Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE):_____DATE:_____

AGE:_____ DATE OF BIRTH:_____ SEX:MALE/ FEMALE MARITAL STATUS:_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE (HOME):_____PHONE (CELL):_____

CELL PHONE CARRIER: VERIZON AT&T T-MOBILE SPRINT OTHERS: _____

OCCUPATION:_____ EMAIL ADDRESS:_____

EMPLOYED BY:_____

REFERRED BY:_____

CONTACT IN CASE OF AN EMERGENCY:_____CELL PHONE #_____

REASON FOR VISIT TODAY:_____

HAVE YOU HAD ACUPUNCTURE BEFORE? _____ CHINESE HERBAL MEDICINE?_____

HOW LONG HAVE YOU HAD THIS CONDITION?_____

WHAT SEEMED TO BE INITIAL CAUSE?_____

WHAT SEEMS TO MAKE IT BETTER?_____

WHAT SEEMS TO MAKE IT WORSE?_____

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW?_____

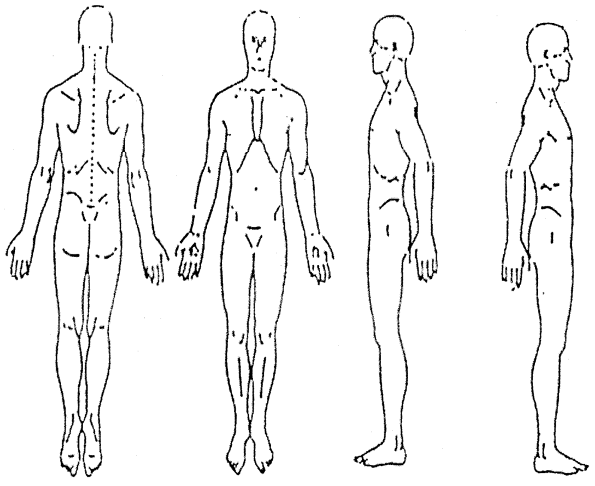
NAME OF YOUR PHYSICIAN:_____PHYSICIAN"S PHONE_____

MEDICATIONS YOU ARE TAKING:_____

VITAMINES/SUPPLEMENTS YOU ARE TAKING:_____

LIST ANY SURGERIES YOU HAVE HAD:_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS ETC)_____



INDICATE PAINFUL OR DISTRESSED AREAS with "X", if you have any

Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

General
□ Chills
□ Low energy
□ Dizziness
□ Insomnia
□ Allergies
□ Fatigue
□ Fevers
□ Excess thirst
□ Nervousness
□ Numbness
□Sweat spontaneously
□ Night sweating
□ Lack of sweating
□ Weight loss
□ Weight gain
□ Aversion to heat
□ Aversion to cold

Head & Neck
□ Blurred vision
□ Heaviness of head
□ Headache
□ Phlegm in throat
□ Cataract
□ Double vision
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Vomiting
□ Vomiting blood

Genitourinary
□ Dilute urine
□ Dark urine
□ Blood in urine
□ Cloudy urine
□ Burning urination
□ Scanty urine
□ Profuse urine
□ Frequent urination
□ Poor bladder control
□ Urgency to urinate
□ Frequent UTI

Musculoskeletal Pain
Weakness, numbness in
□ Arms
□ Feet
□ Hands
□ Joints
□ Legs
□ Hips
□ Neck
□ Shoulders
□ Pain all over
□ Cold Limbs
□ Knee problems
□ Lower back
□ Upper back
□ All over weakness
□ Lack of strength
□ Broken bones

Respiratory
□ Asthma
□ Hay fever
□ Persistent cough
□ Shortness of breath
□ Recurrent bronchitis
□ Phlegm production
□ Difficulty inhaling
□ Difficulty exhaling

Cardiovascular
□ Chest pain
□ High blood pressure
□ Low blood pressure
□ Irregular heartbeat
□ Poor circulation
□ Swelling of ankles
□ Varicose veins
□ Hypochondriac pain

Neurologic
□ Fainting
□ Convulsions
□ Handwriting change
□ Paralysis
□ Stroke
□ Seizures
□ Recent clumsiness
□ Drowsiness
□ Vertigo

Gastrointestinal
□ Abdominal Pain
□ Bloating
□ Belching
□ Gas
□ Constipation
□Diarrhea/loose stools
□ Bloody stools
□ Black stools
□Difficulty swallowing
□ Poor appetite
□ Heartburn/reflux

Misc.
□ Anxiety
□ Irritable
□ Depression
□ Vision, see halos
□ Eye pain/strain
□ Red/inflamed eyes
□ Corrected vision
□ Nasal discharge
□ Loss of sense of smell
□ Earache
□ Ear discharge
□ Hearing loss
□ Ringing in ears
□ Sinus problems
□ TMJ
□ Nose bleed
□ Hoarseness
□ Sore throat
□ Sores on lips
□ Sores on tongue
□ Taste change
□ Teeth problems

I understand that a physician should evaluate me for the condition for which I am requesting consultation and treatments. The diagnosis, treatment plan and herbal formula that will be given and prescribed for me by this office is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a Western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation and treatment, I am to seek advice from a Western medical doctor. Furthermore, it is my responsibility to advise my physician and provide this office with a referral/or prescription for acupuncture.

Sign_____ Date_____

Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care, Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements
Your full portion of the bill is expected when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement Past due balances may have an interest charge of 1.5 % applied per month.

Assignment of Benefits
By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

Signature:_____Date_____

Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. 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. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: **Dr. Christi Jin, L.Ac., O.M.D., PhD**

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) 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.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has 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.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call. You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Jin's Acupuncture

80 Kinderkamack Rd, Oradell, NJ 07649 | P: (201) 261-2676 | healingartacu@gmail.com

Sign-in Log
This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends
The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to
Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.
Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list such as a paper or electronic copy.
Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
Request copies of your PHI in electronic format if this office maintains your records in that format.
Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
Receive notice of any breach of confidentiality of your PHI by the Practice.
Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Rm 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS
The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____