Name: (First): _____ (Last): _____

(Middle Initial): _____ Age: _____ Today's Date: _____

Last 4 digits SSN: XXX-XX-_____ Sex: ____ Date of Birth: _____

Address:_____

_____ Zip: _____

Phone: (H)_____ (W)_____ (Cell)_____

OK to leave a message at these phone numbers? Check those that apply: (H)___ (W)___ (Cell)___

Email:_____

Emergency Contact:(name)_____(relationship)_____

ph #('s) _____

Females: currently or any chance of being pregnant? _____

Allergies: _____

Height: _____ Weight: _____ Occupation: _____

Marital Status: married ___ single ___ in a relationship ___ other ___

Are you currently being treated for a medical condition? If so, please describe:

_____

_____

Please list the name(s) of your current medical provider(s): _____

Medications/Supplements (Dosage): _____

_____

_____

_____

Primary Concern(s): _____

_____

_____

_____**When did it start?**_____

Secondary Concern(s): _____

_____

_____**When did it start?**_____

Past Surgeries, Hospitalizations (**with dates**):_____

_____

_____

_____

Spring Wind Acupuncture
610 W. 2nd Ave, Suite 100
Anchorage, AK 99501

Name: _____ Date: _____

Please indicate if you have ever had any of the following:

	Past	Current
Headaches		
Dizziness or Light headedness		
Fainting		
Numbness		
Weakness		
Stroke		
Head injury		
Seizures		
Any other neurological condition?		
If so, please state:		
Eye condition		
Asthma		
Pneumonia		
Difficulty breathing		
Chronic cough		
Allergies/hay fever		
Sinus infection		
Chronic sinus congestion		
Frequent colds/flu		
Coughing up phlegm or blood		
Ear infections		
Have you ever smoked?		
If so, what & how much/day?		
For how many years?		
Would you like to quit?		
Any other respiratory condition?		
If so, please state:		
Chest pain or discomfort		
High blood pressure		
Low blood pressure		
Heart attack		
Heart surgery		
Pacemaker		
Cardiac stent		
Heart palpitations		
Racing heart		
Congenital heart Defect		
Heart murmur		
Blood clots		
Varicose veins		
Raynaud's		
Any other cardiovascular condition?		
If so, please state:		

	Past	Current
Trouble digesting		
Diarrhea		
Constipation		
Nausea/Vomitting		
Eating disorder		
Weight gain/loss >10 lbs in past yr?		
Abdominal pain		
Abdominal bloating		
Blood in stools		
Black tarry stools		
Mucus in stool		
Irritable bowel		
Crohn's Disease		
Ulcerative colitis		
Poor appetite		
Excessive appetite		
Any other gastrointestinal condition?		
If so, please state:		

Please list/describe your typical diet:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Coffee? # of cups/day: _____

Caffeinated or decaf? _____

Tea? # of cups/day: _____

Caffeinated or decaf? _____

How much alcohol do you drink? _____ per day/wk/mnth/yr

Beer _____ Wine _____ Liquor _____ Other _____

How often do you have a bowel movement? _____ # times every day/week (circle one)

Are you having any pain? If so, where? _____

_____

How long has it lasted? _____

Blood Sugar issues		
Waking up at night to urinate		
Urinary Tract Infection		
Any other difficulty urinating		
Muscular or skeletal issues		
Any skin condition		

Any reproductive or genital issues? _____

Females Only:

Painful or difficult menstruation _____ _____

Does your cycle come at regular intervals? Yes/No

# of days in between each cycle: _____

Spotting in between? Yes/No. # days cycle lasts: _____

Endocrine disorder		
Cancer		

Notice of Privacy Practices
Spring Wind Acupuncture
Anchorage, AK

Effective Date: April 14, 2003

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.

What is this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how we at SpringWind Acupuncture, will protect your medical information, how we may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact us directly at 907-440-8660.

Understanding Your Health Information During each appointment, we record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A tool with which we can assess and work to improve the care we provide

Your Health Information Rights You have the following rights related to your medical record:

- *Obtain a copy of this notice.*
  You can read this notice in the waiting room, and you can also obtain your own copy if you would like.
- *Authorization to use your health information.*
  Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information.*
  You may request a copy of your medical record from us at any time.
- *Change your health information.*
  If you believe the information in your record is inaccurate or incomplete, you may request that we correct or add information.
- *Request confidential communications.*
  You may request that when we communicate with you about your health information, we do so in a specific way (e.g. at a certain mail address or phone number). we will make every reasonable effort to agree to your request.
- *Accounting of disclosures.*
  You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment or healthcare operations.

Our Responsibilities

- We are required by law to protect the privacy of your health information, to provide this notice about our privacy practices, and to abide by the terms of this notice.

- We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice.
- Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

When Can We Legally Disclose Your Health Information Without Your Specific Consent?

- *In order to facilitate your medical treatment.*
  For example: Your primary care physician or your psychotherapist might call us to discuss your treatment, and in that situation we would disclose information about your diagnosis, your medications, and so on.
- *In order to collect payment for health care services that we provide.*
  For example: In order to get paid for our services, we have our billing staff send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, we fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.
- *In order to facilitate routine office operations.*
  For example: Occasionally, we dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

Will We Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), our office policy is that we will *never* share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if we believe you pose an immediate danger to yourself or someone else—in that case, we will do whatever is necessary, even if that means breaching confidentiality.

Less Common Situations in Which We Might Disclose Your Health Information

- Workers compensation: we may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
- Law enforcement: we may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
- Food and Drug Administration (FDA): we may disclose to the FDA your health information relating to adverse events due to medications.
- Business associates: We hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us, Spring Wind Acupuncture at any time at (907) 440-8660. If you feel your privacy rights have been violated in any way, please let us know and we will take appropriate action.

You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights,
Hubert H. Humphrey Building 200 Independence Avenue

S.W. Room 509 HHH Building
Washington, D.C. 20201

Informed Consent for Acupuncture and Traditional Chinese Medicine
Spring Wind Acupuncture

Traditional Chinese Medicine is a healing system that includes multiple therapeutic modalities. This system facilitates the body's innate healing capability. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is attained.

Acupuncture and Traditional Chinese Medicine Treatments That May Be Administered:

1. **Acupuncture** is a technique utilizing fine, sterile, stainless steel needles inserted at specific points in the body to facilitate a positive or regulatory response. This practitioner uses disposable, single-time use needles. The location of the application of these needles and the depth of their insertion is determined by the nature of the problem. I understand that with the application of these needles that there is a slight possibility that minor swelling, bleeding, discoloration, hematoma, or bruise that may occur at the site of insertion. A sensation of momentary light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems.

_____**initials**

2. **Moxibustion** is the application of heat supplied by burning the herb Follium Artemisiae vulgaris, or commonly known as "mugwort", over a single or group of acupuncture points. The area of treatment may remain red and warm for several hours afterwards. In rare incidences a minor burn may occur at the site of moxibustion. I will immediately notify the acupuncturist if I experience any symptoms or problems.

_____**initials**

3. **Cupping** utilizes round suction cups over a large muscular area such as the back to enhance blood circulation to the designated area. This method may produce deep redness, discoloration, and on rare occasion a minor blister may form that may persist up to several days but will eventually disappear.

_____**initials**

4. **Traditional Chinese Herbal Supplements** are used to facilitate the body's own restorative process. These herbs can be taken in pills, or tea by boiling plants in their natural form, or applied topically. Chinese herbal teas tend to taste bitter. They are made mostly from plants, but also mineral and some animal substances. If I experience hives or other adverse reaction, I should discontinue taking the herbs.

_____**initials**

5. **Massage Therapy** is a specialized body work technique utilized in facilitating healing and pain management. There occasionally may be increased soreness or bruising at the sites of the treatment.

_____**initials**

There are risks involved in any procedure or treatment. I do not expect the acupuncturist to be able to anticipate all risks and complications related to my condition. I understand that an acupuncturist is not a medical doctor. I give consent to my acupuncturist to exercise judgement during the course of treatment which the acupuncturist deems appropriate. I also understand that I must continue to seek treatment with a medical doctor for any conditions that cannot be resolved appropriately by acupuncture or Chinese Medicine.

_____**initials**

I have had an opportunity to view and receive a copy of my **HIPAA privacy rights.** _____**initials**

Please note: If you miss your appointment or do not provide 24 hours (48 hours for Nome and rural locations) notice of a change, you will be charged half of the cost of a treatment.

_____**initials**

I hereby certify, by signing below, that I have read this entire form, and that I consent to the provisions described above. 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.

Statement of Consent for Treatment

I confirm that I have read and understood the above information, and I consent to treatment. I understand that I can refuse treatment at any time.

Signature .....

Print name in full .....

Date .....

Consent for Use of Information for Research Purposes -- (Optional)

I give permission for information obtained during the course of my treatment, with all identifying information removed, to be used for the purpose of research in Traditional Chinese Medicine.

Signature .....

Print name in full .....

Date .....

Health Insurance Claim Form
Spring Wind Acupuncture – Roxanne Chan, L.Ac. #98.

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

Patient's Name (Last, First, M.I.)	*Patient's DOB* ___/___/___	*Insured's Name (Last, First, M.I.)*
Patient's Address	*Patient's Sex* Male ( ) Female ( )	*Insured's Policy #* *Group #*
	Relationship to Insured Self ( ) Child ( ) Patient's Spouse ( ) Other ( )	*Insured's Address Check here if same* ( )
Telephone #	*Was Condition Due To:* Work Injury ( ) Auto ( ) Other ( )	*City, State, Zip Code*

Other Health Insurance (Name of Policy Holder, Policy #, Plan Name) *Telephone #*

I authorize the release of any medical information necessary to process this claim.
Patient's Signature: *Date:*

I authorize payment of medical benefits to undersigned physician or supplier for service described below.
Patient's Signature: *Date:*

PROVIDER INFORMATION

Date of Illness (1st symptom) or Injury _____ *Date first consulted you for this condition* _____
Dates of total disability from _____ *through* _____ *Dates of partial disability from* _____ *through* _____
Date able to return to work ____/____/____ *Has patient ever had same of similar symptoms? Yes ( ) No ( )*
If an emergency check here ( ) *Hospitalization dates from* _____ *through* _____
Names of referring physician or other sources _____
Name & Addresses where services rendered (if other than home or office) _____
Laboratory work outside your office? Yes ( ) No ( )
Diagnosis or nature of illness or injury:
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Date of Service From To	*Place of service*	*Procedure Code*	*Procedures, Medical services, or supplies*	*DXC*	*Days or Units*	*Charges*

Signature of Physician or Supplier
_____
Accept Assignment
Yes ( ) No ( )
Your Patient's Account No.
_____

Employer ID #: **26-3457684**
Fax #: **1-866-747-3256**
Address:
Spring Wind Acupuncture
Roxanne Chan, L.Ac. #98
610 West 2nd Ave Suite 100
99501 Anchorage, Alaska

Total Charges: _____
Amount Paid: _____
Balance Due: _____