

## Jordan Hoffman Acupuncture

### 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? \_\_\_\_\_

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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 \_\_\_\_\_

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Do you have any allergies that you know of? \_\_\_\_\_

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

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Do you have any history of depression or anxiety? \_\_\_\_\_

Please circle any of the following conditions if 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

History of smoking? Y N How long? \_\_\_\_\_ How many per day? \_\_\_\_\_

History of drinking alcohol? Y N How many drinks per week? \_\_\_\_\_

History of drug use? Y N What and When? \_\_\_\_\_

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 \_\_\_\_\_

# Jordan Hoffman Acupuncture

## 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 50% 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.

Medical Consent: The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

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 Acupuncture for 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. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

Jordan Hoffman Acupuncture and the patient or patient's representative hereby enter into this agreement. The patient or patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service."

Patient's Name \_\_\_\_\_

Signature of Patient/Representative \_\_\_\_\_ Date \_\_\_\_\_

# Jordan Hoffman Acupuncture

## **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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