

PF-1000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Triangle Acupuncture Clinic, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that had occurred before you notified us of your decision to revoke your authorization.

Individual Rights.

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Triangle Acupuncture Clinic, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Triangle Acupuncture Clinic, LLC
104 S. Estes Dr. Suite 104
Chapel Hill, NC 27514
919-933-4480

Effective Date

This Notice is effective on or after February 8, 2011

YOU MAY KEEP THIS COPY OR WE CAN STORE IT IN YOUR FILE.

PF-2000 Acknowledgement of Receipt of Privacy Practices

Triangle Acupuncture Clinic, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Triangle Acupuncture Clinic, LLC.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient



Welcome to Triangle Acupuncture Clinic! For your convenience, we will explain our office policies to serve your needs efficiently. Please read carefully.

1. We ask that patients provide a list of any and all medications and or supplements that are currently being taken. These can be listed in your New Patient Health History Form, or provided separately.
2. Please do not be alarmed if some minor bruising results from treatment. This happens occasionally and is normal but if you have any questions or concerns, we encourage you to call our office.
3. We will furnish you with the appropriate receipts so that you can file for reimbursement through your insurance carrier. We do not bill insurance directly.
4. **AT LEAST 24 HOURS NOTICE OF CANCELLATION IS REQUIRED TO AVOID A \$50.00 MISSED/LATE CANCELLED APPOINTMENT CHARGE.** Because we are committed to providing the very best care for our patients, we appropriate a specific amount of time for each individual's care with their practitioner. An advance cancellation notice allows us an opportunity to extend care to the many patients on our waiting list. _____ **(please initial)**
5. You are expected to be on time for your appointments. If you find that you cannot be on time, please notify our office as soon as possible. If you are late for your appointment, the practitioner may not be able to see you at that time or may not be able to give you the full amount of time originally scheduled for you.
6. All herbs must be paid in full at time of purchase.
7. Returned checks are subject to a \$25.00 service charge.
8. It is important for our records that you advise us of any change in your address or phone number(s).
9. For the courtesy and safety of other patients, we request that you refrain from wearing any fragrances while in our office.
10. Please silence your mobile device in the lobby and treatment rooms.

Please read and sign this form and bring with you to your initial appointment.

Name: _____

Signature: _____

Date: _____



104 S. Estes Dr
Suite 104
Chapel Hill, NC
27514

2601 Lake Dr.
Suite 103
Raleigh, NC
27607

Welcome to Triangle Acupuncture Clinic. To help us provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have questions please ask us. Thank you for your time.

CONTACT INFORMATION

Name: Today's Date:
Street Address: City, State: Zip:
Primary (Best) Phone: () home work cell (circle one)
Secondary Phone: () home work cell (circle one)
Email Address:
Do you prefer appointment reminders by: email text both (circle one)
In Case of Emergency, Contact: Phone: () circle: h w c
How did you hear about us?
We like to thank those that refer to us. Name of person who referred you:
Marital/Relationship Status: Occupation:
Birth Date + Age: Height: Weight: Sex:
Primary Physician's Name: Date of last visit:
OB/GYN's Name: Date of last visit:
Reproductive Endocrinologist's Name: Date of last visit:
Other Health Care Providers You See Regularly and For What Conditions:

FERTILITY HISTORY

Age period began: How many days do you normally bleed?
Cycles are regular, days long Cycles are irregular, ranging from to days
Do you ovulate on your own? On what day of your cycle?
Pre-Menstrual symptoms include:
weezy spotting before low back pain
irritable bloating abdominal cramping
depressed headaches acne
breast tenderness digestive upset loose bowels
Heaviest days change pad/tampon every hours on Day(circle) 1 2 3 4 5 6
What color is the blood? Black Brown Dark red Red Pale red
What is the consistency of the blood? Watery Thick Clots Dry Phlegmy
Clots are the size of a dime, quarter, bigger?
If you have painful cramps, it lasts through (circle) Day 1 2 3 4 5 6 7, does pain start before period as well?
Pain is better with (circle): heat, rest, movement, passing clot, taking this medicine, other
Pain is located (circle): mid-abdomen, low back, thighs, ovary area, other

Date of last menstrual period: _____

Number of pregnancies: _____

Number of children and ages: _____

Number of miscarriages or abortions: _____

Number of times a D & C has been performed: _____

Please circle, indicate the date you were diagnosed with any of the following:

abnormal PAP smear

uterine fibroids or polyps

yeast infection

genital sores

endometriosis

cervical biopsy/operation

pelvic adhesions

other: _____

How long have you been trying to conceive? _____ Cause of Infertility (doctor's diagnosis): _____

What is your Birth Control history? _____

Have you had abdominal surgery? _____

Are your tubes open? _____ AMH level? _____ Prolactin level? _____

Have your estrogen or progesterone levels been found to be low? _____

Has your thyroid been tested? (list any medications) _____

Describe in chronological order all other fertility treatments (Clomid, injectables, IUI, IVF, FET):

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Male partners: Has he had a fertility workup? Results? _____

How is your sexual energy? Low Medium High

How is your relationship with your partner now? Not Good Stressed Good Awesome

Place a mark on the line where you would characterize your mood:

Happy ----- Sad
 Content ----- Angry
 Carefree ----- Worried

Do you ever experience:

- OCD foggy head depression
- poor memory panic attack overwhelmed

Describe your stress level and any predominant emotions you are experiencing:

Do you have a support system of friends and family? _____

What do you currently do to promote relaxation and combat stress?

CURRENT HEALTH

Thinking about your internal thermostat, are you usually:

a. Warmer b. Colder c. Same as those around you

Do you have an aversion to or dislike of certain weather:

Dislike Cold inside or Outside? _____

Dislike Damp or Rainy Weather? _____

Dislike Air Conditioning or Drafts? _____

Dislike Summer and can't stand hot weather? _____

Do you have hot flashes? Y N

Do you sweat when not active? Y N

Do you have night sweats? Y N

Do you have allergies? Y N

Sleep (check the box if it applies)

Good

Easy to Fall

Light

Wake Tired

Poor

Hard to Fall

Deep

Wake Rested

Dreamful

Wake Often

Restless

Interrupted by: _____

Do you have an energy drop at certain time of day? When? _____

In general your energy is: c. Average a. Lethargic b. Tired d. High

Urination

Light

Smells strong

Strong Stream

Dark

Weak Smell

Weak Stream

Scant

Burning

Interrupted

Profuse

Painful

Frequent UTIs

Do you wake at night to urinate? How many times? _____

Do you lose your urine when you cough, sneeze, or have a full bladder? _____

Bowels

1-2/day

Diarrhea

Hard

Contains Blood

3-4/day

Constipation

Dry

Contains Mucus

>4/day

Strong Smell

Incomplete

Anal Prolapse

Formed

Weak Smell

Hemorrhoids

Loose

Exercise

Days per week?

Length per workout?

Type of Activity?

Heart, Lungs & Skin

High Blood Pressure

Asthma

Chest Tightness

Palpitations

Cough

Sinus Pressure

Fainting

Phlegm

Hair Falling Out

Leg swelling

Hives

Bruise easily

Blood clots

Excema

Need more than one pillow

Varicose veins

Acne

shortness of breath

Dizziness

Psoriasis

Other:

weak/brittle nails

Dry Skin

Diet & Digestion

How thirsty do you generally feel? a. Not thirsty much b. Normal thirst c. Very thirsty

What type of drink do you prefer? a. Warm b. Cold c. Room Temp

How many per/day? Coffee _____ Milk _____
Soft Drinks _____ Water _____
Energy Drinks _____ Alcohol _____

Do you have a good appetite? _____ Do you crave sugar? salt?

When you eat, do you feel very full easily? _____ Do you forget to eat?

Do you follow a specific diet? vegetarian, paleo, etc? _____

Check all that apply:

- 1-2 meals/day
- 2-4 meals/day
- >4 meals/day
- Bloating
- Belching
- Gas
- Reflux
- Nausea
- Indigestion
- Pain after eating
- Heavy sensation

Briefly describe your diet and a sample day of eating:

Medications/Vitamins/Supplements/Herbs please list here or attach a list:

Please tell us about major surgery or hospitalizations or any other health concerns or information you would like to share:

Please continue to the following forms:

HIPAA

Office Policy

*Arbitration/Informed Consent (front and back) *this form is completed in the office*