



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 1992.

We have included 2 books in PDF format that we hope you will find interesting and useful. The first is Breast Thermography – What Every Woman Must Know Before Having a Breast Thermogram. The second book is Turning Point – Integrative Solutions for Chronic Pain. Both books are also available in digital format on Amazon. Both books were written by our clinic director.

Our clinic specializes in, and is limited to, the treatment of pain and injuries as well as women's health concerns. We have been providing quality health care in Southcentral Alaska since 1992.

We want you to be confident you have chosen the right clinic to help you with your health concerns. If you have not done so already, you can find on our website, video and written reviews of our clinic. We also have posted a couple short treatment videos. A couple of our patients agreed to have their treatment recorded in order to help others be more comfortable if the acupuncture experience is new to them. Our services extend beyond acupuncture. You can find out more on our website if you are interested. Our web address is shown at the top of this page.

To aid in the healing process, we offer classes in acupressure, stress reduction, self-hypnosis and pain management through the practice of Mindfulness Based Stress Reduction (MBSR). We will be adding online classes to educate our patients in selecting quality supplements, the use of herbs in health care and more. MBSR classes are taught by Shelly Jacobs, MA, LPA. Shelly is a practicing psychotherapist, prior adjunct professor of psychology and a long-time meditation practitioner. Shelly is highly trained in the practice and teaching of MBSR.

Registration Forms

Please complete the registration forms and health history. Most of the information can be filled in online, printed and then brought in for your initial appointment. Our preference is to have these forms completed on your computer and then brought in for your initial appointment. This is part of your permanent record and is easier to read when completed on your computer. Please remember to bring them with you when you come in for your first appointment. Not having them with you will result in a significant delay in beginning your appointment. We will likely have to reschedule you if you are delayed due to forgotten paperwork.

We ask for a significant amount of information in order to provide you the best possible care. Thank you for your understanding.



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Appointments, Insurance and Payment Options

To schedule an appointment please call 745-7928. You may contact us via email at premieracupuncture@mtaonline.net. We are open Tuesday 9:30 - 6, Wed 9:30 - 7, Thursdays 8:30 - 3 and Friday 9:30 - 6.

Please do not send private health information to this email address. We have a secure HIPAA compliant email service if we need to exchange personal information.

We are happy to bill insurance, be it Work Comp, private medical, auto or VA. VA coverage requires prior authorization from the VA. We are in network for BCBS, Aetna, EBMS. You will need to provide us with your insurance coverage information so we can confirm coverage, deductible, co-pay, etc. Please bring in ID and your insurance card. Due to the extraordinary time it takes to receive payment, we do not bill secondary insurance. Sorry, Medicare and Medicaid do not cover our services.

Payment is expected at the time of service. We do offer substantially discounted treatment plans which will make receiving care more affordable for you.

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.

Referrals

We would appreciate referrals of your family and friends to our practice. Word of mouth is the life blood of a practice such as ours. If you enjoy your time with us, please consider helping us spread the word with either a written or video testimonial.

Thank you for allowing us to assist you with your health care needs. We are honored to have you part of the Premier Acupuncture family.

Mike
Julie
Barb



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THIS IS A FILLABLE PDF FORM. PREFERABLY, COMPLETE THIS FORM ON YOUR COMPUTER, PRINT, SIGN AND BRING TO YOUR INITIAL APPOINTMENT.

PERSONAL INFORMATION

Last Name First Name MI
Marital Status Married Single How do you wish to be addressed?
Mailing Address City/State Zip
Home Phone Work Phone Cell Phone
Can we leave a message if you are unavailable? Yes No
Date of Birth Age Social Security #
Occupation Employer
Spouse's Name Spouse Date of Birth Phone
Your Email Address

PATIENT / RESPONSIBLE PARTY INFORMATION

Responsible Party Relationship to Patient
Social Security # Date of Birth Phone
Address: City/State/ Zip
Employer Phone

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

VETERANS – Simply put VA under Primary Insurance

PRIMARY Insurance Insurance Phone
Claims Address City/State/Zip
Name of Insured ID#
Insured DOB Group Name/Number Claim #

How did you hear about us? **Community Presentation** **Internet** **Facebook**
Google AdWords Walked by the office Phone Book Family / Friend /Physician

Referred by

Signature _____

Date



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PATIENT RESPONSIBILITIES

Cancellations: The staff at Premier Acupuncture 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. Exceptions will be made on a case by case basis.

If your appointment is not cancelled at least 24 hours in advance and we are unable to communicate with you at the time of your missed appointment, any future appointments you have scheduled will be cancelled, and you will need to call to reschedule.

Appointments for existing patients are typically scheduled every 20 minutes. Please make every effort to be on time. If you are more than 7 minutes late we will need to reschedule your appointment in most cases. This is necessary so we can respect the time of the person that has the appointment following yours. Please arrive a few minutes early so you can complete the PCA (Patient Condition Assessment) form which is required with each appointment. You can also complete the form online, print and bring it with you. If you choose to complete online, please do so as close to your appointment as possible.

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 24 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

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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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, 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.

Acupuncture (and other treatments utilized by Premier Acupuncture & Complementary Medicine, Inc.) are generally safe (very safe) methods of treatment but there may be 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. We **ONLY** use disposable needles which have been sterilized by the manufacture and your skin is prepared with alcohol prior to acupuncture treatment. We always maintain a clean and safe environment. You will never be exposed to needles used by another patient. Herbal and nutritional medicine is generally a very 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, 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 effects 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 by keeping us informed.



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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 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 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 _____ Date _____
(or guardian if under 18)

Print Name

Relationship to Patient



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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.

1. If your insurance approves and then later declines coverage, you remain financially responsible for charges.
2. You are responsible for all balances owed after insurance payment, less any contractual write-offs required by your insurance company.
3. In cases where payment from your insurance has not been received within 60 days of claim submission, you agree to be responsible for charges. We will continue to assist you in obtaining reimbursement from your insurance company. In the event this situation arises, and we ultimately receive payment from your insurance company, we will reimburse you the amount paid by your insurance.

PLEASE READ AND SIGN

We require a credit card / debit card be on file (in our secure system) to cover any outstanding insurance deductible, co-payment, or payment of charges if payment from your insurance company has not been received within 60 days of claim submission. Your information is kept in an encrypted file within our accounting software program.

Authorization

I authorize Premier Acupuncture to release any information required to process my insurance claims. I hereby authorize my insurance benefits to be paid directly to Premier Acupuncture. 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 payment from my insurance company has not been received within 60 days of claim submission. I authorize Premier Acupuncture to charge my credit card to cover the aforementioned situation, or any other reason I agree to in the future. I authorize the release of any medical records to my insurance company which are necessary to process any and all claims filed now or in the future. I authorize Premier Acupuncture to email mail me at the email address I have provided. Emails containing private medical information will be sent via encrypted, HIPAA compliant email.

Signature _____ Date

Printed Name

HIPAA

I have received a copy of PREMIER ACUPUNCTURE & COMPLEMENTARY MEDICINE'S **Notice of Privacy Practice & HIPAA Statement.**

Signature _____ Date

Premier Acupuncture

Patient Name

DOB

Date

Weight

THIS IS A FILLABLE PDF FORM. PLEASE COMPLETE THIS FORM ON YOUR COMPUTER, PRINT AND BRING TO YOUR FIRST APPOINTMENT. USE LOWER CASE LETTERS FOR MORE SPACE. USE A SEPERATE SHEET OF PAPER IF NEEDED.

HEALTH HISTORY

MAIN COMPLAINTS		Intensity	
In the space below, please list the reason you are here today. Please list in the order of importance. Use seperate sheet of paper if more room is required.		On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = <i>no discomfort</i> , 10 = <i>extreme discomfort</i>)	
		on AVERAGE your complaint is	at WORST your complaint is:
1.			
2.			
3.			
4.			
5.			
6.			
Onset		What have you tried doing to resolve these problems that DID NOT work?	
Your best guess as to when complaints began		Please list past and current treatments that have not worked or have had limited effect.	
1	Date began:		
2	Date began:		
3	Date began:		
4	Date began:		
5	Date began:		
6	Date began:		
Frequency		Duration	
How often are these complaints present (Constantly, ___ days per week ___ days per month ___ Other)		When you are feeling your symptoms, how long do your symptoms last? (min, hrs, days, constant)	
1			
2			
3			
4			
5			
6			
What Aggravates or Alleviates your Chief Complaints?			
	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?	
1			
2			
3			
4			
5			
6			

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Patient Name:

DOB:

Date:

How are your health problems interfering with the following areas of your life?	
Work	
Family	
Hobbies	
Life	

How have you taken care of these complaints in the past?

Medications

Dietary Modifications

Chiropractic

Surgery

Vitamins & Supplements

Massage

Injections

Acupuncture

Other:

Exercise

Herbal Medicine

How did the previous methods work for you?

What do you desire from treatment? (choose one)

Just want relief from symptoms then will see what happens

Want to correct the cause of the problem and start a program directed at addressing these causes

Other:

If we were to sit down and discuss your life 2 years from now and look back at today, what would have to have happened for you to be happy with your progress during our time addressing your health concerns? ie. able to engage in activities you love, off pain meds, etc.

What potential barriers do you foresee that would prevent you from achieving your health goals?

Do you feel it is possible to eliminate or reduce these barriers to achieving your goals?

Rate on a scale of 1-10 (1 being lowest, 10 being highest):

How important is it for you to resolve your health concerns?

Are you prepared to make the necessary changes to achieve your goals? Yes No

ARE YOU PREGNANT? Yes No If yes, what is your due date

How much exercise do you get? What type?

Do you smoke? Yes No How much water do you drink? Do you drink soda? Yes No

Do your work activities mostly involve: Sitting Light Labor Heavy Labor

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Patient Name

DOB

Date

If the following imaging methods are relevant to your current complaint(s) please complete. Otherwise you can skip this part.

IMAGING & TESTS	DATES	RESULTS
X-ray		
MRI's		
CT Scan		
Mammogram		
Ultrasound		

Please list all health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

List all medical conditions you are currently being treated for (include the dates of when you were diagnosed if known, approximate if needed):

List all types of surgeries you have had in the past (include dates if known month and year, approximate if needed):

List all significant accidents you have had in the past (include dates if known - month and year, approximate if needed):

List all Allergies (food, medications, pollen, etc.):

List all Medications (prescription & over-the-counter) you are currently taking (include dosage if known):

List all nutritional supplements, herbs, or vitamins you are currently taking:

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Patient Name:

DOB:

Date:

The bottom section of this page is a fillable PDF, the image section is not. In order to complete the image section found below, you will need to print and complete manually.

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.

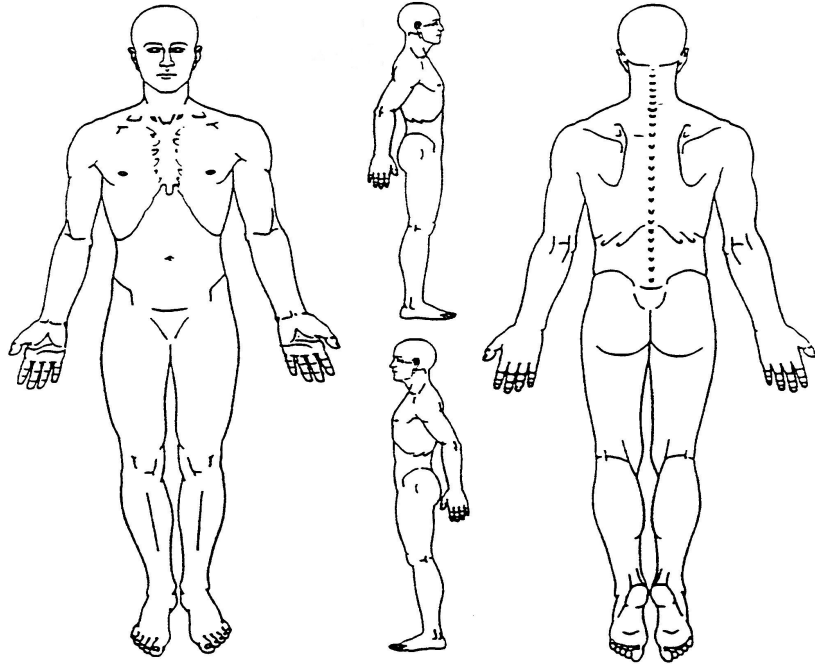
Please Show Areas Of:

Primary Pain using - ***

Secondary Pain using - 0

Numbness using - ////

Pins and needles using - P



If there is any additional information you think would be helpful that has not been asked previously, please include it below. You can complete this section online - the section below is a fillable PDF.

Patient Name

DOB

Date

Please check all symptoms you experience. These questions may not seem to be related to your current complaint, but they will aid in evaluating your health and in looking for contributing factors to your current health concerns.

Shortness of breath / wheezing / difficulty breathing

Slow heart beat (<50 beats/min)

Easily catch colds / chronic infections

Irregular heart beat

Sinus problems

Palpitations / heart fluttering / tight sensation in the chest

Nose bleeds

Bitter taste in the mouth

Cough

Skin rashes (redness, itching)

Snoring loss of smell / taste

Headache at the top & sides of the head, migraines

Dry nose / mouth dry

Numbness / tingling sensation

Dry skin

Muscle twitching / cramping / spasms

Allergies

Seizures / convulsions, tremors, tics

Alternating fever & chills

Lump in the throat

Excessive sweating

Neck & shoulder tension / tightness / pain

Difficult sweating

Joint pain

Headaches

TMJ pain

Chronic sadness

High-pitched ringing in ears

Constipation / hemorrhoids

Difficulty adapting to stress

Alternating diarrhea & constipation

Dizziness / poor balance / vertigo

Sores on tip of tongue

Itchy eyes / burning eyes / dry eyes

Trouble falling / staying asleep

Fatigue after eating

Waking up unrefreshed, tired

Bruise easily

Blood or mucus in stools

Sore achy/ weak knees

Undigested food in stool

Profuse or frequent urination

Diarrhea / constipation

Scanty urination

Bloating, excess flatulence

Low back pain

Acid Regurgitation / sore throat

Muscle tightness

Bad breath

Urinary incontinence

Sores in mouth

Abnormal urination (blood, painful, cloudy)

High stress / over-thinking everything / ADD / ADHD / anxiety

General weakness, low energy, chronic fatigue

Irritable, angry & frustrated frequently

Low / no libido

Mental sluggishness / foginess

Excessively high libido

Mood swings / suffer from depression

WOMEN ONLY

Cold hands / feel cold all the time

Menstrual cramps

Hot flashes & night sweats

Irregular cycle

Thirsty all the time

Premenstrual syndrome

Fast heart beat (>100 beats/min)

Headaches - premenstrually or menstrual



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

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.

continued on next page

Your Rights *continued*

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
- Contact you for fundraising efforts

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 November 12, 2018

This Notice of Privacy Practices applies to the following organizations.

For additional information regarding your rights and obligations under HIPAA contact Michael Wedge, L.Ac. at premieracupuncture@mtaonline.net