Fly Again Acupuncture New Patient Information

Date_____

Name_____

Address_____

City, State, Zip_____

Sex____Age____Birth date_____

Occupation_____

Employer _____

□single □ married □divorced

□widowed □separated □significant other

Partner's Name_____

CONTACT INFORMATION

Phone

Best phone number and time to reach you

_____

Alternate phone _____

Email

_____

By providing my email I give permission for Fly Again Acupuncture to send me appointment reminders and newsletters.

HOW DID YOU HEAR ABOUT FLY AGAIN ACUPUNCTURE?

_____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____

Work Phone _____

Primary Care Physician's Information

Physician's name _____

Physician's phone _____

GENERAL INFORMATION

Have you had acupuncture before? _____

Have you used Chinese herbal medicine? _____

ACCIDENT INFORMATION

Is this condition due to an accident? _____

Date of accident _____

Type of accident _____

HEALTH INSURANCE

Carrier_____

ID number _____

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INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental Medicine provided by members of Fly Again Acupuncture's licensed acupuncturist(s). I have discussed the nature and purpose of my treatment with the licensed acupuncturists named below.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Tui Na (Chinese Medical Massage).

I have been informed that acupuncture is a safe method of treatment but that it may have side effects. Side effects may include bruising, numbness or tingling near the needle insertion sites that may last a few days, dizziness and fainting. Rare and unusual risks of acupuncture treatment include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture (pneumothorax). There is also a risk for infection, however, this site uses sterile disposable needles and maintains a clean and safe environment. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (from plant, animal, and mineral sources) which may be recommended are traditionally considered safe in the practice of Oriental Medicine although some may be toxic in high doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I will notify the licensed acupuncturist who is caring for me if I am, or become pregnant.

I do not expect the licensed acupuncturist to be able to anticipate and explain all possible risks and complications of treatment.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for research purposes, however my name and identifying information will not be disclosed. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent in compliance with HIPAA.

By voluntarily signing below I show that I have read or have had read to me, this consent to treatment, 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 conditions for which I seek treatment.

To be completed by the patient (or the patient's representative if the patient is a minor or is physically or legally incapacitated).	To be completed by the licensed acupuncturist providing information and obtaining consent
Date	Date
Print Name of Patient	Print Name of Licensed Acupuncturist
Signature of Patient (or Representative)	Signature of Licensed Acupuncturist
Print Name of Patient Representative	

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ADVISORY TO CONSULT A PHYSICIAN

To comply with Article 160, Section 821 1.1 (b) of NYS education law, we request that you read and sign the following statement:

Here at Fly Again Acupuncture we are committed to your health, safety, and well being. We believe that Acupuncture and Oriental Medicine are therapeutic and a beneficial asset to your health care and the health care system at large. However, Acupuncture and Oriental Medicine cannot completely replace the resources and treatments available through biomedical physicians. Consequently, we recommend that you consult a biomedical physician regarding any condition or conditions for which you are seeking Acupuncture or Oriental Medical care.

We, the undersigned, do affirm that _____ (patient)

Has been advised by _____ (licensed acupuncturist)
To consult a physician regarding the conditions for which such patient seeks Acupuncture or Oriental Medicine treatment.

_____ _____
Patient Signature Date

_____ _____
Licensed Acupuncturist Signature Date

ACKNOWLEDGEMENT OF PRIVACY POLICY AND OFFICE POLICIES

I acknowledge that I have received a copy of Fly Again Acupuncture's Privacy Policy and Office Policies. I also acknowledge that I have read and understand the terms outlined in the Privacy Policy and the Office Policies. I understand that I should keep the above copy of the Privacy Policy and Office Policies for my records.

_____
Date

_____ _____
Patient's Name Patient's signature

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Name _____ Date _____

PRESENT HEALTH CONCERNS

Please list the main reasons why you are here:

1. _____ Approx. Date of Onset: _____
   Does it interfere with your: (circle all that apply) Work Sleep Daily Routine Recreation
   Other therapies tried: (circle all that apply) Medications Surgery Chiropractic Phys. Therapy
   Pain level on a scale from 1-10_____

2. _____ Approx. Date of Onset: _____
   Does it interfere with your: (circle all that apply) Work Sleep Daily Routine Recreation
   Other therapies tried: (circle all that apply) Medications Surgery Chiropractic Phys. Therapy
   Pain level on a scale from 1-10 _____

Please list all **medications** that you are currently taking (or have used in the past 2 months), with dosages

1. _____ 2._____
3. _____ 4. _____
5. _____ 6. _____

Please list all **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking

1. _____ 2._____
3. _____ 4. _____
5. _____ 6. _____

Please list **allergies** that you have to any of the following

Drugs: _____

Foods: _____

Other: _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approximate dates.

_____

_____

COMMENTS

Please let us know of any other concerns you would like to address:

Fly Again Acupuncture New Patient Information

Personal Habits

□Tobacco packs/day _____
□ Alcohol drinks/wk_____
□ Coffee/tea/cola cups/day _____
□ Recreational drugs times/wk _____

□ High Stress Level Reason _____

Do you follow any diet regimens/restrictions?
□Yes □No
If Yes, describe:
_____

Work Activity

□ Sitting % of time _____
□ Standing % of time _____
□Light Labor % of time _____
□ Heavy Labor % of time _____

Exercise:
Do you exercise regularly? □ Yes □No
If Yes, describe & tell how often:
_____
_____

FAMILY INFORMATION

Do you have children? □Yes □No If Yes, how many? _____ Ages_____
Are you, or could you be currently pregnant? □Yes □No Due date_____

Please check if you have had (**in the last three months**)

GENERAL

□ Poor appetite
□ Heavy appetite
□ Changes in appetite
□ Weight loss/gain
□ Cravings
□ Peculiar tastes
□ Strong thirst
□ Fevers/chills
□ Sweat easily
□ Localized weakness
□ Bleed/bruise easily
□ Sudden energy drop
□ Fatigue
□ Tremors
□ Poor sleeping
□ Heavy sleeping
□ Dream disturbed sleep
□ Night sweats
□ Dizziness

SKIN AND HAIR

□ Rashes/hives
□ Itching
□ Dry skin
□ Dandruff
□ Ulcerations
□ Eczema/psoriasis
□ Hair loss
□ Pimples/acne
□ Fungal infections
□ Recent moles
□ Change in hair or skin texture

HEAD, EYES, EARS, NOSE AND THROAT

□ Concussions
□ Glasses/contacts
□ Eye strain/pain
□ Red eyes
□ Itchy eyes
□ Dry eyes
□ Excessive tearing
□ Poor/blurry vision
□ Night blindness
□ Cataracts/Glaucoma
□ **Headaches** list location, triggers, severity
□ Spots in front of eyes
□ Earaches/infections
□ Ringing in ears
□ Poor hearing
□ Sinus problems
□ Post nasal drip
□ Excessive phlegm Color _____
□ Nose bleeds
□ Recurrent sore throat
□ Swollen glands
□ Sores on lips/tongue
□ Dry mouth
□ Excessive saliva
□ Teeth problems
□ Gum problems
□ TMJ disorder
□ Grinding teeth

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CARDIOVASCULAR

□ Pace Maker
□ Chest pain
□ Irregular heartbeat
□ High blood pressure
□ Low blood pressure
□ Palpitations
□ Fainting
□ Cold hands/feet
□ Swelling of hands
□ Swelling of feet
□ Blood clots
□ Phlebitis

RESPIRATORY

□ Cough
□ Coughing blood
□ Wheezing
□ Asthma
□ Bronchitis
□ Pneumonia
□ Pain with deep breath
□ Shortness of breath
□ Tight chest
□ Production of phlegm – color? _____ is it □ thick or □ thin?

GASTROINTESTINAL

□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Gas/bloating
□ Hiccups
□ Belching
□ Bad breath
□ Blood in stools
□ Black stools
□ Mucus in stools
□ Acid regurgitation
□ Abdominal pain
□ Itchy anus
□ Burning anus
□ Hemorrhoids/fissures
□ History of chronic laxative use

GENITO-URINARY

□ Pain on urination
□ Frequent urination
□ Blood in urine
□ Urgency to urinate
□ Unable to hold urine
□ Decrease in flow
□ Bedwetting
□ Kidney stones
□ Impotency
□ Increased libido
□ Decreased libido
□ Premature ejaculation
□ Nocturnal emissions
□ Sores on genitals
□ Frequent urinary tract infections
□ Chronic yeast infections
If you wake to urinate how often?
_____

MUSCULOSKELETAL

□ Neck pain
□ Upper back pain
□ Lower back pain
□ Hand/wrist pains
□ Muscle pains
□ Muscle weakness
□ Cramps/spasms
□ General joint pain/stiffness
□ Shoulder pain
□ Knee pain
□ Foot/ankle pain
□ Hip pain
□ Joint with limited range of motion
_____

NEUROPSYCHOLOGICAL

□ Seizures
□ Loss of balance
□ Areas of numbness
□ Tics
□ Lack of coordination
□ Memory loss
□ Concussion
□ Depression
□ Anxiety
□ Irritability
□ Easily susceptible to stress
□ History of emotional/physical abuse

Have you ever been treated for emotional problems?
_____

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Have you ever considered or attempted suicide?
_____

GYNECOLOGY

Age of first menses _____ If no longer menstruating, approximate date ceased _____
First day of last menses _____ Length between menses: _____ days Duration of period _____ days

□ Unusual flow □ Heavy or Light
□ Painful periods
□ Irregular periods
□ Clots in flow
□ Vaginal discharge – color _____
□ Vaginal odor
□ Vaginal dryness
□ Vaginal sores
□ Hot flashes
□ Breast lumps/soreness

Changes in body or psyche prior to menstruation (PMS) -
_____
_____

Date of last PAP: _____ Results were: □ normal □abnormal □ unsure
If you use birth control, what type and for how long
_____

Have you ever used hormonal methods for contraception or period regulation (i.e. the pill, Depo-Provera, etc.)

PREGNANCY HISTORY

Number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____
Were your births relatively normal?
Explain:_____

FAMILY HISTORY

Please fill in the boxes for each condition that applies to you or one of your family members

	You	Family member	Comments
Addiction (Alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastrointestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental Illness			
Respiratory disorders (asthma, allergies, etc.)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

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OFFICE POLICIES

Payment Policy

Acupuncture, related services, and herbal products are provided and billed by Fly Again Acupuncture PLLC. Services administered must be paid for at the time of treatment.

Fly Again Acupuncture currently, participates in several Insurance plans. If we are not in network with your insurance plan, we can provide you with a form that you can submit to your insurance company to allow them to send any reimbursements directly to you.

Please be aware that with any health plan, there may be deductibles and copayments for which you could be responsible and it is not guaranteed that your acupuncture treatment will be covered. You are responsible for paying for any service that is denied or otherwise considered not covered or not reasonable or necessary by your insurer. You will be notified of any copayments or other fees that you are responsible for. If these fees remain unpaid 180 days after your date of service they will be sent to a collection agency.

Cancellation Policy

If you need to cancel an appointment please do so at least 24 hours in advance. If you cancel less than 24 hours before your appointment you may be charged a $50 fee for a late cancellation. If you need to cancel your appointment due to inclement weather please do so at least 2 hours prior to your appointment via call or text (518) 855-1455. You will not be charged for a late cancellation with at least 2 hours notice.

Late for Your Appointment

If you are more than 15 (fifteen) minutes late for your appointment you may not be treated or you may receive an abbreviated treatment within the time constraints of your originally scheduled appointment.

If your appointment is rescheduled you will be responsible for the $50 late cancellation fee.

Missed Appointment

If you miss an appointment without calling to notify the office at least 24 hours in advance you will be charged the full cost of your missed appointment. You will receive an invoice via email or we will charge your card on file.

Bounced Checks

There will be a $30 fee for each bounced check.

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PRIVACY POLICY

It is important to us at Fly Again Acupuncture that we maintain a safe and professional environment for you and your medical information. It is also important that you know how your information will be handled and disclosed and how you may gain access to your information. PLEASE READ THIS POLICY CAREFULLY.

Who Will Follow This Notice: This notice describes the practices of Fly Again Acupuncture and its personnel.

Our Pledge to You: Here at Fly Again Acupuncture we understand that your personal information is important and private. We are committed to your healthcare and we keep records of every treatment that we administer in order to better serve your healthcare needs. We will only disclose your information with your permission or as required by law. We respect your rights to your information and we welcome any questions or concerns that you may have about how we use and disclose your medical information.

Your Rights Regarding Medical Information about You: You have the following rights to the medical information that we maintain about you.

Right to Inspect and Copy: You have the right to inspect and request copies of medical information that may be used to make decisions about your care. This includes medical and billing records, but may not include some mental health information. To inspect and request copies of medical information that may be used to make decisions about your healthcare you must submit your request in writing to the office. If you request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies related to your request. We may deny your request to inspect and copy in certain limited circumstances.

Right to Amend: If you feel that the medical information that we have about you is incorrect or incomplete, you may submit a written addendum. Your written amendment may not exceed 500 words and will be attached to your records and included whenever we make a disclosure of the items or statement that you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of the medical information about you other than for our own uses for treatment, payment and health care operations. To request this list or accounting of disclosures, you must submit in writing to the office. You must state a time period, which may not be longer than 6 years and may not include dates before August 16, 2014. If more than one list is requested in a 12 month period we may charge for costs involved, however, we will notify you of the cost so you may choose to withdraw or modify your request prior to costs being incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or payment for your care. *We are not required to agree to your request.* If we do not agree we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions you must make a request in writing to the office. In your request you must tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. To request confidential communication, you must make your request in writing to the office. We will not ask for a reason and we will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

How We May Use and Disclose Medical Information About You: The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information fall within one of these categories. We are required by law to keep your medical information private, provide you with this notice of our legal obligations and privacy practices, and adhere to the terms in this notice.

For Treatment: We will use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to any facility personnel who are involved in taking care of you at the office. After you leave our care we may also disclose medical information about you to people outside the office who may be involved in your medical care.

For Payment: We may use and disclose medical information about you so that the treatment that you receive at the office may be billed to, and payment may be collected from, you, an insurance company, or a third party.

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For Office Function: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure you receive quality care.

To Your Family and Friends: Prior to disclosing any information we will provide you with an *opportunity to object***.** No information will be released without your permission. In the event of an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment at the office.

Special Events: We may use medical information about you to contact you in the case of a special event, class, or seminar being held at the office or by the staff of Fly Again Acupuncture. We will only release contact information such as your name, address, and phone number. If you do not want the office to contact you for special events you must notify the office in writing.

As Required by Law: We will disclose medical information about you when we are required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Clinic Quality Assurance: We may use your medical information within the office to assess the performance of our personnel and effectiveness of treatments.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities including, the prevention or control of disease, injuries or disabilities, reports of births and deaths, reports of abuse or neglect of children and elders, reports of reactions to medications or products, notifications of product recalls, and notifications of victimization in the case of abuse, neglect or domestic violence when required by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law including but not limited to audits, investigations, inspections, and licensure of our facility.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute but only if efforts have been made to notify you of the request or to obtain and order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official. This may be in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if, under certain limited circumstances we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the facility; or in an emergency to report a crime, the location of the crime or victims, or the identity description or location of the person who committed the crime.

Coroners and Medical Examiners: We may release medical information to a coroner or medical examiner.

National Security: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

<u>Other Uses of Medical Information:</u>

Changes to This Notice: We reserve the right to change this notice at any time and the right to make the revised or changed notice effective for medical information we have about you, as well as any information we receive in the future. We will post a copy of the current notice in the facility.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the office. All complaints must be submitted in writing. To file a complaint contact: Alycia Askew LAc. 518-232-1759 info@flyagainacupuncture.com