

Our Clinic Protects Your Health Information and Privacy

Dear Valued Client,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

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

Types of information that we gather and use:

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

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

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (206)579-1654.

Yours truly,

Jodie Scott, L.Ac.



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

X _____
Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

Accepted _____
 Denied Signature Title Date



Consent for Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Nourish: Healing Arts Studio. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call my acupuncturist as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

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

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

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

Signature: _____

Date: _____

Printed Name: _____

Date of Birth: _____


nourish
healing arts studio
4775 Ballard Ave. NW
Seattle, Wa 98107
206.579.1654

Fees and Policies

Fee Schedule for Payment at Time of Service

- Acupuncture-First Office Visit \$90
- Acupuncture-Return Office Visit \$75
- Facial Rejuvenation-First Office Visit \$150
- Facial Rejuvenation-Return Office Visit \$115
- Reflexology-30 min. \$40
- Reflexology-60 min. \$60
- Reflexology + Acupuncture \$75

Payment Policies

I accept cash, check, Visa, MasterCard, American Express, and Discover

- Payment is due at the time services are provided
- Administrative Fees \$20/hour

Billing Policies for Insurance

I will bill your insurance company directly under the following conditions:

(Please initial)

- _____ **Medical Insurance:** If your insurance company won't pay for the session for any reason then you will be responsible for payment in full (fee will be the same as time-of-service)

All insurance accounts not paid in full within 90 days from the date of service will be charged interest. Interest rates are 12% annually and 1% monthly. Interest is calculated on the principle amount; interest is not compounded.

Office Policy for Appointment Cancellations

Cancellations must be made 24 hours in advance of the scheduled appointment time. For cancellations made less than 24 hours in advance or if you do not show up for your appointment, you will be charged a fee of \$35. I will not charge your insurance company for a missed appointment. You will be responsible for payment out-of-pocket.

Signature _____

Date _____



Health Intake Form

Name _____ Date _____
(Last) (First) (M.I.)

Address _____
(Street Number) (City) (State) (Zip Code)

Phone: Home _____ Work _____ Cell _____

D.O.B. _____ Sex M / F Email _____
(MM/DD/YYYY)

How did you hear about us? Website Healthcare Provider Friend Insurance
referral HealthPros.com Newspaper PriceDoc.com Other _____

If a friend referred you, whom may we thank? _____

Insurance Provider _____ Insurance I.D. # _____

Employer _____ Phone _____

Address _____

Primary Insured _____ Primary Insured D.O.B. _____

In case of emergency, whom may we contact? _____

Phone _____ Address _____

What is your main complaint today? _____

When did it begin? _____

How severe is the problem? _____

Have you had any previous treatment? _____ If yes, explain _____

Past Medical History (please indicate dates)

Cancer _____ High Blood Pressure _____ Rheumatic Fever _____ Asthma _____

Diabetes _____ Venereal Disease _____ Heart Disease _____ Pacemaker _____

Stroke _____ Thyroid Disease _____ Seizures _____ Hepatitis _____ H.I.V. _____

Other _____

Surgeries (type and date)_____

Significant trauma (i.e. auto accidents, falls, etc.)_____

Birth History: # Pregnancies_____ # Births_____ # Abortions_____

Did you have any difficulties during labor?_____

Are you still menstruating?_____ If so, date of last menstruation _____

Do you practice birth control?_____ What type?_____

Allergies (drugs, chemicals, foods, plants, animals)_____

Family Medical History (check all that apply)

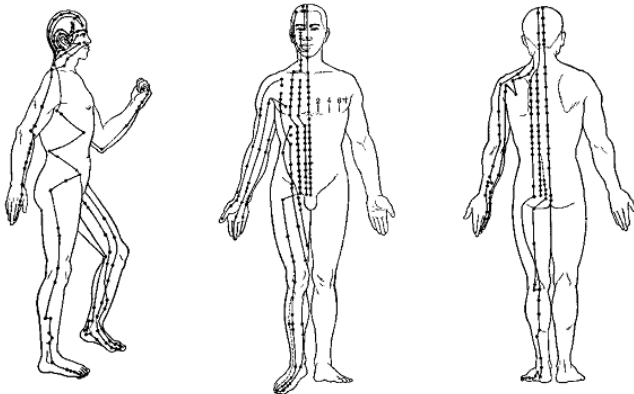
High blood pressure___	Alcoholism___	Cancer___	Allergies___
Heart Disease___	Seizures___	type_____	_____
Stroke___	Asthma___	_____	_____
Arteriosclerosis___	Diabetes___	_____	_____

Do you experience stress on the job? (chemical, physical, psychological) Y/N

If yes, please explain_____

Do you exercise regularly?_____ What types of exercise?_____

Indicate the areas you want to focus on today



What are your treatment goals? _____

Are you currently taking any medications? (prescription, vitamins, herbal) _____

Have you ever experienced: (please circle all that apply)

General

Night sweats
Localized weakness
Bleed or bruise easily
Peculiar tastes or smells
Edema
Poor sleeping
Tremors
Poor balance
Weight change

Skin & Hair

Rashes
Itching
Ulcerations
Eczema
Oozing skin lesion
Hives
Loss of hair

EENT

Dizziness
Migraines
Headaches
Blurry vision
Cataracts
Earaches
Ear discharge
Nose bleeds
Sinus congestion
Concussions
Recurrent sore throats

Cardiovascular

High blood pressure
Low blood pressure
Chest pain
Swelling of hands/feet
Blood clots
Fainting
Difficulty Breathing

Respiratory

Asthma/wheezing
Difficulty breathing while
lying down
Phlegm
Coughing blood
Pneumonia
Bronchitis

Gastrointestinal

Nausea
Vomiting
Diarrhea
Constipation
Blood in stools
Black stools
Abdominal pain
Rectal pain
Hemorrhoids

Genito-Urinary

Pain on urination
Urgency to urinate
Frequent urination
Blood in urine
Decrease in flow
Dribbling
Kidney Stones
Impotency
Change in sex drive
Sores on genitals

Neuropsychological

Seizures
Numbness
Weakness
Sleep disorder
Vertigo
Lack of coordination
Depression
Loss of balance
Poor memory
Anxiety
Substance abuse

Last Physical: Date: _____ Doctor: _____

Results: _____