Initial Health and Wellness History

Welcome to FLOAT: Chinese Medical Arts!

At FLOAT, we offer an integrative, East/West approach to health and wellness, and encourage our patients to take an active role in the healing process. Our purpose is to help you achieve your health-related goals, which means you will be invited to participate as actively as possible in the work we do together. We believe that true healing comes from within each patient; our job is to help expedite that process.

The first step in this integrative approach is asking you to complete a thorough health and wellness history. By completing this form before your initial consultation, you will allow us to make the best use of our time together, focusing on the issues most important to your overall health.

Please bring any appropriate medical records, x-ray reports, and pathology or lab reports with you to your first visit.

FLOAT provides many services that are considered complementary to the western medical approaches most commonly reimbursed by typical insurance companies. Insurers vary in their rules regarding reimbursement for acupuncture, massage therapy and other modalities, and their rules are constantly changing. Therefore, we require private payment at the time of service. We accept MasterCard, Visa, checks and cash.

If your PPO insurance plan covers acupuncture, we will bill your insurance for you as a courtesy, but you are responsible for any co-payments and any amounts for which your insurance does not reimburse us. If you would like to find out the extent to which your insurance plan covers our services, please ask us.

Once again, welcome to FLOAT. We look forward to becoming health partners with you!

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Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit FLOAT: Chinese Medical Arts, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating heath professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of FLOAT: Chinese Medical Arts, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528

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- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:
FLOAT: Chinese Medical Arts is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the Clinic Director at 818-392-8797.

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by a licensed acupuncturist or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your licensed acupuncturist will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, your licensed acupuncturist and all members of your healthcare team will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. For example: Members of the FLOAT: Chinese Medical Arts staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business Associates: There are some services provided at FLOAT: Chinese Medical Arts through contacts with business associates. Examples include certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate(s) so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

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Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, FLOAT: Chinese Medical Arts may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to FLOAT: Chinese Medical Arts' Notice of Privacy Practices for a more complete description of such uses and disclosures. (This allows your information to be used for clinic and teaching purposes only! We will not release this information unless we receive a subpoena or authorization to release signed by you.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. FLOAT: Chinese Medical Arts reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FLOAT: Chinese Medical Arts Privacy Officer at 610 N. Central Ave. Suite 109, Glendale, CA 91203.

FLOAT: Chinese Medical Arts 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 call pertaining to my clinical care, including laboratory results among others.

FLOAT: Chinese Medical Arts may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

FLOAT: Chinese Medical Arts may e-mail to me appointment reminder cards and patient statements. I have the right to request that FLOAT: Chinese Medical Arts restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to FLOAT: Chinese Medical Arts' 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, FLOAT: Chinese Medical Arts may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

___________________________________ _____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

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CONFIDENTIALITY AND PAYMENT AGREEMENT

Last Name ______________________**First Name** _________________________

DOB _______/_______/_______ **Today's Date** ________/________/_______

A. FLOAT: Chinese Medical Arts follows HIPAA guidelines, and respects your privacy with the utmost care. If you have not received a copy of the **Notice of Privacy Practices** explaining these guidelines and how we implement them, you may request one from our office or download one from our website: www.floatchinesemedicalarts.com.

Sign here to acknowledge that you have read our HIPAA guidelines and agree with our approach:

____
(Signature)

B: I authorize FLOAT: Chinese Medical Arts to release information to my insurance company, pertaining to my care, in order for them to process a claim which is being submitted for reimbursement.:

____
(Signature)

C: Please read thoroughly and acknowledge that you will adhere to the following FLOAT payment policies:

1. I am responsible for paying fees at the time of service. Accepted forms of payment are cash, personal checks, Visa, and MasterCard. I will be responsible for a $25.00 service charge for non-sufficient funds.

2. I understand that if my insurance company covers all or some of my acupuncture treatments, I am still responsible for any co-payments and any amounts for which my insurance does not reimburse FLOAT.

3. I will inform FLOAT 24 hours in advance, should I need to cancel or reschedule an appointment, or I may be held responsible for the full service fee.

4. I understand that Herbal Products and Supplements are not covered by insurance, and are not returnable.

I have read and agree to the above terms and conditions.

Print Name____

Signature ____

Date____________________

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PATIENT CONFIDENTIAL INFORMATION

YOUR CONTACT INFO

Last Name:________________________________ First Name: ____________________________
Address:____
City:_____________________________________State:__________Zip:___________________
Home Phone (   ) ______-______________Work: (   ) ______-__________________________
Cell/Alternate: (   ) ______-__________ Fax: (   ) ______-_____________________________
E-mail: ____
Today's Date: _______/_______/_______ S.S.#_____________________________________
Date of Birth: _______/_______/_______ Age:______ Sex:_____________________________
Status: (Circle) Single Married Domestic Partnership Divorced Widowed
Occupation: ____
Employer: ____
Employer Address: ____
Employer Telephone: (   ) ______-______________

EMERGENCY CONTACT

Name: ___________________________ Relationship to you: ___________________________
Address: ____
City: ______________ State: ______________ Zip: ___________________________________
Daytime Phone: (   ) ______-__________ Evening: (   ) ______-_____________________________
Cell/Alt: (   ) ______-__________

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Circle One) Check Cash MC Visa

INSURANCE INFORMATION

Do you have a personal, group health or accident insurance? (Please circle one)

Insurance Company:____
Claims Address:____Phone:___________________
Name of Insured:___________________ Insured's ID/Claim #:___________________________________
Group Number: ____________________

I have read the above information and certify it to be true and correct to the best of my knowledge and belief, and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED:_____________ **PATIENT'S SIGNATURE**:___________________________________
(Signature of legal guardian if patient is a minor)

Referred By:____

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Medical History Questionnaire

Please complete the following as accurately as possible.

Name:____ Date: ______________

1. Present Illness:

What is your chief complaint?

When did this condition begin?

What treatment(s), if any, have you received already?

2. **Medical History:**

Please list any surgeries you have had, and the dates you had them:

Please list any serious illnesses or injuries you have had, and when you had them:

Please list any medications you are taking, and dosages (if known):

Please list any supplements or herbs you are taking, and dosages:

Please list any known allergies:

3. Which, if any, of your blood relatives have had:

Stroke
Cancer
Heart Disease
Tuberculosis
Bleeding disorders
Diabetes
High blood pressure

4. Recreational Substance Usage:

History of smoking? ______
How many years? ______
How many per day? ______
History of smokeless tobacco use?
History of drinking alcohol? ______
How many drinks per week? ______
History of recreational drug use?___
How many cups of coffee per day?__
How many sodas per day? _____

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FOR WOMEN:

5. Menstrual History:

Are you currently pregnant? Yes No Unsure
Indicate number of occurrences:
Live Births _______ Pregnancies_______ Miscarriages _______ Abortions _______
Are you currently breastfeeding? Yes No
Age of: First Period________ Menopause (if applicable)________
Is your menstrual cycle regular? Yes No
Length of cycle, from day 1 of one cycle to day 1 of the next (i.e. 28 days, 35 days, etc.) :______
Length of flow (# of days):__________
Quality of flow: Light Moderate Heavy
Color of flow: Light Red Bright Red Dark Red Purple Brown Light brown
Day one of your last period:__________________
Have you ever skipped a period/s? Yes No
Do you have any of the following menstrual-related signs and symptoms?

(Circle all that apply:)

Pain with menstruation	Blood Clots	Bleeding between periods
Cramps	Vaginal Discharge	Spotting
Pain before menstruation	PMS	Breast Distension
Pain during ovulation	Nausea	Pain with intercourse

6. Pregnancy Information (If currently pregnant, please answer):

How many weeks pregnant?______ Estimated due date or due date window?_______________________
Who is the Obstetrician, Group Practice, Midwife, or GP managing your pregnancy?

____

What type of birth are you planning? (Circle)
Hospital Birth Center Out-of-Hospital Birth
Do you have or have you had any complications with this pregnancy? (Describe)

____

____

Do you have any concerns about your pregnancy?

____

____

7. FOR MEN:

Do you have any bothersome urinary symptoms? Yes No
Describe:____
Do you get up at night to urinate? Yes No How Often?________________________________
Circle all that apply:

Erectile dysfunction	Premature ejaculation
Impotence	Pain or swelling of testicles
Difficulty with orgasm	Frequent nighttime urination
Coldness or Numbness in external genitalia	

To what extent do these symptoms interfere with your daily life? (Work, sex, sleep, social life, exercise, etc.)

____

Have you sought any medical treatment(s) for these problems? Yes No

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CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST

HEAD AND NECK:
____ Dizziness
____ Fainting
____ Neck Stiffness
____ Enlarged lymph glands
____ Headaches
________________ Other

EARS:
____ Infection
____ Ringing
____ Decreased hearing
________________ Other

EYES:
____ Blurred vision
____ Visual changes
____ Poor night vision
____ Spots/Floaters
____ Eye inflammation/Styes
________________ Other

NOSE, THROAT & MOUTH:
____ Bleeding
____ Sinus infection
____ Hay fever or allergies
____ Sore throat
____ Hoarseness
____ Changes in taste
____ Difficulty swallowing
____ Changes in smell
____ Oral ulcers/Canker sores
________________ Other

SKIN:
____ Hives
____ Rashes
____ Eczema
____ Psoriasis
____ Seborrhea
____ Night sweating
____ Excess sweating
____ Dryness
____ Bruises easily
____ Changes in moles or lumps
________________ Other

NEUROLOGICAL:
____ Numbness or tingling of limbs
____ Seizures
____ Tremors
____ Pain
____ Paralysis
____ Epilepsy or Convulsions
________________ Other

INFECTION STATUS:
____ HIV/AIDS, or HIV risks: Self or partner
____ TB: Self or household
____ Hepatitis, or Hepatitis risk: Self or partner
____ History of sexually transmitted
diseases: Self or partner:
____ Gonorrhea ____ Herpes (oral)
____ Chlamydia ____ Herpes (genital)
____ Syphilis ____HPV
____ Genital warts `

RESPIRATORY:
____ Chronic cough
____ Coughing up blood
____ Coughing up phlegm frequently
____ Difficulty breathing
____ Wheezing/Asthma
____ Frequent Colds
____ Emphysema
____ Pneumonia repeatedly
____ Other

CARDIOVASCULAR:
____ Palpitations
____ Chest pain or tightness
____ Rapid heart beat
____ Irregular heart beat
____ Heart Disease
____ Poor circulation
____ Swelling of ankles
____ Phlebitis
____ Cold hands/feet
____ Cardiac Pacemaker
____ High blood pressure
____ Stroke
________________ Other

GASTROINTESTINAL:
____ Indigestion
____ Nausea
____ Stomach pain
____ Irritable bowel disease
____ Colitis
____ Crohn's Disease
____ Pancreatitis
____ Celiac Disease
____ Recent change in bowel habits
____ Diarrhea (___ stools/day)
____ Constipation (___ stools/week)
____ Dry, hard stools
____ Soft, difficult, sticky stools
____ Irregularly or
poorly-formed stools
____ Poor appetite
____ Excessive hunger
____ Blood in stool or black stools
____ Hemorrhoids
____ --with pain or blood
____ Gall bladder disorder
____ Vomiting blood
____ Peptic Ulcer
____ Recent change in weight
____ Food cravings
________________ Other

MUSCLES AND JOINTS:
____ Joint disorder
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Spinal curvature
____ Backache
____ Back pain
____ Fibromyalgia

MALE:
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Impotence
____ Premature ejaculation
____ Prostate problems
____ Infertility (e.g., abnormal sperm)
________________ Other

FEMALE:
____ Frequent vaginal infections
____ Infertility
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Pelvic inflammatory disease
____ Abnormal Pap smear
____ Irregular periods
____ Emotional changes with menses
____ Clots with menses
____ Painful menstrual periods/cramps
____ Premenstrual Syndrome
____ Abnormal bleeding
____ Menopausal symptoms (hot flashes, etc.)
____ Breast lumps/cysts
____ Breast swelling and/or pain
________________ Other

URINARY:
____ Frequent urinary tract/bladder infections
____ Weak urinary stream
____ Recent change in bladder habits
____ Kidney Disease
________________ Other

GENERAL:
____ Fatigue
____ Thirst
____ Aversion to cold
____ Insomnia
____ Frequent dreams/nightmares
____ Depression
____ Agitation
____ Irritability
____ History of psychiatric treatment
____ Poor memory
____ Difficulty concentrating
____ Frequent night urination (___ X)
____ Frequent day urination (___ X)
____ Sores that don't heal
____ Congenital abnormalities
____ Surgical implants
____ Unusual bleeding or discharge
____ Jaundice
____ Hernia
____ Epstein Barr virus (EBV)
____ Rheumatic Fever
____ Diabetes mellitus
____ Thyroid Disorder
____ Cancer
____ Anemia or other blood disorder
____ Lupus Erythematosus
________________ Other

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