



**Center for Integrated
Eastern Medicine**

7283 Ellis St.
Arvada, Co. 80005
Ph: 303-810-9255

**Consent for Purposes of Treatment, Payment & Healthcare Operations
(11/06)**

In this document, "I" and "my" refer to the patient,
and "Acupuncturist" refers to Center for Integrated Eastern Medicine.

I consent to the use or disclosure of my protected health information by Acupuncturist for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Acupuncturist. I understand that analysis, diagnosis or treatment of me by Acupuncturist may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Acupuncturist is not required to agree to the restrictions that I may request. However, if Acupuncturist agrees to a restriction that I request, the restriction is binding on Acupuncturist.

I have the right to revoke this consent, in writing, at any time, except to the extent that Acupuncturist has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Acupuncturist and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Acupuncturist. The Notice of Privacy Practices for Acupuncturist is also posted in the waiting room at 6354 Winona St., Arvada, Co. This Notice of Privacy Practices also describes my rights and duties of the Acupuncturist with respect to my protected health information.

Acupuncturist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Acupuncturist and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority



Appointment Date:

I General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____ May we contact them? Y/N

Have you had Acupuncture or Oriental medicine before? Y/N

Are you presently under a doctor's care? Y/N Who and for what? _____

Are there any other therapies which you are involved? Y/N Who and for what? _____

II Insurance Information

Insurance Company _____ Contact # _____

Group/Plan # _____ Co-pay \$ _____ Visit # _____ Referral Y/N Covered % _____ Ded.(?) _____

Date called _____ Contact Name _____

III Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

<input type="checkbox"/> Work	<input type="checkbox"/> Standing	<input type="checkbox"/> Sexually	<input type="checkbox"/> Other
<input type="checkbox"/> Sleep	<input type="checkbox"/> Emotional	<input type="checkbox"/> Recreation	_____
<input type="checkbox"/> Walking	<input type="checkbox"/> Relationships	<input type="checkbox"/> Bending	_____
<input type="checkbox"/> Sitting	<input type="checkbox"/> Social Life	<input type="checkbox"/> Stretching	_____

What have you done about this? _____

Are you interested in: Pain Relief Performance Care Maintenance Care Other

Preventative Care Holistic Health Stress Relief _____

Oriental Nutrition Meridian Yoga Herbal Therapy _____

What are your health goals? _____

List any past or future surgeries. _____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in: _____

IV Signs/Symptoms

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Dark stools | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Impotence | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Irritable | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive phlegm
Color of | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Fever | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Gas/belching | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Headache | <input type="checkbox"/> Migraine | <input type="checkbox"/> Rash | <input type="checkbox"/> Weight loss/gain |
| | | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Redness of eyes | <input type="checkbox"/> Wheezing |

V Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N _____ Is your cycle painful? Y/N _____ Have you ever been pregnant? Y/N _____

Birth control? Y/N _____ How long? _____ PMS Clotting Vaginal sores Vaginal pain Discharge

VI Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|---------------------------------------|--|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Metal breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | | <input type="checkbox"/> Multiple Sclerosis |

Do you sleep well? Y/N

Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

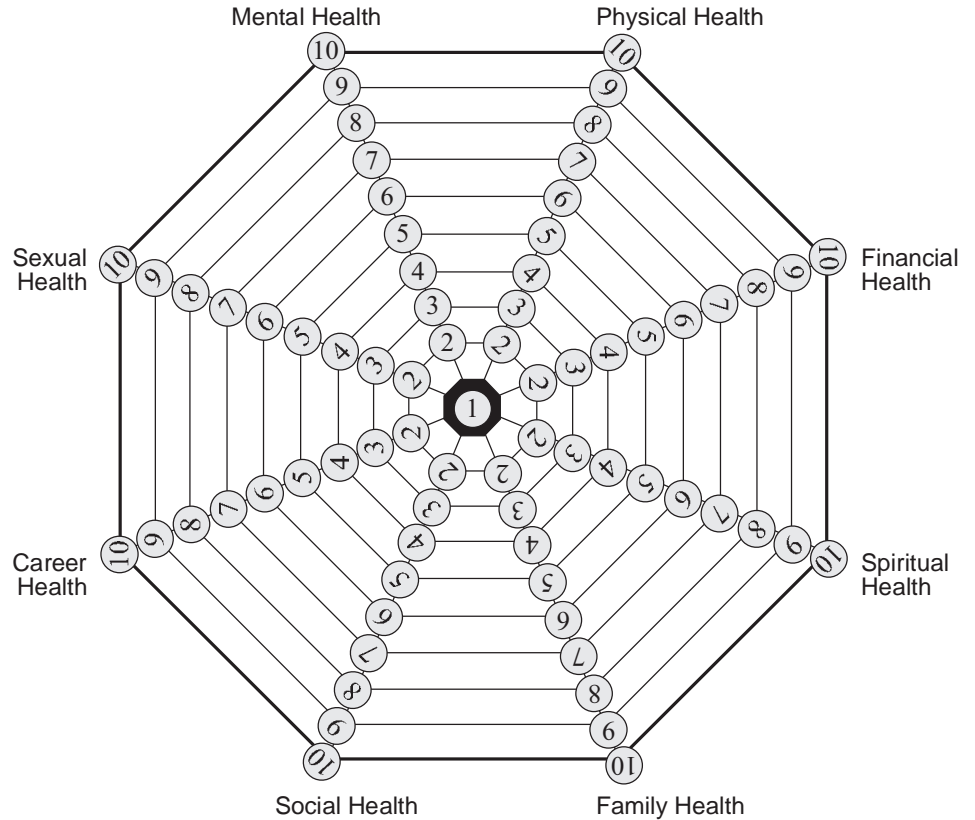
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career.

1 = Not happy

10 = Extremely satisfied



VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain
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Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep
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Work - Can do:

Usual work	25% of work	50% of Work	No work
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Frequency of pain

25% of time	50% of time	75% of time	100% of time
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Travel

No problem on long trips	Moderate pain on trips	Severe pain
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Recreation - Can do:

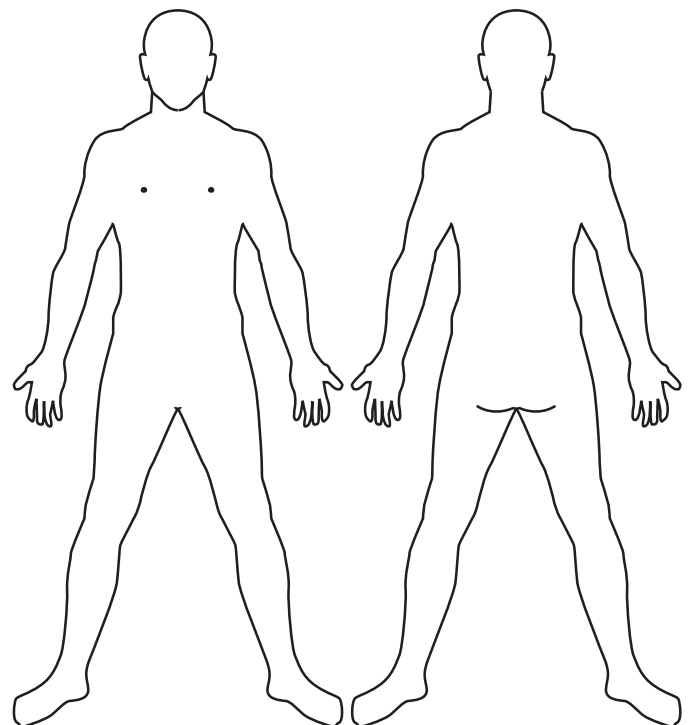
All activities	Some activities	No activities
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Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk
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Sitting

No pain sitting	Some pain while sitting	Cannot sit
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Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



Acute Care

Obvious symptoms and signs

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care

Symptom and signs disappear

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care

You feel great

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

(Signature) _____ (date) _____



Center for Integrated Eastern Medicine

1140 US Hwy 287
Suite 100
Broomfield, Co 80020

Notice of Privacy Practices (8/06)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective August 13, 2006, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

- (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
- (2) We are required to abide by the terms of this Notice currently in effect.
- (3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for





Notice of Privacy Practices (8/06)

your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to

SCOT SOMES,
7283 ELLIS ST.
ARVADA, CO 80005

