

Jordan Hoffman Acupuncture

2001 S. Barrington Ave. Ste 116 Los Angeles, CA 90025

Patient Confidential Information (All information is required)

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Contact Phone (work/home/cell) _____ DOB _____ Age _____

Email _____ Marital Status S M D W Sex M F

Emergency Contact _____ Phone # _____

Referred By _____

Family Physician _____ Phone # _____ May we contact them? Y N

History (Please complete the following as accurately as possible)

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

When did this condition begin? _____ What was the initial cause? _____

What treatments have you already received? _____

Rate the severity of pain: No Pain 0----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Intolerable pain

What makes it better? _____ Worse? _____

How does this condition affect your daily life? _____

Medical History

What surgeries have you had and when? _____

List all serious injuries/medical conditions and when _____

Do you have any allergies that you know of? _____

What medications/supplements are you taking, why, and for how long? _____

Do you have any history of depression or anxiety? _____

Please circle any of the following conditions if you have had it or there is a history of it in your family:

Stroke Cancer Heart Disease Tuberculosis Bleeding Disorders Diabetes High Blood Pressure

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Menstrual History

Age of your first period _____ Are you or do you believe you are pregnant? Y N

Are you taking any Birth Control? Y N If Yes, which one? _____

Length of typical cycle Day 1 to Day 1 _____

Length of typical flow (days) _____ Date of your last period _____

Clots? _____ Vaginal Discharge? _____

Recreational Substance Usage

Do you smoke? _____ For how long? _____ How many per day? _____

Do you drink alcohol? _____ How many drinks per week? _____

Do you use drugs? _____ What and how often? _____

How many cups of coffee per day? _____ Sodas? _____

Diet

Describe your typical breakfast _____

Describe your typical lunch _____

Describe your typical dinner _____

What cravings do you have? _____

Exercise

Describe your weekly exercise routines _____

Treatment Goals

What are your short-term treatment goals? _____

What are your long-term treatment goals? _____

Payment Information

Credit Card _____ Credit Card Number _____

Exp Date _____ Authorizing Signature _____ Date _____

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Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, how?

1.

2.

3.

4.

5.

How do you handle stress?

What brings you joy in life?

What would you most like to address about your current state of health? Please prioritize them):

- Physical well-being
- Emotional well-being
- Spiritual well-being
- Level of stress or anxiety
- My level of exercise

- My pace of living
- Nutrition & Food choices
- Wellness & Optimal health

Other:

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Office Terms and Conditions of Service

24-Hour Cancellation Policy: In order to provide you and patients like you with the highest standards of care, all cancellations must be made within a minimum of 24 hours notice. Failure to do so or failure to show for your scheduled appointment will result in your credit card account being charged 75% of the appointment fee.

Admissions and Medical Services Agreement: The patient or the patient's representative consents to the admission of the patient to Jordan Hoffman Acupuncture if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

Release of Information: Jordan Hoffman Acupuncture is authorized to furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

Medical Records: The patient or patient's representative hereby authorizes Jordan Hoffman Acupuncture to obtain his/her medical records from previous medical histories rendered by other physicians or medical centers.

Financial Agreement: The patient or patient's representative shall pay Jordan Hoffman for all services rendered in accordance with the regular rates and terms of Jordan Hoffman Acupuncture. When this agreement is executed by the patient or the patient's representative or a financial guarantor, all shall be jointly and individually liable for the patient, whether or not the patient's insurance company pays. Should accounts be referred to an attorney or collection agency, I agree to pay all collection costs, court costs, and attorney's fees in addition to the fees for services rendered.

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of the acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named 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), massage, Chinese Herbal Medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may be 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. 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 this clinic uses single-use sterile disposable needles as per California State law, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and 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 in 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 releases 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 and Terms and conditions of Service, 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.

Patient's or Patient's Representative Signature _____

Date _____

Clinic Signature _____

Date _____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Jordan Hoffman Acupuncture may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jordan Hoffman Acupuncture's Health Information and Privacy Policy (HIPP) for a more complete description of such uses and disclosures.

I have reviewed and received a copy of the HIPP prior to signing this consent. Jordan Hoffman Acupuncture reserves the right to revise its HIPP at anytime without notice to me. A revised HIPP may be obtained by submitting a written request to Jordan Hoffman Acupuncture.

With my consent, Jordan Hoffman Acupuncture may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any information pertaining to my clinical care.

With my consent, Jordan Hoffman Acupuncture may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Jordan Hoffman Acupuncture may email to me appointment reminder cards and patient statements. I have the right to request that Jordan Hoffman Acupuncture restrict how it uses or discloses my PHI to carry out TPO. However, Jordan Hoffman Acupuncture is not required to agree to my requested restrictions.

By signing this form, I am consenting to Jordan Hoffman Acupuncture's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jordan Hoffman Acupuncture may decline to provide treatment to me.

Health Information and Privacy Policy (HIPP)

This notice describes Jordan Hoffman Acupuncture'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 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 or others that you authorize.

Safeguards in place at Jordan Hoffman Acupuncture 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 are kept on permanent file

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 concerning your healthcare
- From healthcare providers, insurance companies, workers' compensation and your employer, and other third party administrators (e.g. request for medical records, claim payment information).

We here, at Jordan Hoffman Acupuncture, value our relationship with you and respect your privacy. If you have any questions about our privacy guidelines, please call us during regular business hours.

Thank you for placing your trust in us.

By voluntarily signing below, I show that I have reviewed and received a copy of Jordan Hoffman Acupuncture's HIPP.

Patient's Name _____

Signature of Patient/Representative _____ Date _____

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** PATIENT COPY**

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