East-West Integrative Medicine Clinic
605 Chenery Street, Suites B + C
San Francisco, CA 94131
415.585.1990 www.eastwestsf.com

East-West
INTEGRATIVE
MEDICINE

New Patient Fertility Forms: Female

General Information: Date: _____

Name:_____ Birthdate:_____ Age:_____

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

Phone Numbers: *Please mark * next to the best phone number(s)*

Home: _____ Cell: _____ Work: _____

Email:_____

Please note: an email address is necessary for us to schedule appointments using the confidential online scheduling system.

Gender:_____ Marital Status: _____ Number of Children: _____

Occupation:_____ #Hrs./Wk: _____ Health Insurance: _____

How did you hear about us?_____

Emergency Contact:

Name:_____ Ph:_____ Relationship:_____

Physicians:

Primary Physician:_____ Ph:_____

If applicable: OB/GYN:_____ Ph:_____

Reproductive Endocrinologist: _____ Ph:_____

Other Specialist:_____ Ph:_____

Cancellation Policy & Financial Agreement:
Please arrive on time for your appointments. Please give at least 24 hours notice to avoid a late cancellation charge of full treatment fee. Insurance companies do not pay for missed appointments and insurance patients will be charged the full price of service for late or missed appointments.

I understand that payment is due at the time of service. I agree to the above terms and authorize my practitioner to bill my credit card for amounts unpaid by insurance or as otherwise specified above. We will never charge this number without giving you prior notice.
Visa and Master Card accepted.

Card No._____ Exp date:_____ VIN # (on back):_____

Billing address (if different than personal address above):

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

_____ _____
Patient Signature Date

East-West Integrative Medicine Clinic
Office Policies and Procedures

Initial Appointments:
- Please allow about a 60-90 minutes for your initial visit.
- Please arrive 5 minutes early, with your forms completed.

Cancellations and Changes:
- If you need to reschedule an appointment, please notify us a minimum of 24 hours in advance. This allows us to schedule someone else who is waiting for an appointment.
- Patients who miss their appointment or cancel less than 24 hours prior to their appointment will be required to pay for the missed visit. Missed appointments will be billed to a credit card on file.

Your Visits:
- We value your time. In order to keep on schedule, we request that you arrive on time for your appointment. If you arrive more than 15 minutes late for our appointment, we may need to reschedule you. We will make every effort to reschedule you as soon as possible, contingent on space availability. Please allow sufficient travel time.
- There are occasions where extenuating circumstances arise and we may be delayed for a brief time. This will not affect the length of your visit. Please accept our apologies for any inconvenience.
- Please allow enough time for your complete visit. If you know you need to leave our office by a specific time, please let us know when you first arrive and we can accommodate you.

Herbs, Supplements & Prescriptions:
- If for any reason you are unable to take your prescribed items as directed or have questions about their use, please let our office know as soon as possible.
- Unopened bottles in resalable condition can be returned for credit at East-West within 30 days of purchase.
- The following items cannot be returned: refrigerated items, special order items, custom formulas.

Payment:
- Payment is due at the time of your appointment, unless alternate arrangements have been made.
- Accepted methods of payment are: **Visa, MasterCard, Check and Cash.**
- We require all patients to have a current signed credit card authorization form on file to secure your appointments.
- If you have an insurance policy you are using that sends you payments directly we will charge your credit card on file once we receive the explanation of benefits in the mail. If your copay is not paid at the time of service we will charge the credit card on file after 30 days past due.

A Note About Insurance:

- Verification of insurance does not guarantee coverage of acupuncture benefits. Description of benefits is not an authorization or guarantee of payments. You are financially responsible for all services/treatments rendered at East-West Integrative Medicine when your insurance denies coverage. Your insurance company may deny coverage for certain diagnosis or dates of service. We advise that you become fully aware of your insurance benefits and are proactive in communicating directly with your insurance company when this occurs.

I have read and understand the East-West Policies and Procedures:

Signature: _____ Date:_____

Health History

Name:_____ Date:_____

Please list 5 major health concerns in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

Family History	Self	Father	Mother	Sibling(s)	Children
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					
Blood Disorder/Anemia					
Seizures					
Kidney/Bladder					
Stomach/Intestinal					
Drug Abuse					
Tuberculosis					
Depression					
Autoimmune Disease					
Age at Death					

Have you ever had acupuncture treatment? _____ If so, for what? _____

If your complaint is pain related, please answer the questions below:

Rate the following on a scale of 0 to 10 (0 being none and 10 being the maximum possible):

Pain intensity right now _____Usual pain intensity experienced over the past week ____

Amount that the pain interfered with daily activities ____

Frequency of Pain

☐ Continuous
☐ Several Times /Day
☐ Once / Day
☐Three times / week
☐ Once / week

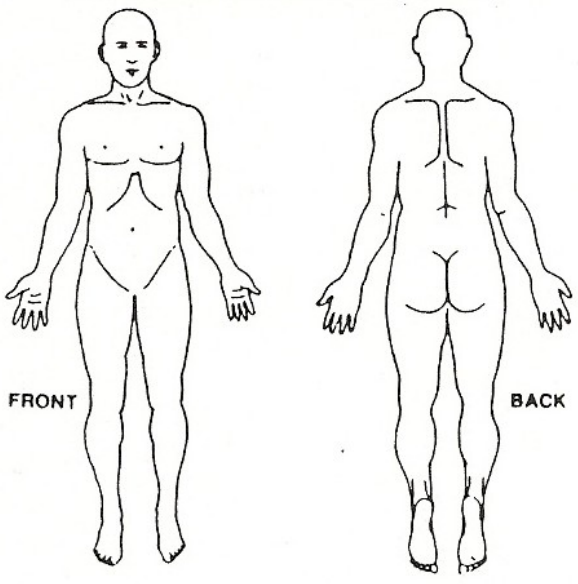
Duration of Pain

☐ Seconds
☐ Minutes
☐ Hours
☐ Days
☐ Continuous

Description of Pain (Check all that apply)

☐ Throbbing
☐ Gnawing
☐ Tender
☐ Cramping
☐ Hot ☐ Cold
☐ Dull
☐ Burning
☐ Heavy
☐ Aching
☐ Stabbing

PLEASE MARK YOUR AREAS OF PAIN



Surgeries & Hospitalizations

Description	Date	Comments

Medicines and Supplements

Check any medications you are currently taking:

☐ Aspirin
☐ Antacids
☐ Blood thinners
☐ Sleeping pills
☐ NSAIDs (Ibuprofen)
☐ Fiber or other laxatives
☐ Blood Pressure Pills
☐ Tranquilizers
☐ Acetaminophen (Tylenol)
☐ Diet pills
☐ Insulin
☐ Anti-depressants
☐ Oral Contraceptives
☐ Allergy medication

Please list all prescription medications and supplements you use. Include those that you only use occasionally. Remember inhalers, eye drops, nose sprays, topical creams, and vitamins.

MEDICATIONS

Prescription Name	Purpose	How Long	Dose	How Often

SUPPLEMENTS

Supplement Name	Purpose	How Long	Dose	How Often

Habits
Please check any habits which apply to you now or in the past:

Coffee ☐ Y ☐ N per day_____ per week _____ age started _____ age quit _____

Tobacco ☐ Y ☐ N per day_____ per week _____ age started _____ age quit _____

Alcohol ☐ Y ☐ N per day_____ per week _____ age started _____ age quit _____

Marijuana ☐ Y ☐ N per day_____ per week _____ age started _____ age quit _____

Diet

Dietary restrictions:

_____

_____

Please describe your typical daily diet:

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

Would you like us to evaluate your diet over a week period? ☐ Y ☐ N

Please describe any regular program of exercise:

_____

_____

Current / Recent *Past* **LIVER / GALLBLADDER**

- ☐ ☐ Depression / Stress
- ☐ ☐ Headaches / Migraines
- ☐ ☐ Red / Dry / Itchy Eyes
- ☐ ☐ Visual Problems / Blurred Vision
- ☐ ☐ Dizziness
- ☐ ☐ Gall Stones
- ☐ ☐ Numbness/Tingling
- ☐ ☐ Aversion to wind
- ☐ ☐ Paralysis
- ☐ ☐ Feeling of Lump in Throat
- ☐ ☐ Clenching of Teeth at Night
- ☐ ☐ Muscle Cramping / Twitching
- ☐ ☐ Neck/Shoulder Pain / Tightness
- ☐ ☐ Joint Pain
- ☐ ☐ Poor Circulation
- ☐ ☐ Soft / Brittle Nails
- ☐ ☐ Bad Taste
- ☐ ☐ Bad Breath
- ☐ ☐ Do you crave: Sour
- ☐ ☐ Irritability / Anger
- ☐ ☐ Insomnia
- ☐ ☐ Vivid Dreams
- ☐ ☐ Fainting
- ☐ ☐ Seizures

Current / Recent *Past* **KIDNEY / URINARY BLADDER**

- ☐ ☐ Kidney Stones
- ☐ ☐ Urinary Problems
- ☐ ☐ Bladder Infection
- ☐ ☐ Frequent Urination
- ☐ ☐ Dropped Bladder
- ☐ ☐ Incontinence
- ☐ ☐ Lack of Bladder Control
- ☐ ☐ Weakness / Pain in Low Back
- ☐ ☐ Decreased Bone Density
- ☐ ☐ Feel Cold Easily
- ☐ ☐ Cold Hands / Feet
- ☐ ☐ Low Sex Drive / Libido
- ☐ ☐ Excess Sex Drive / Libido
- ☐ ☐ Poor Memory
- ☐ ☐ Loss of Hair / Grey Hair
- ☐ ☐ Hearing Problems
- ☐ ☐ Cavities
- ☐ ☐ Hot Flashes / Night Sweats
- ☐ ☐ Do you crave: Salt
- ☐ ☐ Fear

Current / Recent *Past* **HEART / SMALL INTESTINE**

- ☐ ☐ Heart Palpitations
- ☐ ☐ Chest Pain
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Insomnia / Sleep Problems
- ☐ ☐ Vivid Dreams
- ☐ ☐ Easily Startled
- ☐ ☐ Do you crave: Bitter
- ☐ ☐ Restlessness / Agitation

Current / Recent *Past* **LUNG / LARGE INTESTINE**

- ☐ ☐ Bloody Cough
- ☐ ☐ Dry Cough
- ☐ ☐ Cough with Sputum
- ☐ ☐ Nasal Discharge– Circle Color: White / Yellow / Green
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Sinus Infection / Congestion
- ☐ ☐ Itchy, Red, or Painful Throat Dry
- ☐ ☐ Mouth / Throat / Nose
- ☐ ☐ Skin Rashes / Hives Snoring
- ☐ ☐ Shortness of Breath
- ☐ ☐ Allergies / Asthma
- ☐ ☐ COPD
- ☐ ☐ Laryngitis / Horse Voice
- ☐ ☐ Pneumonia
- ☐ ☐ Low Resistance to Illness
- ☐ ☐ Sneezing
- ☐ ☐ Mild Fever Comes & Goes
- ☐ ☐ Smoke Cigarettes
- ☐ ☐ Emphysema
- ☐ ☐ Bronchitis
- ☐ ☐ Acne
- ☐ ☐ Eczema / Psoriasis
- ☐ ☐ Black or Bloody Stools
- ☐ ☐ Constipation
- ☐ ☐ IBS
- ☐ ☐ Diarrhea
- ☐ ☐ Colitis / Spastic Colon
- ☐ ☐ Do you crave: Pungent
- ☐ ☐ Grief / Sadness

Current / Recent *Past* **SPLEEN / STOMACH**

- ☐ ☐ Body Heaviness
- ☐ ☐ Hard to get up in the Morning
- ☐ ☐ Muscles Often Feel Tired
- ___ ___ Energy Level: 1-10 (low to high)
- ☐ ☐ Edema: ☐Hands ☐Feet
- ☐ ☐ Easily Bruising / Bleeding
- ☐ ☐ Bad Breath
- ☐ ☐ Bleeding Gums
- ☐ ☐ Nausea / Vomiting
- ☐ ☐ Gas / Belching / Bloating
- ☐ ☐ Ulcers
- ☐ ☐ Hemorrhoids / Fissures
- ☐ ☐ Rectal Pain
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Abdominal Pain
- ☐ ☐ Indigestion / Heartburn
- ☐ ☐ Brain Foggy
- ☐ ☐ Tendency to Gain Weight
- ☐ ☐ Do you crave: Sweet
- ☐ ☐ Overthinking / Worry
- ☐ ☐ Excess appetite

Woman's Fertility History

Name: _____ Date: _____

MENSTRUAL CYCLE

Age of first menses: _____ Are your menstrual cycles regular? ☐ Y ☐ N Days of flow: _____

Cycle length (e.g. 28 days):_____ Date of last cycle: _____ Today is cycle day _____

Date of last cycle:_____Today is cycle day _____

Do you have premenstrual symptoms? ☐ Y ☐ N

If yes, please describe:_____

_____

Please check any current or past conditions

Current / Recent	*Past*		*Current / Recent*	*Past*	
☐	☐	Chronic vaginal discharge	☐	☐	Uterine fibroids
☐	☐	Regular yeast infections	☐	☐	Pelvic adhesions
☐	☐	Venereal disease (STDs)	☐	☐	Polyps
☐	☐	Chlamydial infection	☐	☐	Pelvic abnormality
☐	☐	Genital sores	☐	☐	Endometriosis
☐	☐	Pelvic inflammatory disease	☐	☐	PCOS

Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? ☐Y ☐N

Have you ever had a cervical biopsy, operation, cauterization, or conization? ☐Y ☐N

Have you taken medications (other than contraceptives) for gynecological conditions? ☐Y ☐N

*Medication:*_____ *Reason:*_____ *How long:* _____

Do you ovulate on your own? ☐Y ☐N *What day in your cycle?*_____

Have you taken medication to aid ovulation? ☐Y ☐N

*Medication:*_____ *Date:*_____ *How long:* _____

Have you had any tubal operations? ☐Y ☐N *When?* _____

Have you taken oral contraceptives? ☐Y ☐N *When?*_____ *How long?* _____

Have you ever had an IUD? ☐Y ☐N *When?*_____ *How long?* _____

Have you had a diagnosis related to infertility? ☐Y ☐N *What was it?* _____

_____

Has your partner been medically evaluated? ☐Y ☐N *What were the results?* _____

_____

Have you been tested for MTHFR, the gene needed for folic acid metabolism? When and what were the results? _____

What is your blood type with Rh factor (ABO +/-)? _____

OBSTETRICAL HISTORY

How long have you been trying to have a baby: _____

Have you ever been pregnant? ☐Y ☐N

If yes, list the total number of pregnancies:

Living _____Ectopic _____Miscarriages _____Induced _____Abortions _____

Obstetrics history (Natural and ART cycles, including cancelled cycles)

Date	Natural, IUI, IVF, Other	Medication Used	# Mature Eggs / Follicles	Pregnancy (Y / N)	Week of miscarriage, if applicable	Other Comments and Locations

PREVIOUS INFERTILITY EVALUATION

Please fill in any test results that you have previously completed:

I. Reproductive Hormones and Structures

Lab test	Description	Date	Results	Date	Results	Date	Results
CD 3 FSH	Cycle day 3 follicle stimulating hormone						
CD 3 E2	Cycle day 3 estradiol						
CD 3 LH	Cycle day 3 lutenizing hormone						
CCT	Clomid challenge test						
PRL	Prolactin						
P4	Progesterone, 7 days post-ovulation						
HSG	Hysterosalpingogram (evaluation of uterus & tubes)						
AFC	Antral follicle count						
EML	Endometrial lining						

II. Thyroid Hormones, Cortisol, DHEA-S

Hormone	Description	Date	Results	Date	Results	Date	Results
TSH	Thyroid stimulating hormone						
Total T4	Thyroid hormone- total T4						
Free T4	Thyroid hormone - free T4						
Free T3	Thyroid hormone - free T3						
T3U	Thyroid hormone uptake						
Free TT	Free testosterone						
Cortisol							
DHEA-S	Dehydroepiandrosterone-sulfate						

III. Immunology

Lab Test	Description	Date	Results	Date	Results	Date	Results
TPO Ab	Thyroid antibodies (thyroid peroxidase)						
TG Ab	Thyroid antibodies (thyroglobulin)						
ANA	Antinuclear antibodies						
APA	Antiphospholipid antibodies						
NK Cell	Natural Killer cell assay						
ASA	Antisperm antibodies						
CD4	T-helper cell lymphocytes						
HLA	Shared parental human leucocyte antigens						

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PATIENT/PRACTITIONER ACKNOWLEDGEMENT

I hereby acknowledge that I am working with the practitioner identified below as an independent practitioner at East-West Integrative Medicine, and therefore limit any dispute and/or liability that may arise with regard to my care at East-West Integrative to said practitioner, and release and discharge any other independent practitioner at East-West Integrative, as well as East-West Integrative Medicine, from any such liability or obligation.

_____ _____

Patient Name Date

_____ _____

Acupuncturist Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

_____, *a practitioner at East-West Integrative Medicine, understands the importance of privacy and is committed to maintaining the confidentiality of your medical information. This Notice of Privacy Practices is required by law to inform you of how your health information will be protected, how the Practice may use or disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.*

A. How this Practitioner May Use or Disclose Your Protected Health Information

This Practitioner may collect health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of the Practitioner, but the information in the record belongs to you. The sections below outline the purposes for which the law permits the practitioner to use or disclose your health information.

1. Treatment: I use medical information about you to provide your medical care. I disclose medical information to our employees, associates, and others who are involved in providing the care you need. For example, I may share or disclose your protected health information with other practitioners or other healthcare providers to provide, coordinate, or manage your healthcare and any related services. You will be requested to sign an Authorization to Release Medical Information should this occur.

2. Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, I would need to give your health plan the information it requires before it will pay me. I may also disclose information to other healthcare providers to assist them in obtaining payment for services they have provided to you.

3. Healthcare Operations: I may use or disclose your protected health information, as needed, to operate my practice. For example, I may use and disclose this information to review and improve the quality of care I provide. I may use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. I may also share your medical information with my "business associates," such as billing service, or others that may perform administrative services for me. I will have a written contract with each of these business associates that contains terms required of them to protect the confidentiality of your medical information. Although federal law does not protect health information that is disclosed to someone other than another healthcare provider, health plan, or healthcare clearinghouse, under California law, all recipients of healthcare information are prohibited from re- disclosing it, except as specifically required or permitted by law. I may also share your information with other healthcare providers, healthcare clearinghouses, or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities; efforts to improve health or reduce healthcare costs; review of competence, qualifications, and performance of healthcare professionals; training programs; accreditation, certification or licensing activities; or healthcare fraud and abuse detection and compliance efforts.

4. Appointment Reminders, Follow-up and Sign in Sheets: In addition, I may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. I may also call you by name in the waiting room when your physician is ready to see you. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by email or telephone, or by messages left on an answering machine, voice mail, or with the person who answers your telephone.

5. Marketing: I may contact you regarding case management or care coordination, to give information about our services, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. I may periodically send a postal mail or email card, letter, notice, or other written information or small gift to the address provided by you.

6. Required by Law: Under the law, I must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of Section 164.500. I may use or disclose your protected health information in the following situations without your authorization. These situations include: Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Additionally, I may disclose your protected health information, without a written Consent from you, in the following instances:

a. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
b. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your healthcare.
c. Emergency Situations – For the purpose of obtaining or rendering emergency treatment to you provided that I attempt to obtain your Consent as soon as possible, or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for the purpose of coordinating your care with such entities in an emergency situation.
d. Communication Barriers – If, due to substantial communication barriers or inability to communicate, I have been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

7. Workers' Compensation: I may disclose your health information as necessary to comply with Workers' Compensation laws. For example, to the extent your care is covered by Workers' Compensation, I will make periodic reports to your employer about your condition. I am also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

8. Change of Ownership: In the event that my practice is sold or merged with another organization, your health information or record will become the property of the new owner, although you will maintain the right to request that copies of your health information by transferred to another doctor or medical group.

9. Research: I may disclose your health information to researchers in conducting research for which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information that identifies you without your written authorization. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. I am unable to take back any disclosure I have already made with your permission.

C. Your Health Information Rights

1. Right to Inspect and Copy: You have the right to inspect and copy your protected health information, with limited exception. To access your medical information, you must submit a written request detailing the specific information to which you want access and whether you want to inspect it or obtain a copy of it. I will charge a reasonable fee, as allowed by California law. If the file is large, I may require the use of a copy service for this purpose. You will pay the cost of this service. I may deny your request under limited circumstances; however, you may request a review of our denial. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

2. Right to Amend or Supplement: You have the right to request that I amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. I am not required to change your health information, and, if denied, I will provide you with information about this medical practice's denial and how you can disagree with the denial. If I deny your request for amendment, you have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect. I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

3. Right to Request Special Privacy Protections: You have the right to request certain restrictions of your protected health information. Your written request must state the specific restriction requested and to whom you want the restriction to apply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. I reserve the right to accept or reject your request and will notify you of my decision. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

4. Right to Request Confidential Communication: You have the right to request that you receive confidential communication or your health information from me in a specific way or to a specific location. For example, you may ask that I send information to a particular e-mail account or to your work address. I will comply with all reasonable requests submitted in writing which specify how or where you wish to receive communication.

5. Right to an Accounting of Disclosure: You have the right to receive an accounting of certain disclosures I have made, if any, of your protected health information except as is not required by law, or pursuant to your written authorization, or for disclosures provided to you.

6. You have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

D. Changes to this Notice of Privacy Practices

I reserve the right to change the terms of this notice and will inform you in person or by mail of any changes. You then have the right to object or withdraw as provided in this notice. Until such amendment is made, I am required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that I maintain, regardless of when it was created or received. I will keep a copy of the current Notice posted in our reception area.

E. Complaints

Please direct any complaints about this Notice of Privacy Practices or how this practice handles your health information to me as Privacy Officer. If you are not satisfied with the manner in which I handle a complaint, you may submit a formal complaint to:

Secretary of Health and Human Services
Office of Civil Rights, Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W. Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Summary and Acknowledgement of Receipt of Notice of Privacy Practices

_____ ("Practitioner"), an independent practitioner at East-West Integrative Medicine's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, to obtain payment for that treatment, and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice would be available to me at any future appointment and at my request at any other time.

1. The Practitioner reserves the right to change privacy practices that are described in the Privacy Notice.

2. I understand, and consent to, the following communication that may be used by the Practitioner: a) a card, letter, or other written information mailed to me at the address provided by me; and b) telephoning and leaving a message on my answering machine, voice mail, or with the individual answering the phone; and c) sending an electronic mail to the address provided by me.

3. The Practitioner may maintain a directory of and sign-in log for individuals seeking care and treatment in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the Practitioner's offices.

4. The Practitioner may use and/or disclose my PHI to treat me and obtain payment for that treatment, and as necessary for the Practitioner to conduct his/her specific healthcare operations.

5. I understand that I have a right to request that the Practitioner restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the Practitioner is not required to agree to any restrictions that I have requested. If the Practitioner agrees to a requested restriction, then the restriction is binding on the Practitioner.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practitioner has already taken action in reliance on this consent.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practitioner will not treat me. I understand that if I revoke this consent at any time, the Practitioner has the right to refuse to treat me.

I acknowledge that I have received a copy of the Practitioner's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I am required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with me. Signature below is acknowledgement that you have received this Notice of Privacy Practice and that you have read and understand the foregoing notice, Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Informed Consent To Treatment and Treatment Policies

I, _____

print first and last name

give consent to receive acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Marnie McCurdy, LAc., and /or any guest acupuncturist working under her supervision. I understand that the methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electric stimulation, Tui-Na massage, herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including, but not limited to: 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. Other risks of acupuncture treatment could include (although unusual and extremely rare) spontaneous miscarriage, nerve damage, and organ puncture (including lung puncture - pneumothorax).

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of treatment which based upon the facts known and my condition, is in my best interests.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

- **I will notify my practitioner if I am or become pregnant.**
- **I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties, I will notify my practitioner as soon as possible.**
- **I understand the practitioner and clinic staff may review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.**

Continued on next page

Informed Consent To Treatment and Treatment Policies

By voluntarily signing below, I am demonstrating that I have read (or have had read to me) this consent to treatment and treatment policies, have been told about the risks of acupuncture and other procedures, and have had the opportunity to ask questions. I understand this consent is intended to cover my entire course of treatment for my present and future conditions for which I seek treatment at this office.

_____ _____

Patient's/Representative Signature Date