320 Acupuncture Clinic

320 Old Country Rd Ste 105
Garden City, NY. 11530
(516) 739-7777

PATIENT PROFILE

Last Name:	First Name:	M.I:	Date of Birth:
☐ Male ☐ Female	Age:	☐ Single ☐ Married ☐ Other	
Address:			
City:	State:	Zip Code:	
Cell Phone:	Home:	Preferred Contact:	
Email Address:	Would you like to subscribe to our newsletter? ☐ yes ☐ no		
Emergency Contact Name: Phone Number:	Relationship:		
What is the secondary insurance if you have other than NYSHIP- Empire Plan?			
Where do you work and what is your occupation?			
How did you hear about us?			

What To Expect At Your Visit

Please be aware of the services that are being given to you during the session in our office:
ACUPUNCTURE + ACUPRESSURE

This includes:
Step 1: Examination prior to treatment
Step 2 Acupuncture: small acupuncture needles are inserted into the cartilage of the ear and placed in specific areas to help with your symptoms and relaxation (Auricular Acupuncture).
Step 3 Acupressure: Massage/Reflexology

Total treatment time: 50 minutes

By signing below, I confirm that the information provided above is correct and accurate. I authorize that 320 Acupuncture Clinic to utilize the information provided to contact my physician, attorney, insurance company and its agent to secure my benefits.

Also, I hereby acknowledge receipt of the clinic's Notice of Privacy Practices.

Patient/Guardian Signature:_____ Date:_____

INFORMED CONSENTS TO TREATMENT(S)

I, the undersigned, do affirm that I have been advised at 320 Acupuncture Clinic by Licensed Acupuncturist and / or Acupressure / Massage Therapist, and / or clinical staff to consult a physician regarding the condition or conditions for which such patient seeks acupuncture / acupressure / massage treatment. I hereby request and consent to the performance treatments and other procedures within the scope of the practice of acupuncture and massage therapy on me (or on the patient below, for whom I am legally responsible) by the licensed acupuncturists and massage therapist in this facility.

Informed Consent to Acupuncture Treatment:

1. I understand that methods of treatment may include but are not limited to: traditional acupuncture, auricular and scalp acupuncture, heat lamp (Infrared), electric stimulation, therapeutic massage, moxibustion, cupping, etc.

2. I have been informed that acupuncture is a safe method of treatment, but it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few hours or days, and dizziness or fainting. Burns and / or scarring are a potential risk of moxibustion and / or heat lamp. Bruising of cupping therapy, (which is actually often required for a better treatment effect), is a common side effect though only lasting hours or days. Highly unusual risks of acupuncture may include infections, nerve damage, and organ puncture.

3. I understand that the clinic uses sterile disposable needles and maintains a clear and safe environment.

Informed Consent to Acupressure / Massage Therapy:

1. I understand that the Acupressure / Massage Therapy I receive is provide for the purpose of relaxation, stress reduction, relief of muscular tension. I further understand that Acupressure / Massage should not construed as a substitute of medical examination, diagnosis or treatment and that I should see a physician, or licensed acupuncturist for mental or physical ailment that I am aware of.

2. I understand that Acupressure / Massage Therapists are not qualified to perform skeletal adjustments, diagnose and / or prescribe and nothing said in the course of session should be construed as such and may feel sore for days after treatment.

3. Because Acupressure / Massage Therapy is constrained under certain conditions, I affirm that I stated all my known medical conditions and answered all questions honestly. I agree to keep the therapists updated as to any changes in my medical profile and understand that there will be no liability on the therapist's part should I forget to do so.

Informed Consent to Herbal Remedy/Supplement:

1. I understand that the herbs and / or nutritional supplements used and recommended in Herbal Medicine are from plant, animal and mineral sources which are traditionally considered safe.

2. I understand that the herbs need to be prepared and consumed according to the instructions provided orally and in writing by the attending acupuncturist(s) and or clinical staff. The herbs may be an unpleasant taste or smell. Possible side effects from taking herbs are nausea, stomachache, vomiting, diarrhea, rashes, hives, or tingling of the tongue. Taking large doses may be toxic. Some herbs may be inappropriate during pregnancy.

3. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I understand that it is my responsibility to inform my treating acupuncturist / therapists if I become pregnant or suspect that I am pregnant before each treatment begins. I do not expect the acupuncturist / therapists to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment in my best interest during the course of treatments which are determined based upon the facts clearly presented to the treating acupuncturist prior to treatment. I understand that results are not guaranteed. I understand that all of my records will be kept confidential. I authorize the acupuncturist or the clinical staff to release information as required by my physician for the purpose of treatment, and to my insurance company and its agents to secure my insurance benefits, and to my attorney for the legal reason.

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

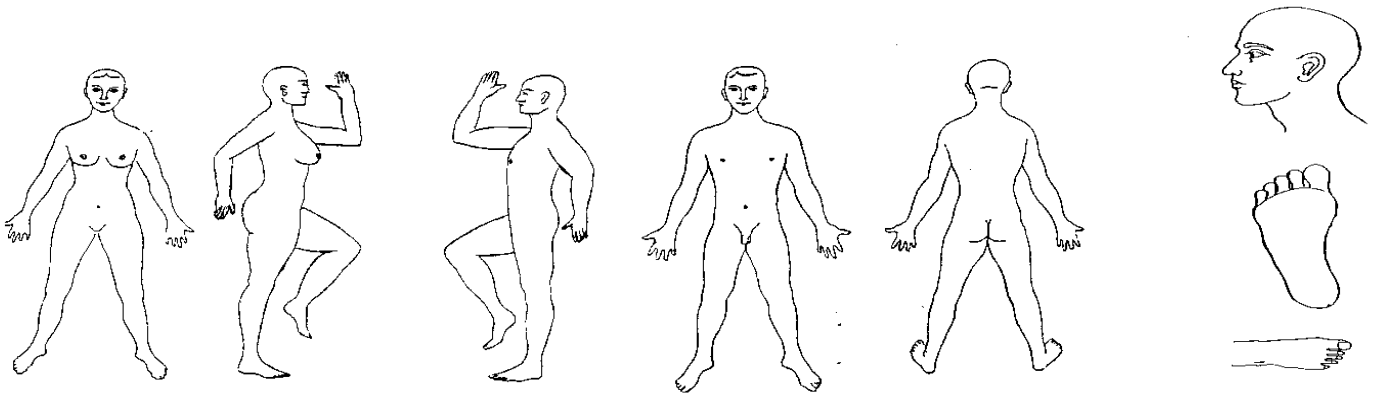
_____	_____	_____
Print Patient/Guardian's Name	Patient/Guardian's Signature	Date

Questionnaire

Chief Complaint(s):
When did this pain begin?
What caused your current pain?
Does anything make your pain better or worse?
Are you currently under a doctor's care?

Pain Scale:

* Please circle areas of pain using the diagrams below



Description:	▢Ache	▢Numbness	▢Stabbing	▢Burning
Intensity:	▢ No pain	▢Minor	▢Moderate	▢Severe
Frequency:	▢25 %	▢50%	▢75%	▢100 %
Work- can do:	▢Usual work	▢50% of work	▢25% of work	▢Unable to work
Sleeping:	▢No problem	▢Disturbed	▢Unable to sleep	
Traveling:	▢No problem	▢Moderate	▢Unable to travel	
Recreation:	▢All activities	▢Some activities	▢No activities	
Walking:	▢Walking fine	▢Short Distance	▢Unable to walk	
Sitting:	▢No pain sitting	▢Some pain	▢Cannot to sit	
Standing:	▢No pain standing	▢Some pain	▢Cannot stand	

Medical History:

List of allergies:

_____

List of medications/supplements:

_____

Please indicate if you or any family member(s) have or had any of the following conditions:

- ▢ Pneumonia
- ▢ Anemia
- ▢ High Blood Pressure
- ▢ Bleeding Disorders
- ▢ HIV/AIDS
- ▢ Tuberculosis
- ▢ Obesity
- ▢ Low Blood Pressure
- ▢ Hepatitis
- ▢ List Past Surgeries:_____
- ▢ Jaundice
- ▢ Cancer
- ▢ Heart Disease
- ▢ Mental Illness

General Signs & Symptoms:

- ▢ Abdominal Pain
- ▢ Blood in urine
- ▢ Cold hands/ feet
- ▢ Dark Stool
- ▢ Eye strain/tension
- ▢ Frequent/ Urgent urination
- ▢ Heart palpitations
- ▢ Kidney stones
- ▢ Nasal congestion
- ▢ Indigestion
- ▢ Loss of Hair
- ▢ Neck/Shoulder pain
- ▢ Shortness of Breath
- ▢ Vomiting
- ▢ Asthma
- ▢ Breast Lump
- ▢ Constipation
- ▢ Dizziness
- ▢ Cramping
- ▢ Dry Mouth
- ▢ Fever
- ▢ Hemorrhoids
- ▢ Joint Pain
- ▢ Muscle Pain
- ▢ Poor appetite
- ▢ Ulcerations

▢Other:_____

- ▢ Memory Loss
- ▢ Upper/ Low Back Pain
- ▢ Acid Regurgitation
- ▢ Blurry Vision
- ▢ Confusion
- ▢ Depression
- ▢ Excessive phlegm
- ▢ Gas/Bloating
- ▢ Fatigue
- ▢ Headache/Migraine
- ▢ Intestinal Pain
- ▢ Night Sweats
- ▢ Swollen glands
- ▢ Weight loss/gain
- ▢ Bad breath
- ▢ Bruise Easily

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my acupuncturist may need to contact my physician or other medical health provider if my condition needs to be co-managed. Therefore, I give authorization to my acupuncturist to contact them if necessary.

Patient Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES (HIPPA)

1. What This Is: This Notice describes the privacy practices of 320 ACUPUNCTURE CLINIC.

2. Our Privacy Obligations: The clinic chooses to maintain the privacy of health information about your ("Protected Health Information" or "PHI") and to provide you with this Notice of our duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the used or disclosure).

3. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section 4 below, we must obtain your written authorization in order to use and/or disclose your PHI. We do not need the authorization from you for the following uses and disclosures.

1) Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you and conduct our "clinic care operations" (e.g., internal administration, quality improvement, and customer service) as detailed below:

- Treatment. We use and disclose PHI to provide treatment and other to you for example, herbal treatments. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other practitioners involved in your treatment.
- Payment. We may use and disclose PHI to obtain payment for services that we provide to you.
- Health Care Operations. We may use and disclose PHI for our clinic operations, which include internal administration and planning and various activities that improved the quality and cost effectiveness of the treatment that we deliver to you. E.g., we may use PHI to evaluate the quality and competence of our practitioners and providers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us. We may also disclose PHI to your other health care providers when such PHI is required for them to treat you or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of professionals, or for health care fraud and abuse detection or compliance.

2) Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Office Manager. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location and general condition.

3) Public Health Activities. We may disclose PHI for the following public health activities: To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability; To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; To report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; To report information to your employer as required under law addressing work-related illness and injuries or workplace medical surveillance.

4) Victims of Abuses, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services, agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

5) Health Oversight Activities. We may disclose PHI to health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs.

6) Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

7) Law enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grant jury or administrative subpoena.

8) Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

9) Organ and tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye, or tissue procurement, banking or transplantation.

10) Research. We may use or disclose PHI without your consent or authorization if an Institution Review Board/Privacy Board approves a waiver of authorization for disclosure.

11) Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person or the public's health or safety.

12) Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

13) Worker's Compensation. We may disclose PHI, as authorized by law and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs.

14) As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

4. Use and Disclosures Requiring Your Written Authorization

1) Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section 3, we only may use or disclose PHI when you give us your authorization on our authorization form "Your Authorization"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

2) Special Authorization. Confidential HIV-related information (for example, information regarding whether you have ever been subject of an HIV test, have HIV infection, have HIV-related illness, or have AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your care, and in certain limited circumstances, to public health or other government officials (as required by law), to persons specified in a special court order, or to certain persons with whom you have had sexual contact or have shared needles or syringes. This special written authorization is a New York State approved from which is a separate document from Your Authorization.

5. Your Individual Rights

1) For Further Information of Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to PHI, you may contact Privacy Compliance Officers. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Compliance Officers will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us.

2) Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment, and other treatment operations; (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care; or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our clinic and submit it to the clinic. We will send you a written response.

3) Right to Receive Confidential Communications. You may request and we will accommodate any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

4) Right to Inspect and Copy Your Health Information. You may request access to your treatment file maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from our clinic and submit the complete form to our clinic. If you request copies, we will charge you $.75 (seventy-five cents) for each page. We will also charge you for our postage costs, if you request that we mail the copies to you.

5) Right to Revoke Your Authorization. You may revoke your Authorization or your Special Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to our clinic.

6) Right to Amend Your Records. You have the right to request that we amend PHI maintained in your clinic record file. If you desire to amend your records, please obtain an amendment request form to the clinic and submit the completed form to the clinic. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

7) Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years.

8) Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

6. Right to Change Terms of this Notice. We may change the terms of this notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice. You may also obtain any revised notice by contacting the clinic.

By signing below, I hereby acknowledge receipt of the clinic's Notice of Privacy Practices.

Patient/Guardian Signature:_____ Date: _____

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Effective 01/01/2023

Patient Education Form

It is certified that I understand that:

1. This is an **Out-of-Network provider** clinic, and I may be responsible for the expenses of deductible and the co-insurance.

2. **NYSHIP sends payment checks to me directly.** I am obligated to either bring the checks and EOB over to this office on time, or write personal checks if I cash them.

3. To get payment checks on time, I will answer the questions the insurance company may have and I will bring all letters and envelopes to the office.

4. I shall take treatments no less than **20 visits per calendar** year to be entitled to sign the Financial Hardship Agreement, which assists to save me burden from paying expenses of the deductible and co-insurance.

5. I shall pay $100 each visit if I take treatments under 20 visits per year, which covers expenses of the deductible and co-insurance.

6. I understand that I will be responsible for a $40 fee if I cancel without notice within 12 hours or no show to my appointment.

7. I understand to be on time for appointments. The office offers a 10 minute grace period for lateness, after that your treatment will be cut short as much as you are late, and you will still pay in full for your treatment. No exceptions.
    a. Please note these policies apply to everyone whether you are under insurance or if you are paying out of pocket.

By signing below you are agreeing that you have read and understand the above policies. Please check one of the following:

Date: Date:

Patient Signature: Witness Signature:

Print Name: Print Name: