**INNER BALANCE ACUPUNCTURE** LL
114 East Main St.
Somerville, NJ 08876
(732) 322-2523. ibacpt1@gmail.com. ibacpt.com
Sylvester Rich, MS LAc.

# Notice of Privacy Practices

This notice together with our Practices Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. This also describes how you can gain access to your health information.

**Please review this information carefully.**

## Understanding your health Record:

A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis, and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

## Your Health Information Rights:

Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

## Our Responsibilities:

We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of privacy practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient Name: _____ (please print)

Patient / Guardian Signature: _____

Date: _____

**INNER BALANCE ACUPUNCTURE** LL
114 East Main St.
Somerville, NJ 08876
(732) 322-2523. ibacpt1@gmail.com. ibacpt.com
Sylvester Rich, MS LAc.

## Practices Regarding Disclosure of Patient Health Information

**Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent is not required in these circumstance.**

Treatment – Information obtained by us will be entered into your treatment record and used in the course of your treatment. Your health information will be shared with other health practitioners as we, in the exercise of our professional judgment, deem is appropriate. Information regarding our assessment of your health and information regarding consultations, may also be retained in your file.

Payment – Your record will be used to receive payment for services. A bill or other payment information may be mailed to your home or to a third party provider. That information will likely contain diagnostic determination, practitioner impressions, and treatment procedures.

Quality Monitoring – We will use your health information to assess the care you have received and to compare outcomes. This information may also be used in conjunction with various scientific studies regarding your specific condition or Oriental Medicine itself.

**The following disclosures are required by law and do not require your consent.**

Food and Drug Administration (FDA) – We are required to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects, for surveillance to enable product recalls, repairs or replacements.

Workers Compensation – We will release health information to the extent required under the workers compensation law.

Public Health – We are required to disclose health information to public health entities or legal authorities responsible for tracking birth and morbidity, communicable disease, injury or disability, and matters relating to organ/cadaver donations.

Law Enforcement – we are required to provide your health information to law enforcement and professional oversight personnel under State and Federal law. Similarly, we will disclose such information in the event we believe there is a risk of harm to yourself or others.

We also consider the following uses as routine use and disclosure. If you do not want your health information used in the following circumstances, please immediately advise us in writing.

Business Associates – Professionals and others whose services we require in the normal course of our business. Examples include our accountant, lawyer, and pharmacy. We require these individuals to follow the same procedures / standards as our staff.

Communication with Family – we may contact a family member or some other person designated by you to assist them in enhancing your wellbeing.

Marketing and fundraising – we may periodically send information to you regarding treatment alternatives and other health related benefits we believe may be useful to you. We may also request your charitable support on behalf of alternative medicine research projects or other medically relating charitable events. This contact will not disclose information regarding your specific medical condition.

**INNER BALANCE ACUPUNCTURE** LL
114 East Main St.
Somerville, NJ 08876
(732) 322-2523. ibacpt1@gmail.com. ibacpt.com
Sylvester Rich, MS LAc.

# Medical History

Please complete this form as part of your initial session. All information is confidential and protected under the HIPAA laws. If you have any questions, please don't hesitate to ask. If there is anything not asked on this form that you feel should be brought to our attention, please note this in the Comments section below.

| | | |
|---|---|---|
| Name | Home Phone | Date |
| Street | Cell Phone | Ht. Wt. |
| City | Work Phone | DoB Age |
| State Zip | Occupation | Education |
| Email | Emergency Contact | Emergency # |
| Marital Status | Number of Children | Religious Requirements |
| Referred by | Have you ever had Acupuncture before? | |

**Section 1 – Past Medical History (Please include dates)**

- Hospitalizations (Med/Psych) _____
_____
- Significant Illnesses _____
_____
- Surgeries _____
_____
- Significant trauma (auto accidents, falls, etc)_____
_____
- Allergies (drug, chemicals, food) _____
_____
- Medicines Taken within the last two months (vitamins, OTC drugs, herbs) _____
_____
_____
- Occupational Stresses (chemical, physical, psychological, etc. _____
_____

**Section 2**

**Exercise** (types & frequency) _____
_____

**Describe your average daily**

**diet**_____ **Habits** (amount

**INNER BALANCE ACUPUNCTURE** LL
114 East Main St.
Somerville, NJ 08876
(732) 322-2523. ibacpt1@gmail.com. ibacpt.com
Sylvester Rich, MS LAc.

and frequency) Cigarettes _____Coffee _____ Tea _____
Alcohol _____Drugs _____ Other _____

**Family Medical History (circle if applicable)**

Alcoholism Drug Abuse Allergies _____
Asthma Diabetes Seizures Cancer & Type _____
Heart Disease Arteriosclerosis High Blood Pressure Low Blood Pressure Stroke

**Section 3**

Main Problem you would like to address (including initial cause, duration) _____

_____

Diagnosing physician _____ Physician Phone _____

Are you currently receiving care for this condition? Yes ___ No ___ How Long? _____

Current Therapies & Results _____

How severe is your problem right now: 1 (minimal) – 10 (worst pain I have ever felt) _____

To what extent does this problem interfere you're your daily activities? (work, sleep, eating, sex…)

_____

**What are your treatment goals?**

Temporary relief of symptoms/pain control

Eliminate root or cause of problem (if possible)

Maintenance care (periodic balancing / tune-up to keep in good health.

**Comments:** _____

| | Great | Good | Fair | Poor | Bad | Your Comments |
|---|---|---|---|---|---|---|
| Mate | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Family | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Diet | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Sex | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Self | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Work | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Spiritually | ☐ | ☐ | ☐ | ☐ | ☐ | |

_____

Who should we thank for referring you? _____

How do you **FEEL** about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experienc

# Inner Balance Acupuncture

Questions & Concerns

**General**
- ___ Chills
- ___ Fever
- ___ Body aches
- ___ Poor appetite
- ___ Insomnia
- ___ Fatigue
- ___ Poor Circulation
- ___ Cold Hand / Feet
- ___ Excessive thirst
- ___ Bodily heaviness
- ___ Vertigo or Dizzy
- ___ Weight Loss / Gain
- ___ Night sweats
- ___ Spontaneous sweating
- ___ Bruise easily
- ___ Stress
- ___ Other_____

**Head, Eyes, Ears, Nose, Throat**
- ___ Headaches
- ___ Concussions
- ___ Eye pain
- ___ Red / Itchy eyes
- ___ Spots in eyes
- ___ Poor / Burred vision
- ___ Night Blindness
- ___ Ringing ears
- ___ Nasal congestion
- ___ Sinus problems
- ___ Hay fever
- ___ TMJ pain
- ___ Facial pain
- ___ Bleeding gums
- ___ Sores on lips / tongue
- ___ Dry mouth
- ___ Recurrent sore throat
- ___ Hoarse voice
- ___ Lumps in throat
- ___ Other_____

**Respiratory**
- ___ Difficulty breathing
- ___ Shortness of breath
- ___ Cough

Wet or dry _____
Color of phlegm ___
Think or thin _____
- ___ Coughing blood
- ___ Wheezing
- ___ Other

**Cardiovascular**
- ___ High blood pressure
- ___ Low blood pressure
- ___ Chest pain
- ___ Tachycardia
- ___ Difficulty breathing
- ___ Palpitation
- ___ Irregular heartbeat
- ___ Phlebitis
- ___ Other _____

**Gastrointestinal**
- ___ Nausea /Vomiting
- ___ Stomach pain
- ___ Acid regurgitation
- ___ Indigestion
- ___ Bad breath
- ___ Bloating
- ___ Gas
- ___ Diarrhea
- ___ Constipation
- ___ Bloody stools
- ___ Black stools
- ___ Mucous in stools
- ___ Hemorrhoids
- ___ Laxative use
- ___ Intestinal pain / cramping
- ___ Rectal pain
- ___ Other _____

**Musculoskeletal**

Pain & weakness, numbness in:
_hands _wrist
_elbow
_shoulder _neck
_back
_hips _knee _legs
_feet _ankle
_ Other _____

**Skin and Hair**
- ___ Rashes
- ___ Fungal infections
- ___ Eczema
- ___ Ulcerations
- ___ Hives
- ___ Scars
- ___ Acne
- ___ Psoriasis
- ___ Hair loss
- ___ Mole Changes
- ___ Other

**Neuro-psychological**
- ___ Seizures
- ___ Numbness
- ___ Poor memory
- ___ Easily stressed
- ___ Irritable
- ___ Anxiety
- ___ Depression
- ___ Suicide thoughts / attempt
- ___ Other _____

**Genital-Urinary**
- ___ Frequent urination
- ___ Urgent urination
- ___ Painful urination
- ___ Blood in urine
- ___ Incomplete urination
- ___ Kidney stone
- ___ Bedwetting
- ___ Increased libido
- ___ Decreased libido
- ___ Impotence
- ___ Other _____

**Gynecological**
- ___ Irregular periods
- ___ Painful periods
- ___ PMS
- ___ Vaginal discharge
- ___ Vaginal sores
- ___ Other _____

**OB/GYN**

Age of menarche _____
Duration of flow _____
Length of cycle _____
Date of last period ____
Currently pregnant
Yes __ No __
# Pregnancies _____
# Live births _____
# Premature births ___
# Abortions/Miscarriage _
Date of last PAP _____
Age of Menopause ____

**Diagnostic Conditions**
- ___ AIDS
- ___ Alcoholism
- ___ Anemia
- ___ Anorexia
- ___ Arthritis
- ___ Asthma
- ___ Bleeding disorders
- ___ Bronchitis
- ___ Bulimia
- ___ Cancer
- ___ Cataracts
- ___ Chemical Abuse / Dependency
- ___ Chicken pox
- ___ Diabetes
- ___ Emphysema
- ___ Epilepsy
- ___ Glaucoma
- ___ Goiter
- ___ Gonorrhea
- ___ Gout
- ___ Heart Disease
- ___ Hepatitis
- ___ Herpes
- ___ High Cholesterol
- ___ HIV Positive
- ___ Kidney Disease
- ___ Liver Disease
- ___ Measles
- ___ Migraine
- ___ Mononucleosis
- ___ Multiple Sclerosis
- ___ Mumps
- ___ Pacemaker
- ___ Pneumonia
- ___ Polio
- ___ Prostate Problem
- ___ Psychiatric Problem
- ___ Rheumatic Fever
- ___ Seizure
- ___ Stroke
- ___ Thyroid Problems
- ___ Tuberculosis
- ___ Ulcers
- ___ UTI
- ___ Venereal Disease
- ___ Other _____