Welcome Letter

Dear New Patient,

We want to welcome you as a new patient of South Florida Acupuncture. Thank you for choosing us.

We look forward to partnering with you to address your health concerns and will do everything we can to ensure you achieve the most successful outcome.

Our mission is to help you achieve your treatment goals and maintain optimal long-term health. We appreciate your trust and confidence in us.

We will need you to fill out these forms before treatment at your first visit. Please fill them out in advance or arrive 15 minutes before your appointment to complete them at our office.

Please remember to bring your completed forms to your first visit. We also ask that you bring a list of any supplements or medications you are taking regularly and copies of any relevant laboratory results or doctor's notes.

This is a list of the documents in this package:

- **Welcome Letter**: Please read the letter first, as it provides essential information regarding how our clinic functions.
- **Informed Consent**: Please review the informed consent document, as it provides essential information about the possible benefits and side effects of acupuncture and Traditional Chinese Medicine (TCM).
- **New Patient Intake Form and Medical History**: Please complete this form with as much specificity as possible. This will assist your physician in recommending the appropriate treatment strategy for your issue(s).
- **Notice of Privacy Policy**: Federal and State regulations require that we provide you with this Notice of Privacy Practices. Please review and retain them for your records.
- **Acknowledgment of Receipt of Privacy Policy**: This form acknowledges that we provided you with the Notice of Privacy Practices. Please sign and bring this acknowledgment with you to your appointment.

Welcome to South Florida Acupuncture
We want you to be comfortable and to receive the best care possible.
Please do not hesitate to ask any questions regarding your visit, billing, or our policies.

Payment
We accept most credit cards, cash, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Insurance Coverage
Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ significantly in terms of deductible and percentage of coverage for Acupuncture. We can provide you with the necessary documentation to pursue reimbursement.

Release Of Information
Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Cancellations
As a courtesy to our office and other patients, please notify the office 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $45.00 fee for any missed appointment or cancellation, giving less than 24 hours notice for non-emergency situations.

Financial Agreement / Assignment Of Benefits

I am receiving or about to receive health care services in this office. I understand I am responsible for paying fees for services rendered, including herbs and other products.

By signing below, I agree to comply with the office policies stated above, which I have read and understood.

Printed Name: _____ Signature: _____ Date: _____

South Florida Acupuncture - Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that treatment methods may include, but are not limited to, acupuncture. I understand that acupuncture is a generally safe method of treatment but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, fainting, or dizziness. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

Although this document outlines the major risks of treatment, other side effects and risks may arise. I do not expect the clinical staff to anticipate and explain all possible risks and complications of the treatment.

I wish to rely on the clinical staff to exercise judgment during treatment, which they believe, based on the facts known at the time, is in my best interest. However, I understand that results are not guaranteed.

I understand that both clinical and administrative staff may review my patient records and lab reports. However, all my records will remain confidential and will not be released without my written consent. By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above consent to treatment. I intend for this consent form to cover the entire course of treatment for my current condition and any future condition(s) for which I seek treatment.

This signature is required before any examination or evaluation can be performed.

Printed Name: _____ Signature: _____ Date: _____

Notice Of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access that information. Please review it carefully.

We understand that your health information is very sensitive, and we work hard to protect your privacy. We will not disclose your information to others unless you authorize it or unless the law permits or requires it.

Health information includes records with diagnosis and treatment information, as well as billing and payment information related to your care. This information enables us to provide you with safe and effective care. We are also required to maintain accurate medical records.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rules require that we:

- Protect the privacy of your health information
- Provide you with this Notice of Privacy Practices
- Advise you of your legal rights
- Comply with the promises in this Notice

We may use and disclose health information about you for the following purposes:

- Health Care - We will use your health information to decide what kind of care you need. We may also share this information with other healthcare professionals to help provide the right care.
- Payment - We may use and disclose health information regarding the services we have provided to bill and collect payment from insurance companies and other health care benefit programs.
- Healthcare Operations - We may use and disclose your health information to effectively manage our practice and ensure that our patients receive quality care. For instance, we may use and disclose information to remind you of appointments. We may also use and disclose information to enhance the quality of care we provide to you. Furthermore, we will use and disclose your health information for accounting, risk management, and practice insurance purposes. Occasionally, we may use and disclose your health information to others who evaluate the quality of care we deliver, assess legal compliance, and audit the accuracy of our medical and billing records. These associates are required to adhere to the same privacy standards that we uphold.

Other uses and disclosures of your health information:

Emergencies - In an emergency, we may disclose your health information to your family or authorized representative, notifying them of your condition and location.
Serious threats - We may disclose your health information to an authorized organization to prevent a serious threat to public health and safety or to assist with disaster relief.

Abuse, neglect, or domestic violence: we may be legally required to report instances of child abuse, domestic violence, or other forms of neglect.

Public health - When mandated by law, we will disclose your health information to authorized organizations responsible for preventing and controlling diseases, injuries, and other health conditions.

Research - Occasionally, we may utilize and share your health information for research purposes. However, such utilization and sharing must adhere to legal guidelines. We will seek your permission before disclosing any information that could allow others to identify you. For most research, we use "de-identified" information.

Legally required disclosures - We will disclose your health information as required by any federal, state, or local law.

Organ and tissue donation - If you are an organ donor, we may release health information to organizations that handle organ donations.
Law enforcement - We may disclose health information if required by law enforcement officials or in response to a court order, subpoena, warrant, summons or other legal process.

Investigations and government activities - We may disclose your health information to government agencies for activities authorized by law, such as payment audits, inspections, and licensure.

Lawsuits and disputes - If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will attempt to contact you about these requests so you may obtain a court order to protect the information from disclosure. We may also use your health information to defend us against legal actions.

Military and veterans - If you are a member of the military, we may be required to disclose your health information to military authorities.

Worked Compensation - We may disclose your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illnesses.

Coroners, medical examiners, and funeral directors - We may disclose your health information to a coroner or medical examiner if necessary to identify a deceased person or determine the cause of death. We may also disclose your health information to funeral directors if required to fulfill their duties.

Correctional Institutions - If you are an inmate in a correctional institution or under the custody of law enforcement, we may disclose your health information to the correctional institution or law enforcement agency.

Your Rights

You have rights under both state and federal laws regarding the use and disclosure of health information that identifies you. We are obligated to use and disclose identifiable health information only as permitted by law.
Right to this notice - You have a right to a copy of this Notice. You may ask for a copy at any time.

Right to Inspect and Obtain Copies of Your Health Information - You can request a copy of certain health information found in your medical and billing records, though psychotherapy notes are excluded. To inspect or receive a copy of your records, please submit a written request to us. We may charge a fee for the costs of copying, mailing, or handling your request as permitted by law. We may also deny your request to inspect and copy the records as allowed by law.

Right to amend records - You have the right to request an amendment to your health information if you believe it is incorrect or incomplete. To request an amendment, please fill out a "Request for Amendment" form available from us. We may deny your request as permitted by law.

If your request is denied, you may submit a written statement of disagreement. This statement will be kept in your health record and included with any release of your records.

Right to Request Restrictions - You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health operations. You also have the right to request a limit on the health information we disclose about you to someone involved in your care or the payment for your care, such as a family member or friend. Unless required by law, I will not disclose information you ask us not to share with your health plan if it relates to the care I provided to you that you paid for entirely out of pocket. We will make an effort to comply with all reasonable requests; however, we cannot agree to withhold information if we are legally required to disclose it. To request restrictions, please complete a "Request for Restrictions" form available from us.

Right to an accounting of disclosures - You have the right to request a list of disclosures we have made regarding your health information to others. To request an accounting, please fill out a "Request for an Accounting" form available from us.

Right to request alternative or confidential communications - You have the right to ask us to communicate about your health information in a specific manner or only at a designated location. For instance, you may prefer that we contact you at your workplace or by mail, or that we avoid using voicemail or email messages. To request alternative communications, please fill out the "Request for Alternative Communications" form available from us. We will accommodate all reasonable requests.

Right to Complain - If you believe your privacy rights have been violated, you may file a complaint with us, the Secretary of the Department of Health and Human Services (HHS), and/ or the Florida Department of Health. To file a complaint, please complete the "Privacy Complaint" form available from us or send us a letter outlining the issue. Complaints to HHS or the Department of Health should also be submitted to them in writing. We will not retaliate or take action against you for filing a complaint.

Right to Notice of Security Breaches - We will provide you notice as required by law of a breach of security that results in unlawful access to your information.

We Need Your Permission

Certain uses and disclosures of your health information require your authorization, such as the release of records to an insurer when you apply for coverage, disclosures related to employment applications, those for research, and those for marketing purposes. We will ask for authorization before recommending products and services for which we are compensated to endorse. Additional restrictions apply to records of communicable diseases, psychotherapy notes, genetic testing, and substance abuse. When necessary, we will request your authorization to release your health information, and we will not condition treatment on your authorization.

We Need Someone Else's Permission

These rights and obligations apply to the person who has the right to control health information. Sometimes, this right belongs to a minor or guardian, and we have an obligation to respect it. We will let you know when such a law applies.

Changes to This Notice

We may change this notice from time to time. We reserve the right to make the changed notice effective for health information we already have about you and any information we may receive about you in the future. We will post a copy of the new notice at our office and on our website.

For privacy questions or requests for health records:

South Florida Acupuncture
3471 N. Federal Hwy.
Suite 500
Fort Lauderdale, FL 33306
954-772-1919

By signing, I confirm that I have read and understood my privacy rights as detailed in this notice.

Printed Name: _____ Signature: _____ Date: _____

Contact Information

First Name: _____ Last Name: _____ Date of Birth: _____

Street Address:

_____

_____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

☐ I give South Florida Acupuncture permission to communicate with me via email and text (SMS) message.

Primary Care Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Background

Chief Complaint:

_____

Secondary Complaint:

_____

When did the Pain or Condition Start:

_____

What caused your Pain or Condition:

☐ Accident ☐ Fall ☐ Other Injury ☐ Cancer ☐ Surgery ☐ Other

If other, please tell us the cause:

_____

What caused your Pain or Condition:

☐ Better ☐ Worse ☐ Stayed the Same

Details of Pain or Condition

Please select ALL that apply:

☐ Aching	☐ Cramping	☐ Fearful	☐ Throbbing	☐ Hot/Burning
☐ Stabbing	☐ Heavy	☐ Sharp	☐ Tender	☐ Splitting
☐ Aching	☐ Sickening	☐ Gnawing	☐ Shooting	☐ Debilitating

How often does this occur:

☐ Continuous	☐ Several Times a Day	☐ Once a Day	☐ Several Times a Week
☐ Once a Week	☐ Less than Once a Week	☐ Never	

How long does this last:

☐ Continuous ☐ Weeks ☐ Days ☐ Hours

☐ Minutes ☐ Seconds ☐ None

Select a number to indicate your HIGHEST pain level over the past week (5 is most):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Select a number to indicate your LOWEST pain level over the past week (5 is most):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Select a number to indicate how much your pain or condition level interfered with your activities this week (5 is most):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Bending	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Sitting	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Standing	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Walking	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Coughing or Sneezing	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Lying Down	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Lifting	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact
Climbing	☐ Increases Pain	☐ Descreases Pain	☐ Has no impact

Please tell us any details we should know:

_____

_____

_____

_____

Current Medications

Medication	Dose	Medication	Dose

Hospitalizations, Operations, or Significant Traumas

Occurance	Approximate Date

Your Medical History

Please select ALL that apply:

- ☐ Asthma
- ☐ Anemia
- ☐ Bronchitis
- ☐ Bird Flu
- ☐ Blood Clots
- ☐ Cancer
- ☐ Colitis
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Epilepsy/Seizures
- ☐ Emphysema
- ☐ Eating Disorders
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Goiter
- ☐ Gallstones
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypothyroid
- ☐ Heart Disease
- ☐ Herpes Simplex
- ☐ Hypertension (High BP)
- ☐ Hypotension (Low BP)
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Meningitis
- ☐ Mumps
- ☐ Mental Illness
- ☐ Mononucleosis
- ☐ Polio
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Physical Abuse
- ☐ PTSD
- ☐ Reynaud's Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ STDs
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Uterine Fibroids
- ☐ **Pacemaker**

If Cancer, please tell us the type and approximate date:

_____

Family Medical History

Please select ALL that apply:

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension (High BP)
- ☐ Stroke

Notes:

_____

_____

Your Lifestyle

Diet:

_____

_____

_____

Exercise:

_____

_____

_____

Please select ALL that apply:

- ☐ Drink Alcohol Often
- ☐ Drink Coffee Often
- ☐ Drink Soda Often
- ☐ Go to Sleep after Midnight
- ☐ Smoke Marijuana Often
- ☐ Smoke Tobacco Daily
- ☐ Use Diet Sweeteners or Drinks Often

Current Conditions

General Symptoms

- ☐ Aversion to Cold
- ☐ Aversion to Heat
- ☐ Aversion to Wind
- ☐ Body Aches
- ☐ Chills
- ☐ Dizziness
- ☐ Edema
- ☐ Fatigue
- ☐ Fever
- ☐ Foggy Headed
- ☐ Low Thirst
- ☐ Insomnia
- ☐ Nasal Congestion
- ☐ Night Sweats
- ☐ Poor Appetite
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Strong Thirst

Head, Eyes, Ears, Nose, and Throat Symptoms

- ☐ Blocked Sinus
- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Concussion
- ☐ Dental Issues
- ☐ Difficulty Focusing
- ☐ Dry Eyes
- ☐ Ear Ache
- ☐ Ear Ringing - High Frequency
- ☐ Ear Ringing - Low Frequency
- ☐ Excess Saliva
- ☐ Eye Strain
- ☐ Facial Pain
- ☐ Floaters
- ☐ Glasses or Contact Lenses
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Hoarse Voice
- ☐ Migraines
- ☐ Mouth Sores/Ulcers
- ☐ Nose Bleeds
- ☐ Plum Pit Feeling in Throat
- ☐ Poor Hearing
- ☐ Poor Night Vision
- ☐ Red Eyes
- ☐ Sore Throat
- ☐ TMJ
- ☐ Vertigo

Cardiovascular Signs, Symptoms, and Diseases

- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Chest Pain
- ☐ Cold Hands or Feet
- ☐ Fainting
- ☐ Heart Beating Fast
- ☐ Heart Palpitations
- ☐ Irregular Heartbeat
- ☐ Left Arm Pain
- ☐ Phlebitis
- ☐ Swelling of Hands or Feet
- ☐ Varicose Veins

Respiratory Signs and Symptoms

- ☐ Asthma
- ☐ Breathe Feels Hot
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Labored Breathing
- ☐ Pain When Breathing Deep
- ☐ Phlegmy
- ☐ Pneumonia
- ☐ Post Nasal Drip
- ☐ Shortness of Breath
- ☐ Tightness in Chest
- ☐ Wet Cough

Gastrointestinal

- ☐ Abdominal Pain or Cramps
- ☐ Acid Regurgitation
- ☐ Anal Fissures
- ☐ Bad Breath
- ☐ Belching
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Hiccup
- ☐ Itchy Anus
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Pain

Genitourinary

- ☐ Bedwetting
- ☐ Dark Yellow Urine
- ☐ Decrease in Flow
- ☐ Decrease in Stream Power
- ☐ Enlarged Prostate
- ☐ Frequent Urination
- ☐ Genital Itching
- ☐ Genital Sores
- ☐ High Libido
- ☐ Impotence (Men)
- ☐ Incomplete Urination
- ☐ Kidney Stones
- ☐ Low Libido
- ☐ Low Semen Volume (Men)
- ☐ Premature Ejaculation (Men)
- ☐ Smelly Urine
- ☐ Unable to Hold Urine
- ☐ Urinary Tract Infection
- ☐ Wakes Up to Urinate
- ☐ Wet Dreams

Gynecological and Obstetrics (Women Only)

- ☐ Currently Pregnant
- ☐ Endometriosis
- ☐ Frequent Yeast Infections
- ☐ Irregular Menses
- ☐ Menopause
- ☐ Menstrual Clots
- ☐ No Menstrual Cycle
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Premenstrual syndrome (PMS)
- ☐ Uterine Fibroids
- ☐ Vaginal Sores

Musculoskeletal Pain

- ☐ Ankle
- ☐ Fingers
- ☐ Foot
- ☐ Full Body Aches or Pain
- ☐ General Muscle Weakness
- ☐ Groin
- ☐ Head
- ☐ Hip
- ☐ Knee
- ☐ Lower Back
- ☐ Lower Leg
- ☐ Middle Back
- ☐ Muscle Tightness
- ☐ Neck
- ☐ Ribs
- ☐ Shoulder
- ☐ Side of Leg
- ☐ Upper Back
- ☐ Upper Leg
- ☐ Toes
- ☐ Wrist

Numbness

- ☐ Ankles
- ☐ Arms
- ☐ Face
- ☐ Fingers
- ☐ Foot
- ☐ Legs
- ☐ Shoulder
- ☐ Toes
- ☐ Wrist

Frequent Emotions

- ☐ Anger
- ☐ Anxiety
- ☐ Depression
- ☐ Fear
- ☐ Grief
- ☐ Irritable
- ☐ Manic
- ☐ Suicidal
- ☐ Worry

Neuropsychological General Symptoms

☐ Anger	☐ Fear	☐ Manic
☐ Anxiety	☐ Grief	☐ Suicidal
☐ Depression	☐ Irritable	☐ Worry

If other, please explain:

_____

Have you had acupuncture before? ☐ YES ☐ NO If YES, when: _____