February, 2016

New Patient Packet

Sheila A Condit EIN #26-4147878, Lic #AC174007
175 W. B. St., Springfield OR 97477 Bld B2
Phone: 541-799-4375
www.PHacu.com

Informed Consent to Release Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patient. Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of this office. In accordance with the Notice of Privacy Practices, this office, via this authorization form, requests that the patient indicated below authorize the release of his/her health information.

I, the undersigned, understand that I have the right to:
- refuse to sign this authorization
- receive a copy of this authorization
- restrict what is disclosed by this authorization
- inspect or request an amendment of the health information to be disclosed
- revoke this authorization, by written notice
- know about any compensation the practitioner/facility will receive resulting from the release of my health information

I recognize that once disclosed my health information is no longer under the control of this practitioner/facility. While I understand that the practitioner/facility will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by Oregon Acupuncture office's privacy practices.

I understand that whether or not I sign this document will not effect my treatment at this practice, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: http://www.hhs.gov/ocr/regmail.html.

Patient Name: ______________________________

Address: ______________________________

Date of Birth: ____________________ Are you allowing health information to be disclosed? ☐ Yes ☐ No

If you choose to disclose health information, which information is to be disclosed:

____

Individual(s), entities or business associates to receive this health information:

____

Specific purpose of this disclosure: ______________________________

Effective dates of this authorization: ____/____/____ through ____/____/____
(The authorization will expire at the end of this period)

I hereby authorize this office to disclose my health information as described in this document.

______________________________ ____________________
Signature of Patient (or authorized representative) Date

______________________________ ____________________
Signature of Practitioner or Facility Representative Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, __ ____, have received a copy of this office's Notice of Privacy Practices. (Please write your signature above),

_______________________________________ _______________
Please Print Your Name Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barrier prohibited obtaining the acknowledgement

□ Other (Please Specify) _ ___ ________________________________

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Health History Questionnaire and Registration – Page 1

PATIENT INFORMATION	CONTACT INFORMATION
Date_______________Birth date _______________	Primary phone ___________________________________
Name_______________________________________	Work phone ___________________________________
☐ Female ☐ Male ☐ Trans Pronoun ☐ He ☐ She	Other/cell phone ________________________________
Address_____________________________________	Email ____
City State & Zip______________________________	Another person we may contact if needed:
Occupation __________________________________	Name ____
Company name _______________________________	Relationship_____________________________________
Primary physician _____________________________	Home phone ____________________________________
Physician phone number_______________________	Work phone_____________________________________

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- ____

2 - ____

3 - ____

How is your sleep? ______________________________

____

How is your digestion?

____

List medications or food supplements you are taking.

____

____

List serious illnesses, accidents or surgeries.

____

____

Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Cancer ☐ Heart disease ☐ Kidney disease

How long has it been since you have had a complete medical exam?

____

Check conditions you have or have had in the past:

☐ AIDS	☐ Allergies
☐ Anemia	☐ Arthritis
☐ Bleeding disorders	☐ Breast lump
☐ Cancer	☐ Diabetes

Check symptoms you have or had in the last year:

☐ Depression	☐ Difficulty in focusing
☐ Dizziness	☐ Easily startled
☐ Excessive worry	☐ Excessive anger
☐ Excessive fear	☐ Fatigue/tiredness
☐ Headaches	☐ Sleep loss/poor sleep
☐ Weight loss	☐ Weight gain
☐ Nervous/irritable	☐ Overwhelmed by life

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature____ Date __________________

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Health History Questionnaire and Registration – Page 2

Check symptoms you have or had **in the last year:**

MUSCLE/JOINT/BONES

- ☐ Tremors ☐ Cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Other________________________________

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing ☐ Blurred/failing vision
- ☐ Difficulty breathing ☐ Earache
- ☐ Enlarged glands ☐ Eye pain
- ☐ Frequent colds ☐ Hay fever
- ☐ Hoarseness ☐ Gum trouble
- ☐ Nose bleeds ☐ Loss of hearing
- ☐ Persistent cough ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

CARDIOVASCULAR

- ☐ Chest pain ☐ Hardening of arteries
- ☐ High blood pressure ☐ Low blood pressure
- ☐ Pain over heart ☐ Poor circulation
- ☐ Previous heart attack ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Belching ☐ Gas
- ☐ Bloating ☐ Colon trouble
- ☐ Constipation ☐ Diarrhea
- ☐ Difficult swallowing ☐ Abdomen distension
- ☐ Excessive hunger ☐ Gallbladder trouble
- ☐ Hemorrhoids (piles) ☐ Indigestion
- ☐ Nausea ☐ Pain over stomach
- ☐ Poor appetite ☐ Vomiting

REPRODUCTIVE ORGANS / ISSUES

- ☐ Erection difficulties ☐ Penis discharge
- ☐ Prostate trouble

- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant? ____________

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature____ Date _________________