Actual Acupuncture and Chinese Medicine

Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:
• Information we receive from you.
• Information we receive from other healthcare providers.
• Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. We will only use and/or disclose your protected health information when the law allows us to do so. Any other use and disclosures will be made only with your authorization and, in those instances; you have the right to revoke that authorization. And if so, that authorization would be honored, where legal to do so, from that date forward.

Treatment: For example, from time to time, our practitioners may decide that it is medically necessary to refer you to a specialist for additional care. That practitioner will need your medical information in order to be able to treat you and that is why we send out your records.

Payment: Many of our patients utilize medical insurance that actually pays for their treatment. The insurers require your medical information to know how to pay us or your care and that is why we send out your records.

Health Care Operations: We are allowed to disclose your medical information if that is necessary for our office to function efficiently. There are also times when we may need the help of a special vendor, such as a medical billing specialist, and we would then send your records to that vendor in order for us to carry on our business.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, holiday cards, thank you cards, newsletters and appointment reminders, by calls, postcards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law. This includes but is not limited to Public Health needs, Health Oversight requirements, and issues of abuse or neglect, legal proceedings.

4029 S Capital of Texas Hwy, Austin, TX 78704
Office: (512)707-1022 Direct: (512)657-8117
Guili Zheng, Ph.D., M.D. (China), Lic.Ac.
TX Lic. # AC00587

Patient Rights

• Upon written request you have the right to access, review or receive copies of your healthcare records. Exceptions are: 1) psychotherapy notes; 2) information we gather in preparation of an administrative action or proceeding; 3) data that is subject to certain provisions of the Clinical Laboratory Improvements Act. We may deny you request (in writing) under certain limited circumstances. Generally, if we agree to provide you with a copy of your records, we will do so within 15 days after you ask for it. We will charge you a reasonable, cost-based fee for the records.

• Upon written request you have the right to receive a list of items this office disclosed about your healthcare information. We are required to give you that data except for any use or disclosure: 1) for treatment, payment and/or health care operations; 2) made with your authorization; 3)that we make to you; 4) for any national security or intelligence purposes; 5) that does not require your authorization. We will provide this date for you (generally within 60 days) at no charge once each year, but after that, we will require that you pay a reasonable fee-based charge for the information.

• You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. You may ask that we limit the use and disclosure of your protected health information; we are not required to accept your request. If we do agree, however, we will do as you wish except in an emergency. You may submit your request to us in writing and tell us: 1) what information you want us to limit 2) how you want us to limit that data and 3) to whom we are to limit the access to this data.

• You have the right to request that we amend your Protected Health Information; the request must be in writing. We have the right to deny that request if you ask about medical information that 1) was not created by any of our practitioners; 2) the information is not part of the medical or billing records; 3) is not part of the records you may access or 4) the medical information is accurate and complete. We may ask that you tell us, in writing, why you want us to amend your medical information. Generally, we must act upon your request within 60 days after receipt of your request. If we agree to your request, we must make the appropriate amendment and follow the law regarding how and whom we inform about this amendment. If we do not agree, then we will tell you our reasons. You then have additional rights, including an appeal (by someone who did not participate in the decision not to allow you to amend your record) and you have the right to submit a written statement of disagreement.

• You have a right to receive all notices in writing.

• You have the right to receive confidential communication by alternative means or at alternative locations. Please make this request in writing to our Privacy Officer. We will agree, so long as your request is reasonable, but you must tell us how to communicate with you and you must give us a complete address or contact information.

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Actual Acupuncture and Chinese Medicine

NEW PATIENT INFORMATION

Welcome to Actual Acupuncture and Chinese Medicine Clinic.

For All Clinic Appointments:

Cancellation Policy - Treatments are by appointment, although walk-ins are occasionally accepted. If you find that you need to cancel an appointment for any reason, it is important that we receive a 24-hour notice. This enables us to fill the time slot. We reserve the right to charge a $30.00 fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment.

Payment for Clinic Services Rendered - Payment is due at the time of service and may be paid in cash, by check or with a medical savings account card, flexible spending account card, health savings accounts card & all major credit cards. In order to keep clinic prices affordable, we do file insurance claims of any kind but we are not a Medicare/Medicaid provider.

Herbal Refills - Please call no less than 24 hours before you wish to pick up herbal refills to allow time to process the request. Herbal formula refills (powder and bulk) are priced per gram.

Actual Acupuncture and Chinese Medicine Clinic

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to Actual Acupuncture and Chinese Medicine Clinic ("Notice of Privacy Practices". I understand that I have the right to review Actual Acupuncture and Chinese Medicine Clinic "Notice of Privacy Practices" prior to signing this document.

I understand that Actual Acupuncture and Chinese Medicine Clinic staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Privacy Rep/Date

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Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Actual Acupuncture and Chinese Medicine Clinic is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the practitioners at Actual Acupuncture and Chinese Medicine Clinic of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

_____

Patient Signature Required Date

Actual Acupuncture and Chinese Medicine Clinic is not responsible for untrue statements made by patient.

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INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at Actual Acupuncture and Chinese Medicine Clinic who now or in the future treat me while employed by, working or associated with or substituting for Actual Acupuncture and Chinese Medicine, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at the Actual Acupuncture and Chinese Medicine clinic.

Patient's name (please print)	Patient's signature	(Date)
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.	(Date)
Signature of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.	(Date)

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Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name:_____ Sex: __F__M Date:____/____/_____

Date of birth: ____/____/_____ Age:_____ Occupation: _____

Height:__'___" Weight now: _____ Weight one year ago: _____

Main phone #: (____)_____ Other phone #: (____)_____

Emergency contact name:_____ Phone #:_____ Relationship:_____

Marital status:_____ # of children: __ E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

Family physician: _____ Chiropractor: _____

Do you have health insurance? __Yes __No If yes, name of insurance company:_____

Does your insurance cover acupuncture? __Yes __No __? Insurance ID# _____Group#_____

Have you ever been treated by acupuncture before? _____

How did you find out about our clinic? __Friends/Relatives (name) _____

__Location or walk by_____ ___ Insurance __Website __Referred by_____

__Yellow Pages __Other (please specify)_____

Main problem(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem?_____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?_____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____ Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental): _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Diabetes			Thyroid disease		
Breathing problems			Tuberculosis			Anemia		
High blood pressure			Venereal disease			Heart disease		
Depression or anxiety			Emotional disorders			Arthritis		
Seizures			Alcoholism			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

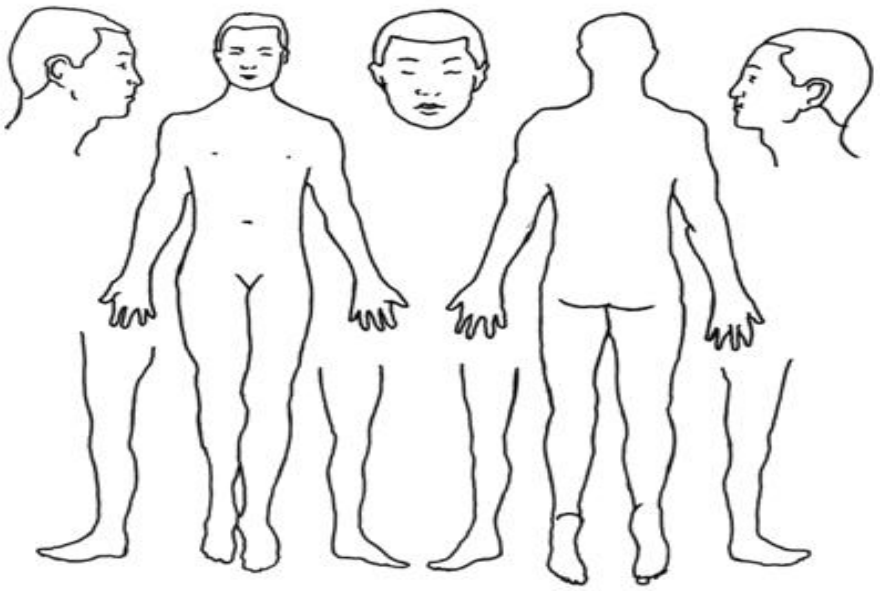
Occupation: _____ Do you usually work __indoors __ outdoors?

Habits Do you smoke? __Yes __No How many per day? _____ Since when?_____

Do you exercise regularly __Yes __No Please describe your exercise program: _____

Diet How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day
What kind of alcoholic beverages do you usually drink, if any? ____ Average number of drinks per week? _____

Indicate painful or distressed areas:



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Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General __Poor appetite __Poor sleep __Fatigue __Fevers __Chills__ Night sweats __Sweat easily __Tremors __Cravings __Change in appetite__ Bleed or bruise easily __ Weight loss __Weight gain

Skin & hair __Rashes __Ulcerations __Hives __Itching __Eczema__ Pimples __Acne

Musculoskeletal __Joint disorders __ Pain/soreness in the muscles __Tremors__ Cold hands/feet __Swelling of hands/feet __ Back pain __Hernia__ Numbness __Tingling __Paralysis__ Neck tightness__ Neck pain __Shoulder pain__ Hand/wrist pain __Hip pain __Knee pain __Joint Sprain __Other?

Head, eyes, ears, nose, and throat __Dizziness __Concussions __Migraines __Poor vision __Cataracts__ Blurry vision __ Ringing in ears __Poor hearing __Sinus problems __Other?_____

Cardiovascular __High blood pressure __Low blood pressure __Chest pain __Palpitation __Fainting __Irregular heartbeat __Other?_____

Respiratory __Cough __Wheezing __Difficulty breathing__ Bronchitis __Pneumonia __Chest pain __Other?__

Gastrointestinal __Nausea __Vomiting __Diarrhea __Constipation __Indigestion __ Hemorrhoids __Abdominal pain/cramps __Gallbladder problems __Parasites __Other?_____

Genito-urinary __Painful urination __Frequent urination __Blood in urine __Urgency to urinate__ Kidney stones __Unable to hold urine __Genital itching __ STD __Other?_____

Female __Frequent vaginal infections __Pelvic infection __Endometriosis __Vaginal/genital discharge__ Fibroids __Ovarian cysts __Irregular periods __ Breast tenderness __Breast Lumps __Fertility Problems __Hot flashes __Mood swings __Other?_____

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male __Prostate problems __Erectile dysfunction __Ejaculation problems__ Frequent seminal emission __Fertility problems __Painful/swollen testicles __Other

I have completed this form correctly to the best of my knowledge.

Signature: _____ Adult Patient __Parent or Guardian __Spouse

(Date)

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