City Wellness

Confidential Acupuncture Patient Information

Name_____ Date_____

Address_____Email_____

Phone numbers (home)_____ (work)_____

(cell)_____ (emergency)_____

Who may I thank for referring you?_____

Date of birth_____ Sex_____ Age_____ Marital status_____ Number of children_____

Occupation_____ Hobbies_____

Responsible party (if not patient)_____ relationship_____

Primary care physician_____ phone_____

Last Physical Exam: Date_____ Doctor_____

Height_____ Weight_____ Recent changes?_____

ALL Current diagnoses_____

_____

Complaint (please rank by priority)	Onset	Frequency	Severity
Example: headaches	*07/01*	*X times/ week*	*mild/ moderate/ severe*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What other treatments have you tried, and what has been your response?

_____

_____

Medicines taken within the past two months: (include vitamins, over-the-counter drugs, herbs, etc)

_____

_____

Occupational stresses: (chemical, physical, psychological, etc)_____

Lifestyle: Indicate quantity, type, and frequency:

Alcohol_____ Coffee_____ Tea_____

Tobacco_____ Sweets_____ Sodas_____

Water_____ Exercise_____ Drugs_____

Typical daily diet_____

_____

Food cravings: sour_____ bitter_____ sweet_____ spicy_____ salty_____ other_____

Current health issues:

_____poor appetite _____strong appetite _____strong thirst (hot or cold drinks?)_____

_____poor sleep _____heavy sleep _____insomnia _____fatigue _____tremors

_____vertigo _____localized weakness _____poor coordination _____cold hands ____cold feet

_____cold back _____cold abdomen _____fevers _____chills _____night sweats

_____sweat easily _____bleed or bruise easily (where) _____ _____sudden energy drop at _____(time)

_____allergies: what kind (food, medications, respiratory) _____

Head, Eyes Ears, Nose, Throat

_____dizziness _____migraines _____dry eyes _____glasses _____eye strain

_____eye pain _____poor vision _____blurry vision _____cataracts _____night vision

_____color blindness _____spots in eyes _____earaches _____ringing in ears

_____poor hearing _____ear infection _____nose bleeds _____sinus problems

_____mucus _____allergies _____dry throat _____dry mouth _____snoring

_____copious saliva _____sores in/on mouth_____teeth problems _____gum problems

_____jaw clicks _____grinding teeth _____recurrent sore throats_____/month _____facial pain

_____headaches (where and when) _____

other head or neck problems: _____

Skin and hair:

_____rashes _____ulcerations _____hives _____itching _____hair loss

_____eczema _____pimples _____dandruff _____change in skin/ hair texture

_____herpes (where) _____ other hair or skin problems_____

Respiratory:

_____cough _____coughing blood _____asthma _____bronchitis _____tight chest

_____pneumonia _____difficulty breathing while lying down _____production of phlegm

other respiratory problems_____

Cardiovascular:

_____high blood pressure _____/_____ _____low blood pressure _____/_____

_____irregular heart beat/ palpitations _____chest pain _____dizziness _____fainting

_____swelling in hands/ feet _____blood clots_____phlebitis _ ____difficulty breathing

other cardiovascular_____

Gastrointestinal:

_____nausea _____vomiting _____diarrhea _____gas _____food allergy

_____belching _____black stools _____heartburn _____bad breath_____bloating

_____rectal pain _____hemorrhoids _____constipation _____bloody stool

_____tenderness in abdomen _____laxative use/ frequency_____ _____pain or cramps

stools: _____frequency _____color _____odor _____texture/ form

other gastrointestinal problems_____

Urogenital:

_____pain on urination _____frequent urination _____blood in urine _____urgency to urinate

_____unable to hold urine _____kidney stones _____urinary infection _____venereal disease

_____impotency _____wake up to urinate how often?_____ per night_____ time of night

other urogenital_____

Pregnancy and Gynecology:

_____number pregnancies _____number births _____premature births _____miscarriages

_____age at first menses _____irregular periods _____painful periods _____PMS _____perimenopausal

_____vaginal sores _____breast lumps _____vaginal discharge: color_____odor_____

_____age at menopause _____length of cycle (days) _____length of period (days) _____birth control, type, duration of birth control_____ other gynecological_____

Musculoskeletal:

_____neck pain _____muscle pains _____tendonitis _____back pain

_____joint pains _____spasms/ cramps _____weakness (where_____)

_____osteoporosis _____broken bones _____broken teeth _____concussion

other bone, joint, or muscular problems_____

Neuropsychological:

_____seizures _____areas of numbness _____poor memory _____depression _____anxiety

_____bad temper _____easily stressed _____moodiness _____treated for emotional problems

_____considered/ attempted suicide other neurological or psychological problems_____

History: Significant illnesses: _____cancer _____diabetes _____high blood pressure _____heart disease

_____hepatitis _____rheumatic fever _____thyroid disease _____seizures _____other (include any which made you very ill, had high fever, recurred, required hospitalization, or took long to resolve)

_____

Trauma: List any injuries, dislocation, head trauma, loss of consciousness, sprains, fractures, or burns

_____

_____

Surgeries: _____

_____

Family medical history:

_____heart problems _____hypertension _____diabetes _____stroke

_____kidney disease _____cancer _____breathing problems _____TB/ tuberculosis

_____seizures _____mental illness _____addiction _____thyroid disease

_____allergies _____arthritis _____other_____

I hereby certify that the above is true, complete, and accurate.

signature_____

City Wellness

Office Policy

Kindly give at least 24 hours notice for cancelled appointments. Giving sufficient notice will allow another patient to benefit from the time that was reserved for you. Missed appointments, or those cancelled with insufficient notice, will be charged a $25 cancellation fee.

Although City Wellness does not accept insurance assignment, we are happy to provide you with the receipts needed to file a claim for yourself. Please let us know if you would like to receive a receipt.

Payment is due at the time services are rendered. Payments in the form of cash, check, debit or credit cards are accepted.

I understand and accept the above policy.

Signature_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize you to disclose health information to (leave message with, pick-up herbs etc.):

__ No person at this time

__ Spouse: _____

__ Family member: _____

__ Friend: _____

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

Social Security Number:_____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

Notice of Privacy Practice

This notice describes how health information about you may be used and disclosed,
and how you can get access to this information. Please review it carefully.
The privacy of your health information is important to us.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights regarding your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect May 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. This may include your primary care physician, their PA or nurse, physical therapist, nutritionist, or dentist.

Healthcare Operations: We may use or disclose your healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification or healthcare professionals, evaluation of practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

To Your Family and Persons Involved in Your Care: We must disclose your health information to you. With your authorization, we may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify or assist in the notification to you. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled herbal prescriptions, medical supplies, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

> Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public authorities.
>
> Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
>
> Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health & Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Workers' Compensation: We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your Health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

Appointment Reminders or Changes: We may use or disclose your health information to provide you with appointment reminders, make appointment changes, suggest treatment alternatives, or return your phone calls. We will request written notice of how you would like all telephone contact to be made.

Patient Rights:

Access: You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. We will charge you a reasonable, cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, and healthcare operations. If you request this accounting more than once every 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information; your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us. You may also submit a written complaint with the U.S. Department of Health and Human Services.

Telephone: 904.671.2860
Address: 120 Sea Grove Main Street, Saint Augustine, FL 32080

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I have had the opportunity to ask questions about it and have been fully answered.

I would like to receive telephone communication or messages via:
(check all that apply)

_____home phone: _____

_____work phone: _____

_____cell phone: _____

Please print name: _____

Please sign name: _____

Date: _____

For Office use only:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but the acknowledgement could not be obtained because:

_____individual refused to sign

_____communication barriers prohibited obtaining the acknowledgement

_____an emergency situation prevented us from obtaining acknowledgement

_____other

A.P. Signature_____Date:_____