CLIENT INFORMATION SHEET

PLEASE PRINT

Date: _____ Home Phone_____

Name: _____ Preferred Name: _____

Street Address: _____e-Mail _____

City/state: _____ ZIP: _____

Birth Date: _____ Age: _____ Height: _____ ft _____ in Weight: _____ Gender: _____

Employer :_____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Medication: _____

Primary Health Care Provider : _____

Date of last visit: _____

Referred by: _____

Primary Reason for appointment: _____

Other health issues: _____

* If your insurance covers acupuncture, please turn this page over and complete the back. *

Do you have or have you in the past had:

surgery?		YES NO	drinking problem?		YES NO
any spinal problems?		YES NO	tendinitis?		YES NO
varicose veins?		YES NO	any blood clots?		YES NO
frequent headaches?		YES NO	cancer?		YES NO
chronic pain anywhere?		YES NO	arthritis?		YES NO
traumatic injury?		YES NO	asthma?		YES NO
any skin problems or allergies?		YES NO	thyroid imbalance?		YES NO
any heart problems?		YES NO	chronic diarrhea?		YES NO
high/low blood pressure?	NO	high low	chronic constipation?		YES NO
pain which radiates to your arms or legs?		YES NO	kidney disease?		YES NO
broken bones?		YES NO	skin disease?		YES NO
diabetes?		YES NO	are you constantly tired?		YES NO
HIV/AIDS or hepatitis?		YES NO	<u>WOMEN:</u>		
smoking?		YES NO	are you pregnant?		YES NO
drug abuse?		YES NO	menstrual problems?		YES NO

Explain all YES answers below.
Please talk with me about anything else in your life of which I should be made aware.

_____

_____

_____

_____

_____

INSURANCE INFORMATION:

NAME OF INS. COMPANY: ***SSN/ID:***

Patient's Name	Patient's DOB Gender F ☐ M ☐	Insured's Name
Address	Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐	Insured's Address
City St.	Patient status Single ☐ Married ☐ Other ☐	City St.
Zip Phone	Empl. ☐ Student Full ☐ Part ☐	Zip
Other insurance name	Is patient's condition related to:	Policy/group #
Other policy	Employment (current or previous) Yes ☐ No ☐	Insured's DOB Gender F ☐ M ☐
Other insured's DOB Gender: F ☐ M ☐	Auto Accicent? Yes ☐ No ☐	Employer's Name
Employer Name	Other accident? Yes ☐ No ☐	Is there another health benefit plan? Yes ☐ No ☐
Patient's or Authorized Person's Signature. I authorize any medical or other information necessary to process this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment below.		Insured's or Authorized Person's Signature. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGN:	Date:	SIGN:

Office of: Stuart Greenleaf, L.Ac.

INFORMED CONSENT FOR ACUPUNCTURE

Procedures - In Oregon, the definition of acupuncture includes but is not limited to 1) the insertion of acupuncture needles, 2) stimulation with electrical, thermal, magnetic, and mechanical devices, 3) massage and bodywork, 4) herbs and nutritional supplements.

Potential Side-effects - While side-effects of acupuncture are rare, with any insertion of needles into the body there is the possibility of unavoidable damage to local tissue, such as residual pain or numbness in the insertion area lasting a few days, or minor bruising. More general side-effects may include but are not limited to temporary nausea, dizziness, or fainting. Although this clinic makes exclusive use of pre-sterilized disposable needles, infection may occur whenever the skin is broken. If you experience any unwanted effects during or after treatment, please inform the staff promptly, as measures may be taken to minimize them.

Possible side-effects of herbs and nutritional supplements include intestinal upset and diarrhea, headache, and hives.

Special Conditions - If any of the following applies to you, you must inform the acupuncturist: bleeding disorders, seizures, pacemaker or heartbeat irregularity, suspected or confirmed pregnancy.

Missed Appointments - The fee for an appointment which is not cancelled with 24 hours notice is 50% of the regular charge for that session. This amount can not be billed to insurance, and is the responsibility of the patient.

Signature - By signing below I show that I have read, or have had read to me, the above information; I understand this information; I consent to and request acupuncture and related procedures according to these terms and conditions for myself or for a person over whose care I have responsibility. I intend this consent to include the entire course of treatment for present condition(s) as well as any future treatment. I acknowledge receipt of a separate sheet containing the Privacy Policy of this office.

_____	_____
Print Name of Patient	Print Name of Witness or Translator
_____	_____
Print Name of Responsible Party (if needed)	Signature of Witness or Translator
_____	_____
Signature of Patient or Responsible Party	Date

4/14/03

PATIENT PRIVACY NOTICE- STUART GREENLEAF, L.Ac.

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.

This office must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information will be available to release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

We reserve the right to change the privacy practices described in this notice in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices a revised copy of this privacy notice will be posted on our web site at www.efn.org/~stuartg.

ONCE YOU HAVE SIGNED OUR TREATMENT AGREEMENT FORM WE CAN USE YOUR HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

1. Treatment: For example, your health care provider may use the information in your medical record to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical record.

2. Payment: In order for an insurance company to pay for your treatment, a bill is submitted that identifies you, your diagnosis and the treatment provided to you. As a result, we will pass such health information on to an insurer in order to help receive payment for your medical bills.

3. Business Associates: In order to carry out treatment and health care operations we may disclose your health information to another party, known as a "business associate" to assist us in carrying out functions and activities such as (but not limited to) claims processing, billing, management or to assist with such things (but not limited to) legal, accounting, consulting, accreditation or financial services. We will disclose your health information pursuant to an agreement with the business associate under which said business associate which said business associate will agree to use the health information only as permitted by law, and under which the business associate also agrees to comply with the provisions of the law relating to the use of your health information.

WITHOUT YOUR WRITTEN AUTHORIZATION, WE CAN USE YOUR HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

1. As required or permitted by law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

2. For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system or for government benefits programs.

3. To avoid a serious threat to health or safety: As required by law and standards of ethical conduct we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

4. For military, national security, or incarceration/law enforcement custody: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

5. For worker's compensation: We may disclose your health information to the appropriate persons in order to comply with the laws related to worker's compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

6. To those involved with your care or payment of your care: If people such as family members, paid caregivers, relatives or close personal friends are helping care for you or helping you pay your medical bills, we may release important health informationabout you to those person. We may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status.

NOTE: *Except for the situations previously listed, any other use or disclosure of your health information requires this office to obtain your written authorization. You may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdrawl your authorization, please submit your written withdrawal request to 1245 Charnelton Suite #3, Eugene, Oregon 97401.*

YOUR HEALTH INFORMATION RIGHTS:
You have several rights with regard to your health information. If you wish to exercise any of the following rights, please submit a written request to Stuart Greenleaf at 1245 Charnelton Street Suite #3 Eugene, Oregon 97401.

1. Inspect and copy your health information: With a few exceptions you have the right to inspect and obtain a copy of your health inormation. However, this right does not extend to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

2. Request to correct your health information: If you believe your health information is incorrect you may request us to correct the information. You may be asked to make such requests in writing and give a reason as to why your health records should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health records are correct we may deny your request.

3. Request restrictions on certain uses and disclosures: You have the right to ask for restriction on how your health information is used, or to whom your information is disclosed, even if the restriction affects your treatment or our payment or healthcare operation activities. You may want to limit the health information provided to family, caretakers, or friends involved in your care or payment of your medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.

4. As applicable, receive confidential communication of health information: You have the right to ask what we communicate your health information to you in different ways or places. For example, you may wish to receive information in a private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosure of your health information: In some limited instances you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information enclosed and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30 day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payments, healthcare operation, national security, law enforcement/corrections and certain health oversight activities.

6. Obtain a paper copy of this notice: Upon your request, you may at any time receive a paper copy if this notice, even if you earlier agreed to receive this notice electronically.

7. Complaint: If you believe your privacy rights have been violated, you may file a complaint with us and with the Federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact Stuart Greenleaf at 1245 Charnelton Street Suite #3 Eugene, Oregon 97401, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the informaiton in this notice, please contact Stuart Greenleaf at 1245 Charnelton Street Suite #3 Eugene, Oregon 97401 or call 541-342-4106.