Patient Information				
Name		Date of Birth		
Address	City		State	Zip
Home	Work		Cell	
Please circle preferred phone number		Okay to leave message? ☐Yes ☐No		
Email address				
I prefer to be contacted by ☐phone ☐email		Would you like to receive our e-newsletter? ☐Yes ☐No		
Employer/School Name		Occupation		
Emergency Contact—Name		Phone		
Primary Care Provider		Provider's Phone		
Referred by: ☐Web ☐Friend ☐Relative ☐Physician ☐Other _____				

Health Information				
Main goals/reasons for acupuncture treatment				
Past Medical History	Hospitalizations			
Significant Diagnoses				
Significant Traumas or Injuries				
Medications or Supplements you are taking				
Allergies				
Review of Systems	Please check all symptoms you have experienced in the last year.			
☐Anxiety	☐Frequent Colds	☐Ringing Ears	☐Nausea	☐Kidney stones
☐Depression	☐Cough	☐Headache	☐Indigestion	☐Low libido
☐Fatigue	☐Difficulty breathing	☐Dry eyes/mouth /skin	☐Belching/Gas Bloating	☐Frequent urination
☐Pain	☐Sinus Issues	☐Chest pain	☐Constipation	☐Dizziness
☐Poor Sleep	☐Allergies/Asthma	☐Palpitation	☐Diarrhea	☐Seizure
☐Fever/Chills	☐Hearing Loss	☐Swelling	☐Abdominal pain	☐Tremor
☐Weight Gain/Loss	☐Vision Loss	☐Poor appetite	☐Incontinence	☐Weakness
☐Other_____				
For women only: ☐Irregular cycles ☐menstrual pain ☐Hot flashes/night sweats ☐PMS ☐Infertility Is there any chance you could be pregnant today? ☐Yes ☐No **Comments**				

Mid Shore Community Acupuncture, Acupuncture Information and Informed Consent for Treatment

I, _____, voluntarily consent to acupuncture services provided by Mid Shore Community Acupuncture. Acupuncture involves the insertion of sterile, single-use, disposable needles through the skin in specific locations. I may also be treated with heat applied to the skin. While side effects are rare, they may include local bruising, slight bleeding, temporary pain or discomfort, fainting, infection, burns, broken needles, pneumothorax (collapsed lung) and spontaneous miscarriage. About 15% of people experience a temporary worsening of their condition or a flare-up of old conditions following their first few treatments. This is known as a "healing reaction" and it is a normal part of getting better. Infectious diseases are carried through the air, through physical contact, and through body fluids. I understand that my acupuncturist follows universally prescribed precautions and procedures to prevent the spread of infectious disease. I understand that each person is unique and each has ultimate responsibility for his/her own healthcare. I agree to inform my acupuncturist about my medical conditions, medications, and any changes that occur during the course of treatment (including pregnancy and suspected pregnancy). I agree to contact my acupuncturist immediately if I experience any problem which I associate with the acupuncture services provided. If I experience a medical emergency, a worsening of my health condition, or a new condition arises, I will consult a licensed physician, or seek medical treatment. I understand that my practitioner is a Licensed Acupuncturist in Maryland, not a licensed physician, and does not provide primary medical care. My acupuncturist will not suggest that I discontinue medical treatment, and may request that I have a consultation with and/or physical examination by a licensed physician. I have had the opportunity to ask my acupuncturist questions regarding the proposed acupuncture services, this consent form, and other pertinent information, including any questions about my practitioner's education and experience, and I have received a satisfactory explanation. I understand the acupuncture services provided at Mid Shore Community Acupuncture, and the fees. Mid Shore Community Acupuncture does not bill insurance. Upon request, they will provide me with a receipt which I can submit to my insurance. Community Acupuncture Services are treatments designed specifically for my needs provided in a group setting. The fee is a sliding scale of $15.00 to $40.00 per treatment, plus a one-time additional fee of $10.00 for the initial evaluation. I decide what I can afford, and no income verification is performed. I understand that what I pay never affects the care I receive. Appointments strongly recommended. I understand that all appointments that are cancelled with less than 24 hours advance notice and appointments missed without notice will be charged the cancellation fee of $15.00. I understand that when I select Community Acupuncture provided in a group setting, conversations in the group room may be overheard. If I wish to discuss a sensitive issue, a private room is available for discussion. I understand that if I need to have a detailed discussion about my medical history, we may need to schedule this separately by phone. I understand that Mid Shore Community Acupuncture will not contact my physician without my written consent. I give my consent to inform my physician _____ that I am receiving acupuncture. I understand that Mid Shore Community Acupuncture will record medical & other information concerning my treatment, and that my health information will be used & disclosed consistent with the Notice of Privacy Practices. I permit a copy of this authorization to be used in place of the original. This

authorization is not intended to allow the release of my treatment records, which require a restricted release under State or Federal Law. I have read and understand all the information on this form. I acknowledge that I have not received any guarantees or promises of results from these services, and I understand that I am free to discontinue services at any time. I have received a copy of the Notice of Privacy Practices (attached to the Patient Registration / Health History form). I am aware that this form is also displayed on the waiting room desk.
Patient's Printed Name _____
*Patient's Signature _____
Date _____

The undersigned represents that he or she is the parent or legal guardian of the minor named above, and represents that he or she has the legal authority to sign this consent and authorize acupuncture treatment.
*Parent's Signature _____
Date _____

Mid Shore Community Acupuncture, 10 South Hanson St. Easton MD, 21601

NOTICE OF PRIVACY PRACTICES
We are dedicated to providing service with respect to human dignity and to your privacy. This notice describes how health information about you may be used and disclosed, and how you can get access to your health information.

I. Understanding your Health Record / Information Each time you visit us, a record of your visit is made. This record may include your health history, symptoms, examination, diagnoses, plan of care, treatments, advice provided, and referrals made to other healthcare providers. This information is maintained in your health record, and it serves as a: a) basis for planning your care and treatment; b) means of communication among health professionals who contribute to your care; c) legal document describing the care you received; d) means by which you or another person can verify that services billed were actually provided; e) source of information for program planning and community education; f) tool for educating our acupuncturists and continually improving the care we provide and the outcomes we achieve; and g) source of information for medical research and for public health officials charged with improving the nation's health.
Understanding what is in your health record and how your health information is used helps you to: a) ensure its accuracy; b) understand who, what, when, where and why others may access your health information; and c) make informed decisions when authorizing disclosure to others.
II. Your Health Information Rights Although your health record is the property of Mid Shore Community Acupuncture the information in it belongs to you. You have the right to: a) obtain a paper copy of this Notice of Privacy Practices on admission and upon request; b) request a restriction on certain uses and disclosures of your health information; c) revoke your authorization to use or disclose health information, except to the extent that action has already been taken; d) obtain an accounting of disclosures of your health information; e) inspect and obtain a copy of your health record; f) amend your health record (under certain circumstances);

and g) request that communications with you be made by alternative means or at alternative locations.

III. Our Responsibilities, Mid Shore Community Acupuncture is required to: a) maintain the privacy of your health information; b) provide you with a notice of our privacy practices, with respect to information we collect and maintain about you; c) abide by the terms of this notice; d) notify you if we are unable to agree to a requested restriction; and e) accommodate reasonable requests by you to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization, except as described in this notice. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will email a revised notice to the e-mail address you supply to us, or mail a copy to the address supplied.

IV. For More Information or to Report a Problem If you have questions and would like additional information, ask your practitioner for clarification. If your questions require lengthy answers, it may be necessary for your practitioner to call you later that day to answer your questions. If you believe your privacy rights have been violated, you can file a complaint with us and/or the U.S. Secretary of Health and Human Services' Office for Civil Rights, with no fear of retaliation by this clinic or its staff.

Mid Shore Community Acupuncture, 10 South Hanson St. Easton MD,21601

Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201 OCR Hotlines – Voice: 1-800-368-1019

V. Examples of Disclosures Needless to say, we will disclose your protected health information with you. For example, we may contact you as a reminder that you have an appointment, to recommend possible treatment options, or share other health-related information that might be of interest to you.

Your health record will be used: a) to provide treatment to you; b) to make referrals for other recommended services; c) for documentation of services rendered to you, for you to obtain reimbursement of payments to Mid Shore Community Acupuncture and for d) quality monitoring.

Your consent, or the opportunity to agree or object, is not required in these instances: a) Treatment and Referrals: Your acupuncturist will obtain and enter health information into your health record, and use that information to develop your plan of care. Your acupuncturist will document your response to treatment, and any referrals to other health care providers. b) Payment for Services Provided: Your health record will be used to receive payment for services provided by us. Payment is expected at the time of service, by cash, check, or major credit card. While we do not bill insurance, we will (upon request) provide you with a receipt that you can submit to insurance or a health savings / flexible spending account. The information on the receipt may include information that identifies you, your symptoms, and diagnoses. c) Quality Monitoring: We will use your health information to assess the care you received, the outcome of your care, and compare the outcomes of your care to others' outcomes. Your information

may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.
In addition, the following disclosures are required by law, and do not require your consent: a) Food and Drug Administration (FDA): This clinic is required by law 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. b) Worker's Compensation: This clinic will release information to the extent authorized by law in matters of worker's compensation, or other similar programs, as required by law. c) Public Health: This clinic is required by law to disclose health information to public health and / or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury or disability, or to comply with mandated reporting requirements for tracking of birth or morbidity. d) Law Enforcement: As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: 1) in response to a valid subpoena; 2) in the event that a staff member or business associate of this clinic believes in good faith that a patient, staff member, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; 3) when a patient is a suspected victim of abuse, neglect, or domestic violence.
It is this clinic's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, this clinic will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here. To protect your health information, we require these Professional Associates to appropriately safeguard your health information, by following the same standards held by this clinic, through terms detailed in a written agreement. □ Communications with Family: We may use or disclose information by notifying the person identified by you on your Health History Questionnaire or other paperwork as your emergency contact. They may be given information to confirm your whereabouts, or general information to enhance your well-being in case of an emergency. □ Educational Materials: The clinic may send information to you about treatment alternatives and other health-related information that you may find helpful. Persons contacting you will know only that you have been a patient, but they have no access to your health records.