a list of the disclosures made of your health information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.
4. **Right to Request Restrictions**. To request a restriction or limitation on the health information we uses or discloses about you for treatment OR payment. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Neither we are required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.
5. **Right to Revoke an Authorization**. There are certain types of uses or disclosures that require your express authorization. For example, we may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your health information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.
6. **Right to Receive a Copy of this Document**. You have a right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting us.

I understand and agree to the patient privacy notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

_____

Print Patient's Name or Guardian

_____

Patient's or Legal Guardian's Signature

_____ _____

Authorized Facility Signature *Date*