SUN ACUPUNCTURE

ACUPUNCTURE • HERBS • SHIATSU-TUINA MASSAGE

Patient Information

Today's Date:_____

Name:_____ **Date of Birth:**_____

Street Address:_____

City, State, Zip Code:_____

Telephone (Cell):_____ **Telephone (Home):**_____

Email:_____

Emergency Contact:_____

Healthcare / Insurance Provider?_____

Do you have acupuncture coverage on your insurance plan? (YES / NO)

Occupation:_____

Referred By:_____

Have you ever had acupuncture or Asian bodywork therapy? (YES / NO)

Primary Health Concerns

Primary Health Concern: *(Please include: When this complaint first occurred, severity and duration).*

- _____

Secondary Health Concerns:

- _____

Have you been diagnosed by a western physician? (YES / NO)

Name of primary physician:_____

Current Treatments and Medications: *(Please list all therapies, medications, supplements, herbs, etc.)*

- _____
- _____

Please list any known allergies:

- _____
- _____

Do you have any of the following infectious diseases or major illnesses?

❑ Cancer ❑ Diabetes ❑ Hepatitis ❑ Heart Disease ❑ High Blood Pressure ❑ Seizures ❑ Stroke

❑ HIV/AIDS ❑ Pneumonia ❑ Tuberculosis ❑ Multiple Sclerosis ❑ Other:_____

Have you been exposed to any known environmental toxins or hormones? (YES / NO):_____

Do you have any reason to believe you may be pregnant? (YES / NO)

Do you have a pacemaker and/or implanted defibrillator? (YES / NO)

Do you have a history of a bleeding disorder? (YES / NO)

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Patient Lifestyle History

How would you best describe yourself?

- ❑ Underweight
- ❑ Normal Weight
- ❑ Over Weight

How would you best describe your exercise habits?

- ❑ Exercise regularly
- ❑ Exercise excessively
- ❑ Exercise less than I should

How often do you exercise?

- ❑ Less than once per week
- ❑ 1-3 times per week
- ❑ 3-5 times per week
- ❑ 5+ times per week

Please list the types of exercise you do:_____

How would you describe your dietary habits?

- ❑ Well-balanced diet
- ❑ Vegetarian diet
- ❑ Paleo diet
- ❑ Gluten-free diet
- ❑ Vegan diet
- ❑ Overeating
- ❑ Under eating
- ❑ Skips meals
- ❑ Craves carbohydrates
- ❑ Craves sweet foods
- ❑ Craves salty foods
- ❑ Cravings for specific foods:_____
- ❑ Food allergies:_____
- ❑ Other:_____

Are you following a specific diet?

- ❑ Low-carbohydrate diet
- ❑ Low-fat diet
- ❑ Crash diet:_____
- ❑ Detox diet:_____
- ❑ Belief-based diet:_____
- ❑ Medically necessary diet:_____
- ❑ Other:_____

How would you describe your water intake habits?

- ❑ Drinks enough water
- ❑ Drinks less than enough water
- ❑ Preference for warm drinks
- ❑ Preference for cold drinks
- ❑ Constant thirst
- ❑ No thirst

What other beverages do you drink?

- ❑ Drinks alcohol: Drinks per week (_____)
- ❑ Drinks coffee: Cups per day (_____)
- ❑ Drinks tea: Cups per day (_____)
- ❑ Drinks milk: Glasses per day (_____)
- ❑ Drinks soda: Cans per day (_____)
- ❑ Drinks juice: Glasses per day (_____)

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Patient Health History

Please check any of the following symptoms you are currently experiencing or any chronic issues you would like to address. Thank you.

General Symptoms:
- ❑ Fevers
- ❑ Chills
- ❑ Body Aches
- ❑ Fatigue
- ❑ Night Sweats
- ❑ Spontaneous Sweats
- ❑ Aversion to Heat or Cold

Respiratory Symptoms:
- ❑ Cough
- ❑ Sore Throat
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Shortness of Breath
- ❑ Other:_____

Head Symptoms:
- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Jaw Pain
- ❑ Other:_____

Eye Symptoms:
- ❑ Blurred Vision
- ❑ Floating Spots
- ❑ Dry Eyes
- ❑ Itchy Eyes
- ❑ Red Eyes
- ❑ Poor Night Vision
- ❑ Cataracts
- ❑ Other:_____

Ears/Nose/Throat Symptoms:
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Ear Infections
- ❑ Tinnitus
- ❑ Hearing Loss
- ❑ Nosebleeds
- ❑ Frequent Sore Throat
- ❑ Frequent Colds/Flu
- ❑ Bleeding Gums
- ❑ Grinding Teeth
- ❑ Other:_____

Skin & Hair Symptoms:
- ❑ Dry Skin
- ❑ Itchiness
- ❑ Rashes/Hives
- ❑ Eczema
- ❑ Bruises Easily
- ❑ Acne
- ❑ Brittle Nails
- ❑ Dry or Brittle Hair
- ❑ Hair Loss
- ❑ Other:_____

Digestive Symptoms:
- ❑ Difficulty Swallowing
- ❑ Nausea or Vomiting
- ❑ Hiccup or Belching
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Excess Thirst
- ❑ Tired after Eating
- ❑ Mouth or Tongue Sores
- ❑ Abdominal Pain
- ❑ Ulcers
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea or Loose Stools
- ❑ Blood in Stools
- ❑ Hemorrhoids
- ❑ Other:_____

Cardiovascular Symptoms:
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Irregular heart beat
- ❑ High/Low Blood Pressure
- ❑ Poor Circulation
- ❑ Other:_____

Urinary Symptoms:
- ❑ Cloudy Urine
- ❑ Dark or Scanty Urine
- ❑ Burning Urination
- ❑ Frequent Urination
- ❑ Nighttime Urination

Emotional Symptoms:
- ❑ Forgetfulness
- ❑ Poor Memory
- ❑ Trouble Concentrating
- ❑ Stress
- ❑ Preoccupation/Worry
- ❑ Irritability
- ❑ Sadness
- ❑ Anxiety
- ❑ Other:_____

Sleep Symptoms:
- ❑ Insomnia
- ❑ Difficulty Falling Asleep
- ❑ Waking at Night
- ❑ Waking Early
- ❑ Light Sleeping
- ❑ Heavy Sleeping
- ❑ Excessive or Vivid Dreams
- ❑ Night Terrors
- ❑ Night Sweating
- ❑ Restless Legs
- ❑ Leg Cramps
- ❑ Other:_____

Neurological Symptoms:
- ❑ Fainting
- ❑ Seizures or Convulsions
- ❑ Paralysis
- ❑ Tics or Tremors
- ❑ Balance Issues
- ❑ Recent Clumsiness
- ❑ Vertigo

~~Men Only Questions:~~
- ~~❑ Impotence~~
- ~~❑ Erectile Dysfunction~~
- ~~❑ Prostate Issues~~
- ~~❑ Male Infertility~~
- ~~❑ Hernia~~
- ~~❑ Genital Pain~~
- ~~❑ Genital Itching~~
- ~~❑ Nocturnal Emissions~~
- ~~❑ Low Sexual Energy~~
- ~~❑ High Sexual Energy~~
- ~~❑ Gout / Fungal Problems~~

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Women's Health History

Age of your first menses?_____

How many days are in your cycle?_____

Average length of your period?_____

Have your periods become: ❑ More Frequent ❑ Less Frequent

Have your periods stopped? ❑ Yes ❑ No

How would you best describe your current periods?

❑ Heavy Periods ❑ Shorter Periods ❑ Bleed Between Periods

❑ Light Periods ❑ Longer Periods ❑ Painful Periods

❑ Irregular Periods ❑ Frequent Spotting ❑ Clots with Periods

How would you best describe the color of your periods?

❑ Bright Red ❑ Dark Red ❑ Pale Red ❑ Purple Red ❑ Brown Red

Which symptoms do you have with your period?

❑ Breast tenderness ❑ Fatigue ❑ Body aches

❑ Irritability ❑ Swelling ❑ Acne or other skin issues

❑ Sadness ❑ Loose stools or digestive issues

❑ Headaches ❑ Cold and flu symptoms

Have you been diagnosed or experiencing any of the following gynecological issues?

❑ Endometriosis ❑ Vaginal itching ❑ Low sexual energy

❑ Cysts (PCOS) ❑ Urinary tract infections ❑ High sexual energy

❑ Fibroids ❑ Candida/yeast infections ❑ Sexually transmitted diseases:

❑ Polyps ❑ Uterine prolapse _____

❑ Fertility issues ❑ Pain during ovulation ❑ Use of contraceptives:

❑ Abnormal vaginal discharge ❑ Pain with intercourse _____

Pregnancy Questions:

❑ Number of pregnancies:_____ ❑ Number of children:_____

❑ Number of miscarriages:_____ ❑ Ages of children:_____

❑ Number of abortions:_____

Have you had any surgical procedures? (YES / NO):_____

Have you undergone a full or partial hysterectomy? (YES / NO):_____

Have you had any cancer treatments? (YES / NO):_____

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Menopausal Transition Intake

Family History:

Number of Siblings: _____

Where are you in the sibling order: _____

Were there any complications with your birth: _____

Have you experienced any severe illnesses as a child or during your life: ❑ Yes ❑ No
- If so, please specify: _____

Have your mother, female relatives, or siblings experienced menopausal symptoms? ❑ Yes ❑ No
- If so, please specify: _____

1.) Hot Flashes

Rate the following symptom based on the severity: Hot flashes, sweating (episodes of sweating):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Do you experience hot flashes?	❑ Yes ❑ No
Do you experience night sweating?	❑ Yes ❑ No
Do you frequently sweat?	❑ Yes ❑ No
Do you sweat easy?	❑ Yes ❑ No
Do you get hot easy?	❑ Yes ❑ No
Do you get cold easy?	❑ Yes ❑ No
Do you only get cold after a hot flash and sweating?	❑ Yes ❑ No
Do only your fingers, toes, ears, or nose get cold?	❑ Yes ❑ No
Does your entire body get cold?	❑ Yes ❑ No
Do you enjoy the warm weather?	❑ Yes ❑ No
Do you prefer cooler temperatures?	❑ Yes ❑ No

How long have you been experiencing hot flashes?
❑ <1 year ❑ 1-3 years ❑ 3-5 years ❑ 5-10 years ❑ 10+ years

How frequent are your hot flashes?
❑ Infrequent ❑ 1x/Hour ❑ 1-3x/Hour ❑ 3-10x/Hour ❑ >10/Hour

How many hot flashes do you experience in 24 hours?
❑ <5 ❑ 5-10 ❑ 10-20 ❑ >25 ❑ Constant

How long does a typical hot flash last for you?
❑ <10 seconds
❑ 10-30 seconds
❑ 30-60 seconds
❑ 1-3 Minutes
❑ 3+ Minutes
❑ Constant

When do you experience hot flashes?
❑ Mornings ❑ Afternoons ❑ Evenings ❑ During sleep ❑ Constant

When are your hot flashes the worst?
❑ Mornings ❑ Afternoons ❑ Evenings ❑ During sleep ❑ Constant

Do your hot flashes interfere or disrupt any parts of your lifestyle?
❑ Work ❑ Leisure ❑ Exercise ❑ Sleep

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When experiencing a hot flash, do you feel heat everywhere in your body or only specific areas?
❑ Everywhere ❑ Only specific areas

Please check the specific areas where you experience heat with a hot flash:
- ❑ Head
- ❑ Face & Cheeks
- ❑ Ears
- ❑ Neck and throat
- ❑ Chest
- ❑ Abdomen
- ❑ Groin and genitalia
- ❑ Neck and upper back
- ❑ Along spine
- ❑ Lower back
- ❑ Arms and forearms
- ❑ Palms and fingers
- ❑ Upper Legs
- ❑ Lower Legs
- ❑ Soles of feet

Do you have any triggers for your hot flashes?
- ❑ Alcohol
- ❑ Coffee or caffeine
- ❑ Any hot beverages
- ❑ Other beverages *(Specify):* _____
- ❑ Dehydration
- ❑ Specific foods *(Specify):* _____
- ❑ Skipping meals
- ❑ Not eating enough
- ❑ During meals
- ❑ After eating
- ❑ Exercise or activity
- ❑ Fatigue
- ❑ Working long hours
- ❑ Sleep
- ❑ Hot or warm environment
- ❑ Cool or cold environment
- ❑ Air conditioning
- ❑ Humidity
- ❑ Sunlight
- ❑ Wind
- ❑ Stress or irritability
- ❑ Worry or depression

Do you experience any peculiar or specific sensations before the start of a hot flash ❑ Yes ❑ No
- If so, please specify: _____

What helps alleviate your hot flashes?
- ❑ Rest
- ❑ Working or Exercise
- ❑ Specific foods *(Please Specify):*_____
- ❑ Drinking water
- ❑ Change in environment or temperature *(Please Specify):*_____
- ❑ Herbal formulas, supplements or vitamins *(Please Specify):*_____
- ❑ Medications *(Please Specify):*_____

2.) Heart Issues

Rate the following symptom based on the severity: Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness):
❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Do you experience heart palpitations? ❑ Yes ❑ No
Does your heart race? ❑ Yes ❑ No
Do you experience heart or chest flutters? ❑ Yes ❑ No
Have you been diagnosed with atrial fibrillation? ❑ Yes ❑ No
Do you have chest tightness or pain? ❑ Yes ❑ No

3.) Sleep Issues

Rate the following symptom based on the severity: Sleep problems (Difficulty falling asleep, difficulty sleeping through the night, waking up early):
❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing any of the following sleep issues?
- ❑ Difficulty falling asleep
- ❑ Waking at night
- ❑ Waking at night to urinate
- ❑ Difficulty falling back asleep
- ❑ Waking early
- ❑ Excessive sleep

Do you feel you get enough sleep? ❑ Yes ❑ No

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4.) Depression

Rate the following symptom based on the severity: Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing depression, sadness, or melancholy? ❑ Yes ❑ No

• If so, when did these symptoms begin?

❑ With the onset of menopausal transition
❑ I've experienced these symptoms before menopausal transition started

5.) Irritability

Rate the following symptom based on the severity: Irritability (feeling nervous, inner tension, feeling aggressive):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing irritability, tension, anger, or rage? ❑ Yes ❑ No

• If so, when did these symptoms begin?

❑ With the onset of menopausal transition
❑ I've experienced these symptoms before menopausal transition started

6.) Anxiety

Rate the following symptom based on the severity: Anxiety (inner restlessness, feeling panicky):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing anxiety, restlessness or panic attacks? ❑ Yes ❑ No

• If so, when did these symptoms begin?

❑ With the onset of menopausal transition
❑ I've experienced these symptoms before menopausal transition started

7.) Energy and Memory

Rate the following symptom based on the severity: Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing fatigue? ❑ Yes ❑ No

Are you experiencing any of the following cognitive issues?

❑ Impaired memory ❑ Memory loss ❑ Forgetfulness ❑ Poor concentration ❑ Fogginess

8.) Sexual Problems

Rate the following symptom based on the severity: Sexual problems (change in sexual desire, in sexual activity and satisfaction):

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Have you experienced an overall increase in sexual desire? ❑ Yes ❑ No
Have you experienced an overall decrease in sexual desire? ❑ Yes ❑ No
Have you experienced an overall increase in sexual activity? ❑ Yes ❑ No
Have you experienced an overall decrease in sexual activity? ❑ Yes ❑ No
Have you experienced an overall increase in sexual satisfaction? ❑ Yes ❑ No
Have you experienced an overall decrease in sexual satisfaction? ❑ Yes ❑ No

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9.) Bladder Problems

Rate the following symptom based on the severity: <u>Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)</u>:

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing an increase with urinary difficulty? ❑ Yes ❑ No
Are you experiencing an increase in the need to urinate? ❑ Yes ❑ No
Are you experiencing an increase in urination frequency? ❑ Yes ❑ No
Are you experiencing urinary incontinence? ❑ Yes ❑ No

10.) Vaginal Dryness

Rate the following symptom based on the severity: <u>Dryness of vagina (sensation of dryness, burning in the vagina, difficulty sexual intercourse)</u>:

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing vaginal dryness? ❑ Yes ❑ No
Are you experiencing vaginal burning? ❑ Yes ❑ No
Are you experiencing difficulty with sexual intercourse? ❑ Yes ❑ No
Are you experiencing painful sexual intercourse? ❑ Yes ❑ No

11.) Joint & Muscular Discomfort

Rate the following symptom based on the severity: <u>Joint and muscular discomfort (pain in the joints, rheumatoid complaints)</u>:

❑ None ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

Are you experiencing joint or muscular achiness or pain? ❑ Yes ❑ No

• If so, when did these symptoms begin?

❑ With the onset of menopausal transition
❑ I've experienced these symptoms before menopausal transition started

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture, shiatsu-tuina and/or Chinese herbs from the Chinese materia medica by a licensed acupuncturist or licensed bodywork therapist at Sun Acupuncture Inc. I understand that acupuncturists practicing in the state of Minnesota are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

• **Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin and/or with the application of heat to specific points on the body to treat bodily dysfunction or disease, to modify or prevent pain, and to normalize the body's physiological functions. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including but are not limited to: Bruising, bleeding, muscle weakness or soreness, sensations of heat, cold, tingling or numbness, brief light headedness or fainting, and the possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks of acupuncture include: Spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic 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. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

• **Shiatsu-Tuina Massage:** I understand that shiatsu and tuina are forms of Asian bodywork therapy based on traditional Chinese medicine principles. Shiatsu and tuina affect the energy and physiological functions of your body using techniques that include: Rolling, kneading, pressure, stretching, tapping, and pounding. In your session you will remain fully clothed. The exception to this is that we may work directly on the skin of your abdomen, exposing only that area, and we may remove your socks. Special attention is made towards your comfort zone and the degree of pressure you are comfortable with. I am aware that certain adverse side effects may result from this treatment including but are not limited to: Bruising, stiffness, soreness, achiness, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable at any time.

• **Cupping Therapy:** I understand that if I receive cupping therapy as part of therapy, there is a risk of circular bruising, blistering, or skin aggravation from its use. I understand that I may refuse this therapy.

• **Chinese Herbs:** I understand that substances from Chinese materia medica may be recommended to me to treat bodily dysfunction or disease, to modify or prevent pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. Herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese medicine. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: Changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. I understand the some herbs may be inappropriate during pregnancy and will inform the practitioner immediately of pregnancy status. *Should I experience any problems, which I associate with these substances, I should suspend taking them and contact Sun Acupuncture Inc. as soon as possible.*

• **Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered along with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: Electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatments offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Consent to Treat a Minor Child

I authorize the acupuncturist and/or whomever they designate as assistants to administer acupuncture and other modalities offered at Sun Acupuncture Inc. as deemed necessary to _____ (Name and Relationship).

_____ _____

Patient/Guardian Printed Name **Date** **Patient/Guardian Signature** **Date**

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Consent for Purposes of Payment and Health Care Operations

Payment Policy
I understand that payment is due at the time of service including all health insurance co-payments, co-insurances, and estimated deductibles. Sun Acupuncture Inc. accepts cash, checks, credit card and Health Savings Account (HSA) cards.

Health Insurance Policy
I understand that Sun Acupuncture Inc. will work with my health insurance company on my behalf to obtain payment for treatments. I agree to pay all charges incurred for services rendered, over and above insurance coverage, and am liable for the out of pocket price if insurance does not cover services.

Cancellation Policy
As a courtesy to all of our patients, we strive to maintain a smooth and efficient operation so that you can enjoy your treatment on time, all of the time. Since our services are by appointment only, please make yourself familiar with my cancellation policy.

- 24-hour notice is required for cancelling or rescheduling an appointment to avoid charges.
- A no call/no show will result in a charge for full price of the treatment missed.
- Emergencies and certain exceptions can be made on a case-by-case basis, but must be done by phone before the appointment.
- A no call/no show charge must be paid before another appointment will be scheduled or administered.

HIPPA
The Health Insurance Probability & Accountability Act (HIPPA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

Patient Agreement
I consent to the use or disclosure of my identifiable health information by Sun Acupuncture Inc. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis or treatment of me at Sun Acupuncture Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. Sun Acupuncture Inc. is not required to agree to the restrictions that I may request. However, if Sun Acupuncture Inc. agrees to a restriction that I request, the restriction is binding upon Sun Acupuncture Inc. I have the right to revoke this consent, in writing, at any time except to the extent that Sun Acupuncture Inc. has taken action in reliance on this consent.

I understand that it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation, and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I understand I have the right to review Sun Acupuncture Inc. Notice of Privacy Policies prior to signing this document. The Notice of Privacy Policies describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. This Notice of Privacy Policies also describes my rights and the duties of my practitioners with respect to my identifiable health information. Sun Acupuncture Inc. reserves the right to change information contained in the Notice of Privacy Policies at any time. I may obtain a revised Notice of Privacy Policies by requesting the most current notice during any office visit.

We greatly appreciate your business and thank you deeply for your cooperation with this policy.

Please sign and date below to acknowledge that you have read and understand Sun Acupuncture Inc. Consent for Purposes of Payment and Health Care Operations and Notice of Privacy Policies.

_____ _____

Signature of Patient or Authorized Representative **Date**

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Notice of Privacy Policies

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

Right to Request Confidential Communications:

You may specifically authorize us to use protected health information for any purpose, or to disclose our health information about you, by submitting an authorization in writing (generally a "release of information" form). Such disclosures will be made to any personal representative you designate to share 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, newsletters, emails, postcards, letters or telephone calls.

Patient Rights:

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have the right to receive all notices in writing.

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 952-935-0600. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to the U.S. Department of Health and Human Services: DHHS (Office of Civil Rights) 200 Independent Avenue S.W. Room 509F HHH Building Washington D.C. 20201

Yours truly,

Sun Acupuncture Inc.
Brian Grosam PhD, LAc
Pam Grosam Certified Asian Bodywork Therapist