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 many 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 polices 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 polices 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

triangle ACUPUNCTURE clinic, LLC

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: _____

triangle ACUPUNCTURE clinic, LLC

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

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:

Other Health Care Providers You See Regularly and For What Conditions:

CURRENT HEALTH

Please describe the main problem you would like to address including a diagnosis if it has been given:

When did the first symptoms begin?

What in your past do you think may have contributed to this problem?

What kinds of treatments, drugs or therapies have you tried? With what success?

Please list your goals for healing with regards to this condition:

Please continue to next page

Pain

	Sharp	Dull	Swelling	Tight	Heavy	Burning	Other
Head							
Jaw/TMJ							
Neck							
Shoulder							
Elbow							
Wrist							
Hand							
Hip							
Knee							
Ankle							
Foot							

Circle on a scale of 1-10 how much pain you are having now:
1(none) 2 3 4 5 6 7 8 9 10(worst imaginable)

Does the pain have a: a. fixed location b. move around c. radiate Other_____

What makes pain better? a. Warmth b.Ice c. Rest d. movement

Thinking about your internal thermostat, are you usually:
a. Hotter than those around you b. Colder than those around you 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 have night sweats? Y N
Do you sweat when not active? 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 would you say your energy is: a. Tired b. Lethargic c. Average d. High

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

Check all that apply:

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

Briefly describe your diet and a sample day of eating:

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			

Mental/Emotional

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

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	

Gynecological

Age menses began_____ Age Ended_____

Do you take birth control? What type_____

How many pregnancies have you had?_____ How many miscarriage or abortions?_____

Cycles are regular, _____days long Cycles are irregular, ranging between _____to_____days

Pain starts before period or with first day and lasts through (circle) Day 1 2 3 4 5 6 7

Pain is better with (circle): heat, rest, movement, passing clot, medicine _____

Pain is located (circle): mid-abdomen, low back, thighs, ovary area

Pre-Menstrual symptoms include:

- □ weepy
- □ irritable
- □ depressed
- □ breast tenderness
- □ spotting before
- □ bloating
- □ headaches
- □ digestive upset

Heaviest Days change pad/tampon every _____hours on Day 1 2 3 4 5 6

Describe the Color: black, brown, dark red, red, pale red as your period goes on:_____

Clots are the size of a dime, quarter, bigger and lots of them or just on the heaviest day? _____

Male/Urology

- □ genital pain/sores
- □ Impotence
- □ low sexual energy
- □ high sexual energy
- □ prostate problem
- □ premature ejaculation

PAST MEDICAL HISTORY

Please list any major illnesses and operations, and their date of onset:

_____

_____

_____

_____

Please continue to the following forms:

HIPAA
Office Policy
*Arbitration/Informed Consent (front and back) *This form is completed in the office.*