Solutions for Health

Premier Acupuncture & Complementary Medicine, Inc.
1901 N Hemmer Road, Suite 208
Palmer AK 99645
907-745-7928

www.PremierAcupuncture.com

Welcome To Our Office!

We are pleased you are here and we will do whatever we can to make your experience an enjoyable one. Let us know how we can help you. We have been serving Alaskans since 1993.

In order to provide you the best care possible, we specialize in the following areas.

- Pain and injury treatment
- Menstrual and breast health concerns
- Medical Thermography

We believe restricting our practice to these areas will allow us to provide you with the best possible care. We offer thermal imaging to aid in our assessment and treatment of pain and injuries as well as breast health. Better diagnosis results in better treatment outcome.

Appointments, Insurance and Payment Options

To schedule an appointment please call 745-7928. You may also contact us via email at premieracupuncture@mtaonline.net We are open Tuesday, Wed, Friday 9:30 - 6 and Thursdays 8:30 - 3.

We accept insurance, be it Work Comp, private medical, auto or VA / Choice. We are an authorized provider for the VA / Choice program. We are in network for BCBS, Aetna, Cigna, EBMS. Not all policies cover our services. We will be happy to check for you, just give us a call. Please note – Thermography is not covered by insurance. Payment is expected at the time of your thermogram

Payment is expected at the time of service. Payment in full if you do not have insurance, and deductibles / co-pays if you have insurance. Discounted treatment package plans are available. Visa and MC accepted.

Emergencies

If you have a problem after hours or at a time we cannot be reached, please contact your physician, go to the emergency room or call 911. Leave a message for us when convenient and we will return your call.

We look forward to helping you achieve your health related goals!

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Is your condition a result of a work injury? Yes___ No
Result of an auto accident? Yes_________ No___

PERSONAL INFORMATION

How do you wish to be addressed? ___________ (by you first name? nickname? last name?)

Last Name:__________________________ First Name:___________________ MI:__________

Mailing Address:______________________ City/State:__________________ Zip:__________

Home Phone:______________ Work Phone:______________ Cell Phone:_______________

Date of Birth:________________ Age:__________ Social Security #:____________________

Occupation:__________________________Employer:______________________________

Spouse's Name:_________________ Spouse Date of Birth:________Work Phone:__________

Email Address:____

PATIENT / RESPONSIBLE PARTY INFORMATION

Responsible Party:_____________________ Relationship to Patient:_____________________

Social Security #:_____________ Date of Birth:______ Home & Cell Phones:______________

Address:_____________________________ City/State:__________________ Zip:__________

Employer:____ Work Phone:________________

INSURANCE INFORMATION (Complete ONLY if your insurance covers our services - we do not bill secondary Ins.)

PRIMARY Insurance Company Name:__________________ Insurance Phone:______________

Claims Address:__________________________________ City/State/Zip:_________________

Name of Insured:_________________________________ ID # or SS #:_________________

Insured DOB:___________ Group Name/Number:_______________ Claim #:______________

How did you hear about our office?____

Referred by (if applicable) :____

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PATIENT RESPONSIBILITIES

Cancellations: The staff at Premier Acupuncture & Complimentary Medicine (PACM) will make every effort to provide you with the best care possible and to do so being respectful of your time. Should you need to cancel an appointment, please allow us to provide someone else the same level of care by cancelling your appointment at least 24 hours prior to your scheduled appointment time.

Cancellations occurring with less than 24 hours notice will incur a $50 cancellation fee. Please be aware your insurance will not cover this charge and this amount cannot be applied to any outstanding balance.

Miscellaneous:

- If you become pregnant, please notify us as this may alter your treatment plan.
- If you have questions or concerns about our care, we invite you to call us anytime and ask rather than waiting until your next appointment. We are here to serve your needs and encourage you to contact us any time you have a question, concern, or require assistance with insurance or your account.
- If you are taking supplements that are special ordered, please provide us with at least a two week notice that you will need a refill, unless you have already arranged with us to keep a supply on hand. If you are taking an herbal formula that is specific to you and requires time to prepare, we ask that you notify us at least 48 hours before needing to pick up the refill.
- Patient records request should be made at least 2 business days before you intend to pick them up.
- There is a $25 fee for a bounced check (NSF, Not Sufficient Funds).

We look forward to working with you to provide you the best in natural medicine health care. Thank you for being here!

PACM Staff

I understand and agree to the above listed Patient Responsibilities.

______________________	______________________	______________
Signature	**Printed Name**	**Date**

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Insurance Coverage

We strongly recommend that you contact your insurance carrier to verify benefits prior to your appointment. We will be happy to assist you by making the call for you if you provide us with the necessary information. Ultimately you are responsible for charges incurred by you. If your insurance approves and then later declines coverage, you remain financially responsible for charges. If you are a Veteran and have been referred through the VA / Choice program, we will address any non-payment issues for you and you will not be held responsible for nonpayment.

Please Read and Sign

We require a credit card / debit card be on file to cover any outstanding insurance deductible or co-payment. If you do not feel comfortable leaving this information with us, then we ask that you pay for your appointment in full when services are rendered. We will bill your insurance as a courtesy. If you are uncomfortable with either of these options, please talk with the front office as other arrangements can be made. It is not our desire to limit your options, but rather to be efficient in dealing with accounts receivable.

Authorization

I authorize Premier Acupuncture & Complementary Medicine, Inc. (PACM) to release any information required to process my insurance claims. I hereby authorize my insurance benefits to be paid directly to PACM. I understand that I am responsible for all fees, regardless of insurance coverage. I understand I will be billed for services if my insurance company denies payment and / or if they have not paid within 90 days. I understand if the balance is not paid by insurance or myself within 90 days, then PACM may use my credit card account for this purpose. PACM will attempt to notify me of any charges that are applied to my credit card.

Signature______________________________________ Date________________________

Printed Name____

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Credit Card Information

Your information will be shredded as soon as it is entered into our computer. If you prefer to not complete this form, then simply provide the necessary information to the front office during your initial appointment.

Card Number_________________________________ Expiration Date______________

EVS (security code on back of card)_________

Signature ____

Printed Name ______________________________________

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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments or other procedures within the scope of practice of an acupuncturist 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 in the future treat me while employed by, working with, associated with, or serving as backup for the acupuncturist named below, including those working at the clinic or office listed below or any other clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, electro-acupuncture, laser therapy, electrotherapy, pain neutralization technique, infrared heat, cupping, Chinese herbal medicine, western herbal medicine, and nutritional therapy and counseling. If I experience any problems or concerns with any recommendation or treatment, I will immediately notify a member of the clinical staff. I am of course free to decline any or all treatment.

Acupuncture (and other treatments utilized by Premier Acupuncture & Complementary Medicine, Inc.) is a generally safe (very safe) method of treatment but it may have some side effects. These may include bruising, numbness, soreness, or tingling near the needle sites that may last from a few seconds to a few days, sore muscles, dizziness, and fainting. The most common side effect, although still uncommon, is a small bruise at the needle site. Other very rare side effects may include miscarriage, nerve damage, and organ puncture. Infection is always a concern and is a possibility anytime the skin is punctured but we ONLY use disposable needles which have been sterilized by the manufacturer and your skin is prepared with alcohol prior to acupuncture treatment. We always maintain a clean and safe environment. <u>You will never be exposed to needles used by another patient</u>. Herbal and nutritional medicine is generally a safe treatment method. Side effects, which are uncommon, include but are not limited to nausea, abdominal cramping, loose stools, diarrhea, and allergic reactions. These are the same side effects that may be associated with consuming anything orally, be it medicine or food. Although herbal and nutritional medicines are generally very safe, it is possible to respond in a manner that is unexpected, for example, headaches, increase in blood pressure, negative interaction with pharmaceuticals, allergies, etc. Additionally, great care is given when providing oral supplements (herbs and other nutritional compounds) in the presence of pregnancy. It is your responsibility to inform the clinical staff if you are pregnant or plan to become pregnant and to inform them of your current medications, medical history, and/or any current allergies or side affects you may experience. This is no different than what is expected when you are taking prescription medications. Helping you obtain the best health possible is our primary goal. We need your help in doing so by keeping us informed.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise their best

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judgment during the course of treatment which, based on the facts known, they think is in my best interest. I understand that results are not guaranteed.

I understand that clinical and administrative staff may need to review my patient records and lab reports or other pertinent medical information, but all my records will be kept confidential and will not be released without my written consent except as required by law.

Michael Wedge, L.Ac. has been educated and holds graduate degrees in Acupuncture and Oriental Medicine and Clinical Hypnosis. He is licensed as an acupuncturist by the state of Alaska, is board certified in acupuncture through the NCCAOM, and is board certified in medical thermal imaging. He is not a medical doctor.

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

With the knowledge provided in this **Informed Consent** form and having my questions answered to my satisfaction, I voluntarily consent to the above procedure(s) as deemed medically necessary, realizing that no guarantees have been given to me by Michael Wedge, L.Ac., or the staff of Premier Acupuncture and Complementary Medicine, Inc. regarding cure or improvement of my condition(s). I hereby release Michael Wedge, L.Ac., and the staff of Premier Acupuncture and Complementary Medicine, Inc. (or any future name Premier Acupuncture and Complementary Medicine, Inc. may operate under) and any of its staff from any and all liability which may occur in connection with the above mentioned procedures/treatment, except for failure to perform the procedures/treatment with appropriate Medical Care. I understand that I am free to withdraw this consent in writing and to discontinue participation in these procedures at any time.

______________________________ ________________________
Signature of patient (or guardian if under 18) Date

____
Print Name

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HEALTH HISTORY

Date__________ Full Name____

Date of Birth___________ Age_______ Gender______ Height___________ Weight_________

Is your condition the result of a work injury? YES NO Result of an auto accident? YES NO

Have you received an acupuncture treatment before? YES NO

Please list the concerns that brought you here today:

Symptoms/Illness Date first noticed (if known)

1)____ ________________________

2)____ ________________________

3)____ ________________________

4)____ ________________________

5)____ ________________________

6)____ ________________________

Have you been previously treated for these complaints? YES NO IF YES:

What was the diagnosis?____

What was the result of treatment?____

Medical History:____

____

Medications____

____

Supplements:____

Allergies:____

Do you smoke?_____ Drink Alcohol?______ Recreational Drugs?_______ Exercise?________________

Any communicable diseases? YES NO If yes – what type?______________________________________

PATIENT HEALTH HISTORY page 2

How much water do you drink daily? ________ Do you drink Soda? ______

If you are being seen for a pain related problem, or if you are experiencing pain but being seen for a non pain related problem, please provide the requested information below.

RELEVANT HISTORY OF PROBLEM:

(Example: 6 mo post MVA with persistent low back pain)

Please Show areas of :

Main Pain *

Secondary Pain ○

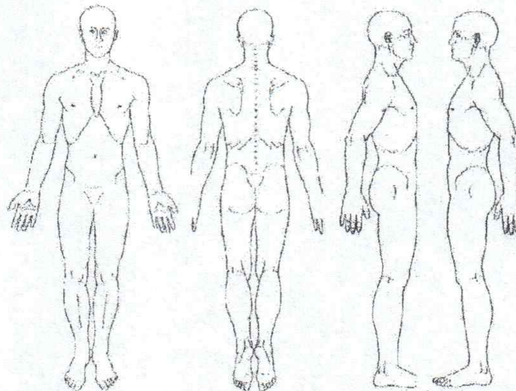
Numbness

////////

Pins and needles

::::::::

Skin lesions / scaring →



Do you know what triggered the pain ? ______________________________

Does anything relieve it ? ______________________________

Does anything aggravate it ? ______________________________

Has it changed since it began ? ______________________________

Have you had any treatment ? ______________________________

History: Injuries / Fractures / Surgery ______________________________

____

____

PREMIER ACUPUNCTURE & COMPLEMENTARY MEDICINE

PO Box 3791; 1901 N Hemmer Road # 211
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Office 907.745.7928 Fax 907.745-7939
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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date September 20, 2013

This Notice of Privacy Practices applies to the following organizations.

Premier Acupuncture & Complementary Medicine

Michael Wedge, L.Ac., M.Ac.O.M., DCH
premieracupuncture@mtaonline.net

907.745.7928