ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

SORRENTO VALLEY CHIROPRACTIC

5440 Morehouse Drive, Suite 1700
San Diego, CA 92121

ACUPUNCTURE NEW PATIENT INFORMATION

Date: _____

PERSONAL INFORMATION

Name: _____ D.O.B._____

Address:_____

City:_____State:_____Zip:_____

Home Ph (landline or cell):_____ Work Ph:_____

Is it okay to text? (Appointment reminders only) Yes ☐ No ☐

Email: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Employer: _____

Occupation: _____

Insurance Plan: _____

Primary Doctor: _____ Phone: _____

Height:_____ Weight:_____ (for insurance purposes) Male ☐ Female ☐

Have you had acupuncture before? Yes ☐ No ☐

Is your condition the result of a(n): Work Injury ☐ Auto Accident ☐ If so date of injury:_____

REFERRAL INFORMATION (Circle one and specify below)

Patient/Friend/Family Insurance referral Website Yelp/Google

Comments: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Contact Ph: _____

Medical Information:

Please indicate any significant illnesses you or a blood relative (parent, sibling) have had:

Illness	You	Your relative	Illness	You	Your relative
Anemia	☐	☐	Heart disease	☐	☐
Auto-immune disorder	☐	☐	Hearing problem	☐	☐
Bleeding disorder	☐	☐	High blood pressure	☐	☐
Cancer	☐	☐	Infectious disease	☐	☐
Circulatory problem	☐	☐	Lung problem	☐	☐
Diabetes (Type I or II)	☐	☐	Reproductive disorder	☐	☐
Emotional disorder	☐	☐	Seizure disorder	☐	☐
Hepatitis	☐	☐	Thyroid problem	☐	☐
			Tuberculosis	☐	☐

Comments:_____

Please indicate if you have a Sexually Transmitted Disease: Gonorrhea □ Syphilis □
AIDS/HIV □ HPV □ Chlamydia □ Herpes □

List any allergies (drugs, chemicals, foods):_____

_____

List any accidents, surgeries, or hospitalizations:_____

_____

Medications you are currently taking:

Medication	Dosage	Reason for taking	How long

Habits: Please mark any of the habits listed below which apply to you:

Smoking: Yes □ No □ If yes, # of cigarettes per day:_____
Alcohol: Yes □ No □ If yes, # drinks per week:_____
Caffeine: Yes □ No □ If yes, # coffee/tea/sodas per day:_____
How much water do you drink? _____

Do you: bruise easily □ have a pacemaker □ have a nerve stimulator □ have an insulin pump □

PRESENT COMPLAINTS:

Conditions	Date Began?	Severity	Frequency
Please list your reasons for coming in (health conditions) in the order of importance	Onset of symptom	Rate pain or symptoms from "0" none to "10" severe None……Severe	Please check box that best represents the amount of time you feel your pain or symptoms
1		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
2		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
3		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%
4		0 1 2 3 4 5 6 7 8 9 10	☐0-25% □ 26-50% □51-75% □ 76-100%

List your daily activities that are limited because of your symptoms:

1._____

2._____

3._____

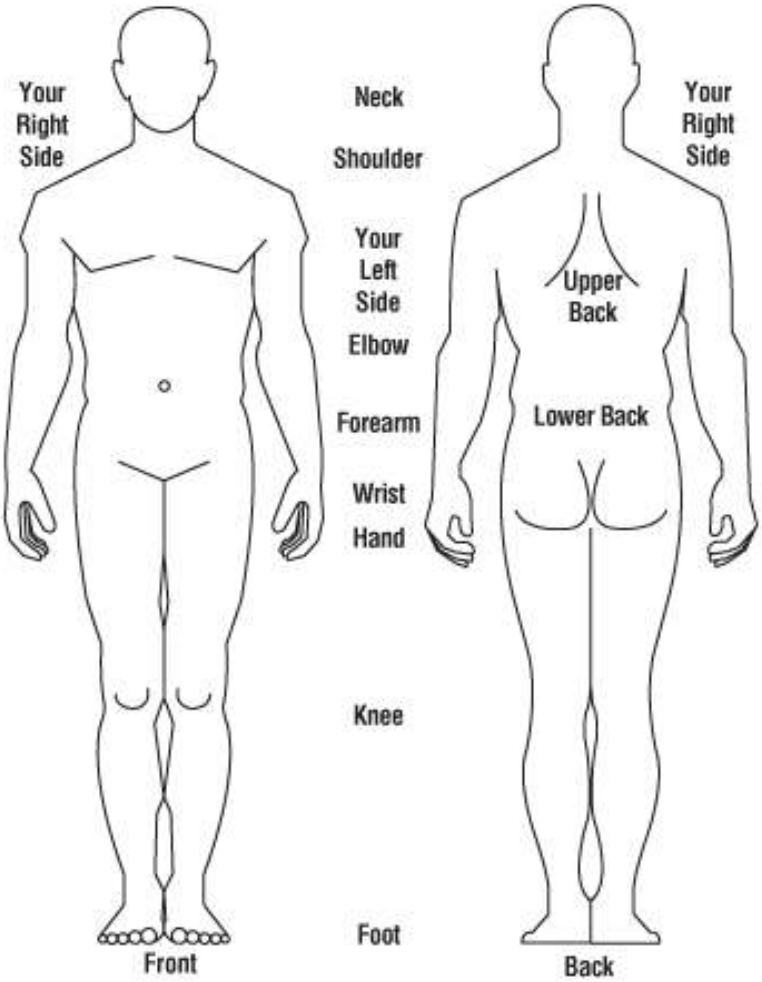
What are your goals in regards to your treatments:

_____

_____

_____

MARK AREAS OF PAIN ON DIAGRAM BELOW (circle or mark an X):



Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE CONTAINS IMPORTANT INFORMATION ABOUT OUR PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. What is this notice?

To run our practice, we must collect, maintain and use non-public personal information on patients to whom we provide services. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure. This notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information as to our legal duties and privacy practices. It also describes your rights to access and control your non public personal information (NPI).

We are required to abide by the terms of this notice. However, we may modify the terms of this notice at any time, and the new notice will be effective for all NPI in our possession at the time of the change, and any created or received thereafter.

Information this practice collects, uses and maintains on you is protected by Federal and state laws: the Health Insurance Portability and Accountability Act (HIPAA) and state public health laws. This practice does not disclose NPI to anyone, except with your authorization or otherwise as permitted by law.

If you believe your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) have been violated you can submit a written complaint to the address of this practice. You may also complain to the Secretary for Health and Human Services if you believe your privacy rights have been violated. There will be no retaliation for filing a complaint.

II. What is "non-public personal information" (NPI)?

Non public personal information (NPI) is information that identifies you as an individual and relates to your participation in treatment, your physical or mental health/condition, the provision of treatment or healthcare to you or payment to us for the provision of services provided to you.

III. How do we protect NPI?

We restrict access to NPI to members of our workforce (staff and trainees) who need to provide care or services to you or are engaged in important agency operations. We maintain physical and procedural safeguards to protect your information against unauthorized access and use. We also commit to developing, educating our workforce about and overseeing the implementation and enforcement of policies and procedures to safeguard your health information against inappropriate access, use and disclosure, consistent with applicable law.

IV. How does this practice use non-public personal information (NPI) and for what purposes?

Here are some examples of what we do with the information we collect and the reasons it might be used:

Treatment: We may use information about you to provide medical treatment and services to you. We may use and share NPI with our staff and trainees who are involved in providing care to you. For example, information obtained by our staff and trainees will be recorded in a treatment record and used to determine your course of treatment.

Payment: We may use and disclose NPI so that treatment and services you receive may be billed to and payment collected from you or a third party. For example, we may complete and submit to your healthcare plan or insurance company a description of treatment provided to you. We also may use and disclose your NPI to obtain payment from other third parties that may be responsible for the costs, such as family members.

Health Care Operations: We may also use and disclose NPI to perform health care operations. This is necessary to make sure that all of our patients receive quality care. For example, we may us NPI to review our treatment and services and to evaluate the performance of our staff and trainees. We may also use and share NPI with the institute's trainees and other personnel for review and learning purposes.

V. What uses and disclosures do not require your authorization?

We may use and disclose NPI without your authorization for the following purposes:

Business Associates: We may contract with outside individuals and organizations that perform business services for us, such as billing, management consultants, accreditation organizations, quality assurance reviewers, accountants or attorneys. In certain circumstances, we may need to share your information with business associates so they can perform a service on our behalf. We will limit the disclosure of information to business associates to the amount of information that is the minimum necessary for the business associates to perform services for us. In addition, we will have a written contract in place with business associates requiring them to protect the privacy of your information.

As Required by Law: We will disclose NPI when required to do so by federal, state or local law.

Public Health Activities/Risks: We may disclose NPI to public health authorities that are authorized by law to collect information for the purpose of:

- Reporting child abuse or neglect;
- Preventing or controlling disease, injury or disability;
- Notifying a person regarding potential exposure to a communicable disease;
- Notifying a person regarding the potential risk for spreading or contracting a disease or condition;
- Reporting reactions to drugs or problems with products or devices;
- Notifying individuals if a product or device we may be using has been recalled;
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of a patient (including domestic violence); and
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Care Oversight Activities: We may disclose NPI to a health oversight agency for activities authorized by law. Oversight activities can include: investigations, inspections, audits, surveys, licensure and disciplinary actions; civil administrative, and criminal procedures or actions; or other activities necessary for the government to monitor compliance with civil rights laws and the health care system in general.

Lawsuits and Disputes: We may use and disclose NPI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your NPI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court order protecting the information the party has requested.

Law Enforcement: We may disclose NPI if asked to do so by a law enforcement official as part of law enforcement activities; investigations of criminal conduct at this practice or of victims of crime; in emergency situations to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator); or when required to do so by law.

Serious Threats to Health or Safety: We may use and disclose your NPI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military: We may use and disclose NPI if you are a member of United States or foreign military forces (including veterans) and if required by the appropriate military command authorities.

Protective Services for the President, National Security and Intelligence Activities: We may use and disclose NPI to federal officials for intelligence and national security activities authorized by law. We also may disclose your NPI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Worker's Compensation: We may release NPI for worker's compensation or similar programs.

VI. What uses and disclosures of NPI require your authorization?

Individuals Involved in Your Care or Payment for Your Care: We may release NPI to a friend or family member identified by you, that is helping you pay for your treatment or who assists in taking care of you.

V. What are your rights governing the information that we collect, use and maintain on you?

The Right to Inspect and Copy: You have the right to inspect and obtain a copy of your NPI that we maintain and have in our possession, including treatment records and billing records. If you request copies, we will charge you a fee for the costs

of copying, mailing, labor and supplies associated with your request. To inspect and copy your NPI, you must submit your request in writing to our address.

Under certain circumstances we may deny your request to inspect and copy your NPI. If you are denied access to this information, you have the right to have that determination reviewed. A licensed health care professional chosen will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

The Right to Amend or Correct NPI: If you feel that any NPI we have about you is not correct or incomplete, you may ask us to correct or amend the information. You have the right to request an amendment for as long as the information is kept (seven years). To request an amendment, your request must be made in writing to the address below. Additionally, you must provide a reason that supports your request.

This practice reserves the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the medical information kept;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The Right to an Accounting of Disclosures: An accounting of disclosures is a list of the disclosures we have made, if any, of your NPI.

You have the right to request an accounting of disclosures made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It also excludes communications of NPI made to you or disclosures authorized by you.

Your request must be made in writing and state a time period that cannot be longer than six (6) years. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The Right to Receive Communications of NPI by Alternative Means or at Alternative Locations: You have the right to request that we communicate with you about your treatment and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We will accommodate all reasonable requests made in writing.

The Right to Request Restrictions: You have the right to request a restriction or limitation on the NPI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a limit on the treatment information we disclose about you to someone who is involved in your care or the payment for your care (like a family member or friend).

We are not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply.

Any request for a restriction on our use and disclosure of your NPI must be made in writing to the address below. Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

The Right to Provide an Authorization for Other Uses and Disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your NPI may be revoked at any time in writing to the address below. After you revoke your authorization, we will no longer use or disclose your NPI for the purposes described in the authorization, except under the following circumstance:

We have taken action in reliance upon your authorization before we received your written revocation

The Right to Obtain a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice of privacy practices at any time.

NOTICE OF PRIVACY PRACTICES

My signature below indicates that a written copy of the institute's Notice of Privacy Practices was provided to me. I have also been informed that if I require additional information about this notice I may call the Privacy Office.

PATIENT NAME:	
PATIENT SIGNATURE:	**DATE:**

Patient Refused to Sign:

STAFF SIGNATURE DATE