I. Patient Advisory to Consult a Physician

NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates is committed to your health and well-being. While Oriental medicine has a great deal to offer as health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education law, it is requested that you read and sign the following statement:

I undersigned, do affirm that _____ has been advised by NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____

Patient Signature Date

II. Informed Consent to Acupuncture Treatment

I consent to receiving acupuncture and other procedures associated with Traditional Oriental Medicine by NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates I have discussed the nature and purpose of these modalities with NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates

I understand that methods used may include but are not limited to: Acupuncture, moxibustion, cupping, guasha, electrical stimulation, Tui Na (Chinese bodywork), Chinese herbal medicine & nutritional counseling.

I have been informed that acupuncture is safe, but that it may have side effects, including but not exclusive of, bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and guasha. Unusual risks of acupuncture include miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates 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) which may be recommended are traditionally considered safe, 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, diarrhea, rashes, hives and tingling of the tongue.

I understand that herbs need to be prepared and consumed according to the instructions provided. The herbs may have an unpleasant smell or taste. I will immediately notify NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates who is caring for me if am or become pregnant.

I do not expect NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates to be able to anticipate and explain all possible risks and complications of all modalities, and I wish to rely on NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates to exercise judgment during the course of my visits which he thinks, based upon the facts then known is best in my interest.

I understand all of my records will be kept confidential and will not released to any party without my written consent, in full compliance of HIPAA regulations. My signature below indicates that a written copy of NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates'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 NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates

By voluntarily signing below I show that I have read, or have read to me, this consent to all procedures, 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 my visits for my present condition and for any future condition(s) during my visits to NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates

Patient:_____ _____ _____

print signature date

Authorization to Release Information & Assignment of Benefits

I authorize the release of any information requested to process health insurance claims. I authorize payment to be made directly to NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates I understand I am responsible for charges not coverd by this assignment.

Patient:_____ _____ _____

print signature date

Payment Policy
Thank you for choosing us as your care provider. We are committed to providing you with quality care. We have developed this payment policy because some of our patients have had questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in some insurance plans. Payment in full is expected at each visit if you are not insured by a plan with which we do business. If you are insured by a plan with which we do business but don't have an up-to-date insurance card, then payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some or all of the services you receive might not be covered or not considered reasonable or necessary. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. This is done for your protection. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care.

8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. One rescheduled appointment will be allowed. You will be billed in full if you miss, cancel, or reschedule the initial rescheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

This is a CONFIDENTIAL questionaire to help us determine the best treatment the best treatment plan for you. If you have questions, please ask. Thank you.

Personal Information

Last Name _____ First Name _____

Date of Birth (MM/DD/YY) _____ Height _____ Weight _____ Gender _____

Home Address _____

City _____ State _____ Zip _____

Contact Phone Number _____ Email _____

I would like to receive confirmation for my appointments by ❑ Email ❑ Phone

Occupation _____

Emergency Contact: Name _____ Phone (_____)_____

Marital Status _____ Number of children _____

Have you received acupuncture therapy before: ❑ Yes ❑ No If yes, then when _____

Who should we thank for referring you to our office: _____

Medical History

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

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer	❑	❑	_____	Diabetes	❑	❑	_____
Hepatitis	❑	❑	_____	Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____	Seizures	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Emotional Disorders	❑	❑	_____
Infectious Diseases	❑	❑	_____	Tuberculosis	❑	❑	_____

Sexually Transmitted Diseases _____

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Continue on back of page if needed

Check the boxes if any of the following statements are true:

❑ I have known allergies ❑ I am taking Coumadin/warfarin

❑ I have a pacemaker ❑ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	❑	❑	_____	Tobacco	❑	❑	_____	Water Intake	❑	❑	_____
Non-medical drugs	❑	❑	_____	Alcohol	❑	❑	_____	Soda	❑	❑	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab results (please provide us with a copy).

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

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	❑	❑	❑	❑	❑	_____
Family	❑	❑	❑	❑	❑	_____
Diet	❑	❑	❑	❑	❑	_____
Sex	❑	❑	❑	❑	❑	_____
Self	❑	❑	❑	❑	❑	_____
Work	❑	❑	❑	❑	❑	_____
Exercise	❑	❑	❑	❑	❑	_____
Spirituality	❑	❑	❑	❑	❑	_____

For Women

Age of 1st period (menarche) _____

Age of last period (menopause) _____

Number of days between periods _____

Number of days of flow _____

Color of flow _____

Clots? ❑ Yes ❑ No Color _____

Are you pregnant? ❑ Yes ❑ No # of Pregnancies _____

# of live births ___ # of abortions ___ # of miscarriages ___

Date of last: Gynecologic Exam _____ Pap Smear _____

Mammogram _____ Bone Density Scan _____

Results _____

_____

Average number of pads you use per day: 1st Day _____ 2nd Day _____ 3rd Day _____ 4th Day _____ + Days _____

Have you been diagnosed with : ❑ Fibroids ❑ Fibrocystic Breasts ❑ Endometriosis ❑ Ovarian Cysts PID Other_____

Location of pain : ❑ Lower abdomen ❑ Lower back ❑ Thighs ❑ Other _____

Nature of pain: (indicate before, during, or after menses)

Cramping _____ Stabbing _____

Burning _____ Aching _____

Dull _____ Bloating _____

Consistent _____ Intermittent _____

Bearing Down Sensation _____

Other Symptoms related to menses

❑ Discharge ❑ Vaginal Dryness ❑ Headache

❑ Nausea ❑ Constipation ❑ Diarrhea

❑ Swollen Breasts ❑ Mood Swings ❑ Ravenous Appetite

❑ Poor Appetite ❑ Hot Flashes ❑ Night Sweats

❑ Increased Libido ❑ Decreased Libido ❑ Insomnia

For Men

Date of last prostate checkup _____ PSA Results _____ Manual prostate exam results _____

Lab Results _____

Frequency of Urination: Daytime _____ Nighttime _____ Color of urine ❑ Clear ❑ Murky Odor: _____

Symptoms related to prostate:

❑ Prostate Problems ❑ Delayed Stream ❑ Dribbling ❑ Incontinence ❑ Urine Retention

❑ Rectal Dysfunction ❑ Increased Libido ❑ Decreased Libido ❑ Premature Ejaculation ❑ Impotence

❑ Back Pain ❑ Groin Pain ❑ Testicular Pain Other _____

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark = never experience ✔ = sometimes experience **X** = frequently experience

___ Lack of Appetite
___ Excessive appetite
___ Loose stool or diarrhea
___ Digestive problems, indigestion
___ Vomiting
___ Belching, burping
___ Heartburn/reflux
___ Feeling the retention of food in the stomach
___ Tendency to become obsessive in work, relationships...
___ Insomnia, difficulty sleeping
___ Heart palpitations
___ Cold hands and feet
___ Nightmares
___ Mentally restless
___ Laughing for no apparent reason

___ Abdominal pain
___ Chest pain
___ Sciatic pain
___ Headaches
___ Pain or coldness in the genital area
___ Cough
___ Shortness of breath
___ Decreased sense of smell
___ Nasal problems
___ Skin problems
___ Feeling of claustrophobia
___ Bronchitis
___ Colitis or diverticulitis
___ Constipation
___ Hemorrhoids
___ Recent use of antibiotics
___ Eye problems

___ Jaundice (yellowish eyes or skin
___ Difficulty digesting oily foods
___ Gall stones
___ Light colored stool
___ Soft or brittle nails
___ Easily angered or agitated
___ Difficulty in making plans or decisions
___ Spasms or twitching of muscles
___ Low back pain
___ Knee problems
___ Hearing impairment
___ Ear ringing
___ Kidney stones
___ Decreased sex drive
___ Hair loss
___ Fatigue

___ Edema
___ Blood in stool
___ Black tarry stool
___ Easily bruised
___ Difficult to stop bleeding
___ Asthma
___ Tendency to catch colds easily
___ Intolerance to weather changes
___ Allergies
___ Hay fever
___ Dizziness
___ Tendency to faint easily
___ High cholesterol levels
___ Sudden weight loss

NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates Notice of Privacy Practices

This notice contains important information about NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates (NYAC/CAC) privacy practices. This notice describes how medical information about you 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 its program, NY Acuhealth Acupuncture, PC and/or Central Acupuncture, PC and their affiliates must collect, maintain and use non-public personal information on patients it provides services to. 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 as to our legal duties and privacy practices. It also describes your rights to access and control your non-public personal information (NPI).

NYAC/CAC is 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 NYAC/CAC collects, uses and maintains on you is protected by Federal and state laws: the Health Insurance Portability and Accountability Act (HIPAA) and New York State Public Health Law. NYAC/CAC 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 NYAC/CAC Privacy Office at privacy@nyacuhealth.com. You may also complain to the Secretary of 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 you participation in treatment, your physical or mental health/condition, the provision of treatment or healthcare to you or payment to NYAC/CAC for the provision of services provided to you.

III. How does NYAC/CAC protect NPI?
At NYAC/CAC, 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 have established a Privacy Office that has overall responsibility for 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 NYAC/CAC use non-public personal information (NPI) and for what purpose?
Here are some examples of what we do with the information we collect and the reason 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 with providing care to you. For example, information obtained by our staff 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 may also 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 use NPI to review our treatment and services and to evaluate the performance of our staff. We may also use and share NPI with other personnel for review and learning purposes.

V. What use 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, quality assurance reviewers, accountants or attorneys. In certain circumstances, we may need to share your information with a business associate so it can perform a service on our behalf. NYAC/CAC will limit the disclosure of information to a business associate to the amount of information that is the minimum necessary for the business associate to perform services for us. In addition, we will have a written contact in place with the business associate requiring it 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 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 an adult 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 may also disclose your NPI in response to a discovery request, subpoena or other lawful processes 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; in investigations of criminal conduct at the NYAC/CAC or of victims of crime; in emergencies in order to report a crime (including the location or victims(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 to 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 the Unites 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 may also disclose your NPI to Federal officials in order to protect the President, and other officials or foreign heads of state or to conduct investigations.

Worker's Compensations: 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.

VII. What are your rights governing the information that Dan Hsu, L.Ac. collects, uses and maintains 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, your must submit your request in writing to info@nyacuhealth.com.

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 by NYAC/CAC will review your request and the denial. The person conducting the review will not be the person who denied your request. NYAC/CAC promises to 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) by us. 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.

NYAC/CAC 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 by us;
- 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 (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 the 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 case or the payment for your care (like a family member or friend).

NYAC/CAC is 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 action in reliance upon your authorization before we receive 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.