Straight To The Point Acupuncture

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.
IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK OUR STAFF.

Straight To The Point Acupuncture understands that your medical information and your health is personal and should be confidentially maintained. We are committed to protecting medical information about you. We are also committed to providing you with the best possible care. In order to serve you properly, we create a record of the care and services that we provide to you. This notice applies to all records that we generate to serve you. The following policy will be followed by every one of our employees to ensure your information is confidentially maintained. This notice will explain the ways we use information about you in order to make sure that you receive all the care you need.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 10/01/2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, healthcare operations and payment. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose medical information in the form of a patient status report to your worker's compensation carrier or insurance company respective so that they may monitor how you are progressing.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six (6) years, but not before October 10, 2011. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by reasonable alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complain to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Derek Durfee, L. Ac.
Straight To The Point Acupuncture
5252 Balboa Avenue, Suite 601
San Diego, California 92117
(858) 699-3266
E-mail: sttpacu@gmail.com

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Straight To The Point Acupuncture Notice of Privacy Practices.

I further acknowledge that a paper copy of the current notice will be on file at all locations and will be available to me at my request during office hours.

Name of Patient: _____ Date: _____

Patient Signature: _____ Phone: _____

If the patient is a minor, parent or legal guardian must sign below:

Parent or Legal Guardian of Minor Signature: _____

FEES, INSURANCE AND PAYMENT AGREEMENT

The fees charged by Straight To The Point Acupuncture are comparable to those charged by other acupuncturists with similar qualifications in this geographic area.

The fees for office services are payable at the time of the visit. **We accept cash or personal checks.**

Upon request, if you carry health insurance covering the services that we offer, we will provide you with the necessary document for you to receive reimbursement from your insurer.

If you agree to the above terms, please sign the space provided below.

_____ _____

Patient's Signature Date

PATIENT PROFILE

Name: _____ Date: _____

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms, thus, it is essential to indicate time on the symptoms.

Indicate with ONE check any condition that you sometimes experience, use TWO checks for those which occur often, and THREE checks for symptoms that are a major concern.

WATER ELEMENT

□ Hearing loss
□ Dizziness
□ Lower back ache/neck pain
□ Sinus congestion
□ Edema
□ Darkness under the eyes
□ Emotional instability
□ Aversion to cold
□ Hair thinning or loss
□ Premature aging
□ Frequent urination
□ Kidney stones
□ Perspire very easily
□ Weakness of legs/knees
□ Asthmatic cough
□ Rapid weight change
□ Loose teeth
□ Reduced sexual energy
□ Thyroid problems
□ Diabetes

WOOD ELEMENT

□ Headaches
□ Migraines
□ Ringing in the ears
□ Poor eyesight
□ Eye infections
□ Dry eyes
□ Eczema
□ Shingles
□ Herpes simplex
□ Warts
□ Nervousness
□ Convulsion, spasms
□ Irritability
□ Constipation
□ Hemorrhoids
□ Hepatitis
□ Ulcer
□ Vomiting
□ Gallstones
□ Indecisive
□ Fullness below ribs
□ Shoulder/neck tension
□ Insomnia 11PM-3AM

FIRE ELEMENT

□ Dry Scalp
□ Skin eruptions, rashes
□ Cysts, tumors
□ Ear infections
□ Sore throat, tonsillitis
□ Lymphatic swelling
□ Hot palms and soles
□ Heart palpitations
□ Aversion to heat
□ Bitter taste in mouth
□ Gum problems
□ Nose bleed
□ Facial redness
□ Itching/burning skin
□ Hot hands/feet
□ Thirst
□ Vivid dreaming
□ Dark urine
□ Night sweats

EARTH ELEMENT

□ Indigestion
□ Flatulence
□ Food allergy
□ Stomach ache/ulcer
□ Diarrhea
□ Anemia
□ Halitosis
□ Sores in mouth
□ Heartburn
□ Strong appetite
□ Weak appetite
□ Nausea
□ Abdominal bloating
□ Low body weight

METAL ELEMENT

□ Bronchitis
□ Asthma
□ Shallow breathing
□ Cough
□ Sinus congestion
□ Nasal infections

OTHER

□ Fatigue
□ Athralgia
□ Sciatica/nerve pain
□ Cold hands/feet
□ Tendonitis
□ Bursitis

PAIN(please describe below)

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OTHER COMMENTS

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Derek Durfee L. A.c - 858.699.3266 - sttpacu@gmail.com 5252 Balboa Avenue, Suite 601 San Digeo, CA 92117

PATIENT'S PERSONAL HISTORY

NOTE: This is a confidential record. Information contained here will not be released to anyone without your written authorization.

Thank you for placing your trust in us!

Name: _____

Sex: _____ Birth Date: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____Cell: _____

Preferred phone # to contact: _____ e-mail address: _____

How were you referred to our office? _____

Employed by: _____ Occupation: _____

Insurance Company: _____ Policy #: _____

Insured's Name: _____ Insured's SSN: _____ Insured's DOB: _____

Have you ever had acupuncture before? _____

Have you ever been diagnosed with the following? Hepatitis _____ HIV Virus _____ AIDS _____

Are you currently under another physician's care for any medical conditions? (If yes, give your doctor's name and the medical condition.) _____

Are you currently taking any prescription medication? If so, please list them: _____

_____

_____

Are you currently experiencing any pain and where? _____

Please list any health conditions that you would like us to focus on: _____

_____

_____

CONSENT FOR ACUPUNCTURE

I, the undersigned, realize that acupuncture may be considered as an investigative procedure in the United States of America. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Patient's Signature _____ Date _____