Spring Wind Acupuncture, LLC
610 W. 2nd Ave, Suite 100
Anchorage, AK 99501
New Patient Registration

Patient Information

Name of Patient:_____Middle Initial:____ Date:_____
Date of Birth:_____ Gender: M____ F____ Soc Sec #: _____-____-_____
Mailing Address:_____ City: _____
State: _____ Zip:_____ Email:_____
Marital Status: Single___ Married ___ In a relationship ___ Other___ Occupation:_____
Home Phone:_____ Work #:_____ Cell #:_____
May we leave a detailed message at any of the above phone#'s? Hm___ Work___ Cell___

Emergency Contact:
Name:_____ Relationship to Patient:_____
Address (if different than Patient):_____City, State, Zip:_____
Home Phone:_____ Work #:_____ Cell #:_____
Email:_____

Optional—I authorize Spring Wind Acupuncture, LLC to speak with the following person about my account: Name:_____ Relationship to Patient:_____
Phone #(s):_____

Minors Only—Person responsible for payment:
Name:_____ Relationship to Patient:_____
Date of Birth:_____ Gender: M____ F____ Soc Sec #: XXX-XX-_____
Address (if different than Patient):_____City, State, Zip:_____
Home Phone:_____ Work #:_____ Cell #:_____
Email:_____

Insurance Information

Insurance: Y___ (please fill out the rest of this form) N___ (skip to signature section)
Are you seeing us for a worker's compensation claim?.....Y___ N___
Are you seeing us for an auto accident?.....Y___N___
Date of injury:_____ Body part(s) injured:_____

Worker's Comp insurance information (fill out only if you are seeing us under worker's comp):
Name of insurance company:_____ Phone#:_____
Address:_____City, State, Zip:_____
Name of employer:_____
Employer Phone #:_____ Contact Person's Name:_____
Worker's Comp Claim #:_____
Case Adjustor's Name & Ph #:_____

Automobile insurance information (fill out only if you are seeing us for an automobile accident):
Your automobile insurance company:_____ Phone#:_____
Address:_____City, State, Zip:_____
Your agent's name:_____ Phone #:_____
Claim #:_____ Police Report #:_____

Name:_____ **Date:**_____

Automobile Insurance Continued:
Other Party's Name:_____
Their automobile insurance company**:**_____ Phone #:_____
Address:_____City, State, Zip:_____
Their agent's name:_____ Phone #:_____

Medical Insurance Company:_____
ID#:_____ Group #:_____
Group or Plan Name:_____
Policyholder info: Same as Patient___(skip to next insurance) Other ___(fill out their info below)
Name:_____ Patient's Relationship to Policyholder:_____
Date of Birth:_____ Gender: M____ F____
Address (if different than Patient):_____City, State, Zip:_____
Home Phone:_____ Work #:_____ Cell #:_____
May we contact this person if we have questions about this insurance? Y___ N___

Secondary Medical Insurance Company:_____
ID#:_____ Group #:_____
Group or Plan Name:_____
Policyholder info: Same as Patient___(skip to next insurance) Other ___(fill out their info below)
Name:_____ Patient's Relationship to Policyholder:_____
Date of Birth:_____ Gender: M____ F____
Address (if different than Patient):_____City, State, Zip:_____
Home Phone:_____ Work #:_____ Cell #:_____
May we contact this person if we have questions about this insurance? Y___ N___

Signature Section .

_____ (initial) I will pay an appointment fee of $62.50 if I fail to show up for my appointment or cancel less than 24 hours from my appointment time.

_____ If Spring Wind Acupuncture, LLC has to send my account to a collection agency, I am responsible for paying all collection charges in addition to the original balance due.

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

<If you do not want us to file insurance for you, you may skip to the signature line below>

_____ I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of my government and/or private insurance benefits directly to Spring Wind Acupuncture, LLC.

_____ I understand that Spring Wind Acupuncture, LLC files insurance for me as a courtesy, and I agree to pay all charges my insurance does not pay or that Spring Wind Acupuncture, LLC cannot collect from my insurance in a reasonable amount of time.

Signature of person responsible for paying for visits: _____Date:_____

Please attach copies of all insurance cards

Name: _____ Date: _____

Allergies: _____
Height: _____ Weight: _____ Females: currently or any chance of being pregnant? ____

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**):_____
_____
_____
_____
_____

Weight (circle one): gain/loss >10 lbs in past year? If so, how many pounds? _____
What do you do for exercise? _____ How often? _____
How many hours of sleep to you get on average/night? _____ Do you feel rested upon waking? _____

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

	Past	Current		Past	Current
Fevers	_____	_____	Feeling hot/cold easily	_____	_____
Night sweats	_____	_____	Insomnia	_____	_____
Headaches	_____	_____	Trouble digesting	_____	_____
Dizziness or			Diarrhea	_____	_____
Light headedness	_____	_____	Constipation	_____	_____
Fainting	_____	_____	Nausea/Vomiting	_____	_____
Numbness	_____	_____	Eating disorder	_____	_____
Weakness	_____	_____			
Stroke	_____	_____		_____	_____
Head injury	_____	_____	Abdominal pain	_____	_____

Name: _____ Date: _____

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

	Past	Current
Seizures	_____	_____
Any other neuro-logical 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 dis-comfort	_____	_____
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 cardio-vascular condition?	_____	_____
If so, please state:	_____	
Blood disorder	_____	_____

	Past	Current
Abdominal bloating	_____	_____
Blood in stools	_____	_____
Black tarry stools	_____	_____
Mucus in stool	_____	_____
Irritable bowel	_____	_____
Crohn's Disease	_____	_____
Ulcerative colitis	_____	_____
Poor appetite	_____	_____
Excessive appetite	_____	_____
Any other gastro-intestinal 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 (circle one): day/wk/mnth/yr of:

Beer _____ Wine _____ Liquor _____

How often do you have a bowel movement?

_____ # times every day/week (circle one)

Are you having any pain? How much? (1-10) __

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 period come at regular intervals? Yes/No

# of days in between each period: _____

Spotting in between? Yes/No.

days period 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**

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 .....