Elevated Acupuncture (https://www.elevatedacupuncture.org)

Edit (/admin/settings/forms_surveys/intake_form_builder/185)

Back to Intake Forms (/admin/settings/forms_surveys/intake_forms)

Profile Information — Step 1 of 4

You are completing the intake form: **Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy** for **

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Preferred Name (if different)

Pronouns

They/Them/Theirs

Prefix / Title

Please provide at least one phone number. Your mobile number can be used to look up your Account.

Mobile Phone – *Required*

us l

A mobile phone is required if you would like to receive SMS appointment reminders.

Home Phone

us l

Country – *Required*

United States

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Postal / Zip – *Required*

Date of Birth – *Required*

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

How did you hear about us?

How did you hear about us?

Please check that all required questions have been answered.

Continue

Insurance Information — Step 2 of 4

You are completing the following intake forms: Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy

Your insurance policy

If you plan on using insurance benefits, our practitioner takes Regence, Premera, Aetna, UHC, Kaiser, ASH/Cigna, and motor vehicle accident/PIP. Please be prepared to show your photo id and insurance card. Please note: Ambetter, Apple Health, and Coordinated Care does not cover acupuncture, even though we are in-network :) Medicare depends on the Insurer.

Insurer

Select an insurer

Back Skip Save and Continue

Questionnaires — Step 3 of 4

You are completing the following intake forms: Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy

Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy

Primary complaint – *Required*

Please indicate the severity of this problem at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this problem at its best (with 0 being no problem)

0 1 2 3 4 5 6 7 8 9 10

When did this problem start

How often do you experience it? Is it constant? Does it come and go? How long are the episodes when you experience it?

What makes it better?

What makes it worse?

Please list a second most important complaint (if you have any)

Please indicate the severity of this problem at its worst

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this problem at its best

0 1 2 3 4 5 6 7 8 9 10

For your chief and or secondary complaint(s) please describe any therapies/treatments you have tried or are currently receiving. Please tell us how these treatments are working.

Please note any other problems or concerns you would like to address

Please check the applicable boxes. You can give details or add any additional information in the notes box after each section.

Important Information: Please check the appropriate boxes.

- [ ] I have a bleeding disorder.
- [ ] I am currently taking blood thinning medication.
- [ ] I have an electrical implant such as pacemaker, insulin pump or stimulator.
- [ ] I am pregnant, may be pregnant or planning to be pregnant.
- [ ] I have epilepsy
- [ ] I have a history of cancer
- [ ] I am currently undergoing treatment for cancer
- [ ] I am currently undergoing treatment for hepatitis
- [ ] Surgical history/hospitalizations
- [ ] I have needling restrictions on areas of my body (note below)
- [ ] Other
- [ ] None of these apply

Please give details for any boxes checked above.

Head

- [ ] Migraines
- [ ] Headaches
- [ ] Facial Pain
- [ ] Concussions
- [ ] Dizziness
- [ ] TMJ Pain
- [ ] Jaw clenching/grinds teeth
- [ ] Vertigo
- [ ] No problems

Details for any boxes checked above or other non listed problem

Skin/hair

- [ ] Normal
- [ ] Dry skin
- [ ] Hair loss
- [ ] Psoriasis - dry
- [ ] Psoriasis - wet
- [ ] Scales
- [ ] Hives
- [ ] Rash
- [ ] Eczema
- [ ] Itchy skin
- [ ] Acne
- [ ] Graying Early
- [ ] Wounds slow to heal
- [ ] Dry/brittle hair/no lustre

Details for any boxes checked above or other non listed problem

Eyes, Ears, Nose, Throat

- [ ] Chronic sinus congestion
- [ ] Chronic cough
- [ ] Yellow sputum
- [ ] Clear sputum
- [ ] White sputum
- [ ] Clear nasal discharge
- [ ] Yellow/green nasal discharge
- [ ] Gum or teeth problems
- [ ] Thirst excessive, dry mouth or lack of

- [ ] Sinus pain
- [ ] Allergies
- [ ] Watery eyes
- [ ] Itchy eyes
- [ ] Red eyes
- [ ] Dry eyes
- [ ] Sore Throat
- [ ] Feeling that something is stuck in throat
- [ ] Cataracts
- [ ] Macular degeneration
- [ ] Eye pain
- [ ] Ear pain
- [ ] Hearing problems
- [ ] Ringing in ears - high pitched
- [ ] Ringing in ears - low pitched
- [ ] Other
- [ ] No problems

Details for any boxes checked above or other non listed problem

Respiratory/Immunologic

- [ ] Asthma
- [ ] Cough
- [ ] Chest Congestion
- [ ] COPD
- [ ] Emphysema
- [ ] TB
- [ ] Fungal infection
- [ ] Frequent colds
- [ ] Frequent low grade fever
- [ ] Chills
- [ ] Fever
- [ ] Immunologic disorder

- [ ] Other
- [ ] No problems

Details for any boxes checked above or other non listed problem

Cardiovascular/Hematological

- [ ] Pacemaker
- [ ] Normal Blood Pressure
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Irregular Heartbeat
- [ ] Palpitations
- [ ] High cholesterol
- [ ] Ankle swelling
- [ ] Chest pains
- [ ] Cold Hand and/or feet
- [ ] Taking RX heart medication (please list below)
- [ ] Anemia
- [ ] Sickle Cell Disease
- [ ] History of DVT
- [ ] Varicosities
- [ ] Other (please list below)
- [ ] No problems

Details for any boxes checked above or other non listed problem

Neurological

- [ ] Seizures
- [ ] Tremors
- [ ] Twitches
- [ ] Lack of coordination

- [ ] Fainting
- [ ] Parkinson's Disease
- [ ] Areas of numbness (list below)
- [ ] Neuropathy
- [ ] Poor memory
- [ ] Loss of balance
- [ ] Other (list below)
- [ ] No Problems

Details for any boxes checked above or other non listed problem

GI

- [ ] Borborygmus
- [ ] Belching
- [ ] Bloating
- [ ] Ulcers
- [ ] Pain after eating
- [ ] Distention of abdomen
- [ ] Pain when hungry
- [ ] Pain/cramping
- [ ] Constant pain
- [ ] Gas
- [ ] Excessive gas
- [ ] Acid reflux
- [ ] Burning when laying down
- [ ] Foul smelling gas
- [ ] Nausea
- [ ] Vomiting
- [ ] Fatty Liver
- [ ] Hepatitis
- [ ] Gall bladder problems
- [ ] Difficulty digesting fats
- [ ] Change in appetite

- [ ] Other

Details for any boxes checked above or other non listed problem

Bowel Movements

- [ ] Well formed, daily
- [ ] Diarrhea
- [ ] Constipation
- [ ] Watery
- [ ] With mucous
- [ ] Hard
- [ ] Dry
- [ ] Loose
- [ ] With blood
- [ ] Incomplete feeling
- [ ] Soft
- [ ] Foul smelling
- [ ] Hemorrhoids
- [ ] 1-2 movements per day
- [ ] 2-3 movements per day
- [ ] 3-4 movements per day
- [ ] more than 4 movements per day
- [ ] Other (please note below)
- [ ] No Problems

Details for any boxes checked above or other non listed problem

Gynecological

- [ ] N/A
- [ ] PMS symptoms (list below)
- [ ] PMDD symptoms (list below)

- [ ] Cycle every 20-22 days
- [ ] Cycle every 23-25 days
- [ ] Cycle every 26-27 days
- [ ] Cycle every 28-30 days
- [ ] Cycle every 30-39 days
- [ ] Cycle more than 40 days
- [ ] Irregular cycle
- [ ] Amenorrhea
- [ ] Dysmenorrhea - moderate pain
- [ ] Dysmenorrhea - heavy pain
- [ ] Spotting before menses
- [ ] Spotting after menses
- [ ] Spotting between menses
- [ ] Light/scanty menses
- [ ] Moderate/normal menses
- [ ] Heavy menses
- [ ] Menstrual discharge contains small clots
- [ ] Menstrual discharge contains small clots
- [ ] Cysts/Breast Lumps
- [ ] Hysterectomy - total
- [ ] Hysterectomy - partial (please give details below)
- [ ] Oophorectomy
- [ ] Inability to conceive
- [ ] Frequent miscarriages
- [ ] Currently working with RE specialist
- [ ] History of failed IUI
- [ ] History of failed IVF
- [ ] C-section
- [ ] Full term delivery
- [ ] Pain with intercourse
- [ ] Pregnancies
- [ ] Deliveries
- [ ] Abortions
- [ ] Miscarriages
- [ ] Menopause

- [ ] Hormone Therapy
- [ ] Birth Control
- [ ] Other (please provide details below)

Details for any boxes checked or other non listed problem

Endocrine

- [ ] Thyroid disease Hypo
- [ ] Thyroid disease Hyper
- [ ] Diabetes
- [ ] Pre-diabetes
- [ ] PCOS
- [ ] Other
- [ ] No Problems

Details for any boxes checked above or other non listed problem

Urological

- [ ] Urgency to urinate
- [ ] Frequent Urination
- [ ] Urinary incontinence
- [ ] Painful urination
- [ ] Incomplete urination
- [ ] Pale urination
- [ ] Dark urination
- [ ] Copious urination
- [ ] Scanty urination
- [ ] Dribbling urination
- [ ] Blood in urine
- [ ] Decrease urine flow/pressure
- [ ] Kidney stones
- [ ] Kidney disease
- [ ] Enlarged Prostate
- [ ] Erectile dysfunction
- [ ] Hormonal therapy (men)
- [ ] Other (please describe below)

Details for any boxes checked above or other non listed problem

Sleep

- [ ] No Problems
- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Difficulty falling and staying asleep
- [ ] Wakes early
- [ ] Pain interfering with sleep
- [ ] Restlessness
- [ ] Night sweating
- [ ] Snoring
- [ ] Wakes frequently because of partner/baby/animals or other outside influence
- [ ] Works night shift
- [ ] Disturbing dreams
- [ ] Waking to urinate 1-2 times per night
- [ ] Waking to urinate 3-4 times per night
- [ ] Waking to urinate more that 4 times per night
- [ ] Sleeps less than 4 hours per night
- [ ] Sleeps 4-6 hours per night
- [ ] Sleeps 6-8 hours per night
- [ ] Sleeps 8-10 hours per night

Details for any boxes checked above or other non listed problem

Perspiration Hot/Cold

- [ ] Normal perspiration
- [ ] Does not perspire
- [ ] Easily perspires
- [ ] Excessive perspiration

- [ ] Hot flashes
- [ ] Night sweating
- [ ] Profuse night sweating
- [ ] Usually feels chilly
- [ ] Usually feels cold
- [ ] Usually feels warm
- [ ] Usually feels hot

Details for any boxes checked above or other non listed problem

Musculoskeletal and pain

- [ ] Joint pain - multiple sites
- [ ] Knee pain
- [ ] Neck pain
- [ ] Back pain
- [ ] Hand pain
- [ ] Foot Pain
- [ ] Wrist pain
- [ ] Carpal tunnel syndrome
- [ ] Elbow pain
- [ ] Hip pain
- [ ] Arthritis
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Visceral Pain

Please note primary area of pain

Please check any applicable boxes describing the nature of your primary pain

- [ ] N/A
- [ ] Constant

- [ ] Intermittent
- [ ] Occasional
- [ ] Sharp
- [ ] Stabbing
- [ ] Achy
- [ ] Fixed
- [ ] Spasm
- [ ] Hot
- [ ] Cold
- [ ] Feels heavy
- [ ] Worse during day
- [ ] Worse at night
- [ ] Migrating pain
- [ ] Better with heat
- [ ] Better with cold
- [ ] Better with pressure
- [ ] Better sitting
- [ ] Better standing
- [ ] Better laying down
- [ ] Better if moving
- [ ] Better when walking
- [ ] Worse with pressure
- [ ] Worse sitting
- [ ] Worse sitting to standing
- [ ] Worse standing to sitting
- [ ] Worse lifting
- [ ] Worse if sedentary
- [ ] Worse standing
- [ ] Worse laying down
- [ ] Worse bending
- [ ] Worse driving
- [ ] Worse stairs - up
- [ ] Worse stairs - down
- [ ] Worse walking
- [ ] Worse with stress

Please indicate the severity of this pain at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this pain at its best (with 0 being best)

0 1 2 3 4 5 6 7 8 9 10

Please provide additional information about your pain. Please include how long you've had the pain and if you've had or are currently having treatment for it.

Please describe the area of any secondary pain

Please indicate the severity of this pain at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this pain at its best (with 0 being best)

0 1 2 3 4 5 6 7 8 9 10

Please check any applicable boxes describing the nature of your secondary pain

- [ ] N/A
- [ ] Constant
- [ ] Intermittent
- [ ] Occasional
- [ ] Sharp
- [ ] Stabbing
- [ ] Achy
- [ ] Fixed
- [ ] Spasm
- [ ] Hot
- [ ] Cold

- [ ] Feels heavy
- [ ] Worse during day
- [ ] Worse at night
- [ ] Migrating pain
- [ ] Better with heat
- [ ] Better with cold
- [ ] Better with pressure
- [ ] Better sitting
- [ ] Better standing
- [ ] Better laying down
- [ ] Better if moving
- [ ] Better when walking
- [ ] Worse with pressure
- [ ] Worse sitting
- [ ] Worse sitting to standing
- [ ] Worse standing to sitting
- [ ] Worse lifting
- [ ] Worse if sedentary
- [ ] Worse standing
- [ ] Worse laying down
- [ ] Worse bending
- [ ] Worse driving
- [ ] Worse stairs - up
- [ ] Worse stairs - down
- [ ] Worse walking
- [ ] Worse with stress

Please provide additional information about your pain. Please include how long you've had the pain and if you've had or are currently having treatment for it.

Please note any other areas of pain not covered above

Psychological, Mood and Energy

- [ ] Brain fog
- [ ] Fatigue
- [ ] Always tired in the afternoon
- [ ] Always tired when waking
- [ ] Low energy
- [ ] Better in the morning
- [ ] Better in the evening
- [ ] Exhausted
- [ ] Jittery
- [ ] Low sex drive
- [ ] High sex drive
- [ ] Fears/Phobias
- [ ] Bad temper
- [ ] Irritability
- [ ] Worry
- [ ] Crying
- [ ] Anxiety
- [ ] Depression
- [ ] In therapy
- [ ] Mood swings
- [ ] Lethargy
- [ ] ADHD
- [ ] Bipolar disorder
- [ ] Other psychological problem (note below)

Details for any boxes checked above or other non listed problem

Any other questions or concerns not covered above

Patient Signature - please type to verify person

Continue

Consents — Step 4 of 4

You are completing the following intake forms: Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy

Communication

Appointment Notifications and Reminders

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Email

☐ Email 2 days before appointment

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

☐ Text Message (SMS) 24 hours before appointment

Intake Questionnaire, Insurance, Consent-Elevated Acupx Copy — Consents

Elevated Acupuncture Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above 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 above or any other office or clinic, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is recommended by this clinic's practitioners. 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, nutritional counseling, QiGong as well as Telehealth (2-Way Video-Audio Conference) Sessions. ADVERSE EVENTS and RISKS: Acupuncture involves the insertion and stimulation of fine, sterile and single use needles through the skin. Acupuncture is considered a safe method of treatment. Treatments can occasionally produce a mild but temporary discomfort, achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and may occasionally leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, pneumothorax and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist. CONTRAINDICATIONS:

Contraindications for acupuncture treatment and certain herbs may include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, or pregnancy. I will inform my practitioner if any of the above apply to me at any time. I will also inform my acupuncturist of any and all medications I am using. TRADITIONAL CHINESE HERBAL MEDICINE: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs such as rashes, hives and tingling of the tongue. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated. HEAT TREATMENTS (Moxa or a TDP Lamp): These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists. CUPPING: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat. GUA SHA: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days. ELECTRO-ACUPUNCTURE:A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment. ACUPRESSURE AND MASSAGE: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records 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 conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as practitioners at Elevated Acupuncture, are not primary care physicians. 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.

☐ By signing below, I am agreeing to the above – *Required*

Elevated Acupuncture Notice of Privacy Practices (HIPAA)

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. Please review it carefully. Elevated Acupuncture respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Safeguards in place include: •Limited access to facilities where information is stored. •Policies and procedures for handling information. •Requirements for third parties to contractually comply with privacy laws. •All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction: Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations and Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations: We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information:

Treatment: notes by a member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. •We may also provide information to others providing you care. This will help them stay informed about your care. •From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

FOR HEALTH CARE OPERATIONS •We use your medical records to assess quality and improve services. •We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff. •We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

YOUR HEALTH INFORMATION RIGHTS: The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you.

YOU HAVE A RIGHT TO: •Receive, read, and ask questions about this Notice •Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request. But we will comply with any request granted •Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice"); •Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request; •Have us review a denial of access to your health information—except in certain circumstances; •Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records; •Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing; •Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.For help with these rights, please contact: Office manager/HIPAA Officer at (201)338-0552.

OUR RESPONSIBILITIES We are required to: a. Keep your protected health information private; b. Give you this Notice; c. Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling and asking for it or to pick one up.

TO ASK FOR HELP OR COMPLAIN If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Elevated Acupuncture 253-987-6049

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to us at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES OF PROTECTED HEALTH INFORMATIONNOTIFICATION OF FAMILY AND OTHER MEMBERS •Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.-Your name, location, general condition, and religion (only to clergy)

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it. We may use and disclose your protected health information without your authorization as follows: •To the Food and Drug Administration (FDA) relating problems with food, supplements, and products. •For Public Health and Safety Purposes as

Allowed or Required by Law: a. To prevent or reduce a serious, immediate threat to the health or safety of a person b. Or public. c. To public health or legal authorities •To protect public health and safety •To prevent or control disease, injury, or disability •To Report Suspected Abuse or Neglect to public authorities. •For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime. •For Health and Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others. •For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site. •To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission. •In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order. For Specialized Government Functions. For examples, we may share information for national security purposes.

OTHER USES OF DISCLOSURES OF PROTECTED HEALTH INFORMATIONS Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

☐ By signing, I am acknowledging the above notice. – *Required*

Billing and Cancellation Policy

PAYMENT POLICY: Elevated and Seattle Healing Acupuncture require payment for your treatment at the time of service. All major credit cards are accepted, as well as HSA, cash, and debit.

INSURANCE POLICY: Our providers are in-network with most insurance companies and copay, coinsurance, or unmet deductible payment is due at time of service. Please contact your insurance company with any questions you may have regarding your coverage. If insurance information is not provided before or at the first appointment, the visit will be covered out-of-pocket by the patient until this information is provided. Any balance will be in excess of copay will be credited to the patient's account.

CANCELLATION AND MISSED APPOINTMENT POLICY: Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file.

☐ I am aware of the Payment, Billing, and Cancellation Policy. – *Required*

Signature

◉ **Draw** ○ **Type**

Please check that all required questions have been answered.

Submit Intake Form