

Hollenbach Family Chiropractic
250 Main Street
Madison, NJ 07949

ACUPUNCTURE OFFICE POLICIES

Patient Name: _____

Patient Date of Birth: _____

Appointments and Scheduling

- Treatments are by appointment only. Emergency appointments are available if there is time in the schedule. Please call.
- Please be on time for appointments. Unfortunately, because the schedule is often tight, your treatment time may be shortened if you arrive late. However, if we are running late, you will always receive a full treatment.
- We value the time we have set aside to see and treat you and/or your child. If you are not available to keep an appointment, we would appreciate 24-hour notice. There is a charge of \$50.00 for missed appointments unless specifically waived by our office.

Financial Responsibility

- The fee for acupuncture is \$150 for an initial evaluation and treatment, which typically lasts 1 to 1.5 hours, and \$90 for each subsequent treatment, which typically lasts 45 minutes to 1 hour. Rates are subject to change with notification.
- If your treatment is not covered by insurance, payment in full is expected from you at the time of your visit, unless other arrangements have been made in advance.
- If previous arrangements have *not* been made with our office, any account balance outstanding longer than 90 days will be forwarded to a collection agency.
- For scheduled appointments, prior balances must be paid prior to the visit.
- A \$50.00 fee will be charged for any checks returned for insufficient funds.
- We accept Visa, MasterCard and American Express.

Acknowledgement of Receipt of Notice of Privacy Practices

- I acknowledge receipt of a Notice of Privacy Practices from the practitioner
- I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

Authorization to Leave Messages in my Absence

- I give the practitioner or its proxy permission to leave a message on my answering machine or addressed to my email regarding appointments or other administrative concerns, in my absence. We will not leave a message with protected health information.

I have read and understand the above policies, and I agree in full to these terms.

Responsible Party's Name/Relationship: _____

Responsible Party's Signature: _____

Date: _____

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Initial Acupuncture Health History Form

Name		
Address	City	
State	Zip Code	
Age	Height	Weight
Home Phone	Cell Phone	
Date of Birth	Social Security #	
Occupation	Marital Status	
Email		
Emergency Contact Name		
Emergency Contact Telephone #		
Family Physician		
Insurance Carrier	Policy Number	

CHIEF COMPLAINTS:

Does this problem affect your daily activities? (work, sleep and eating, etc.)

How long have you had this condition?

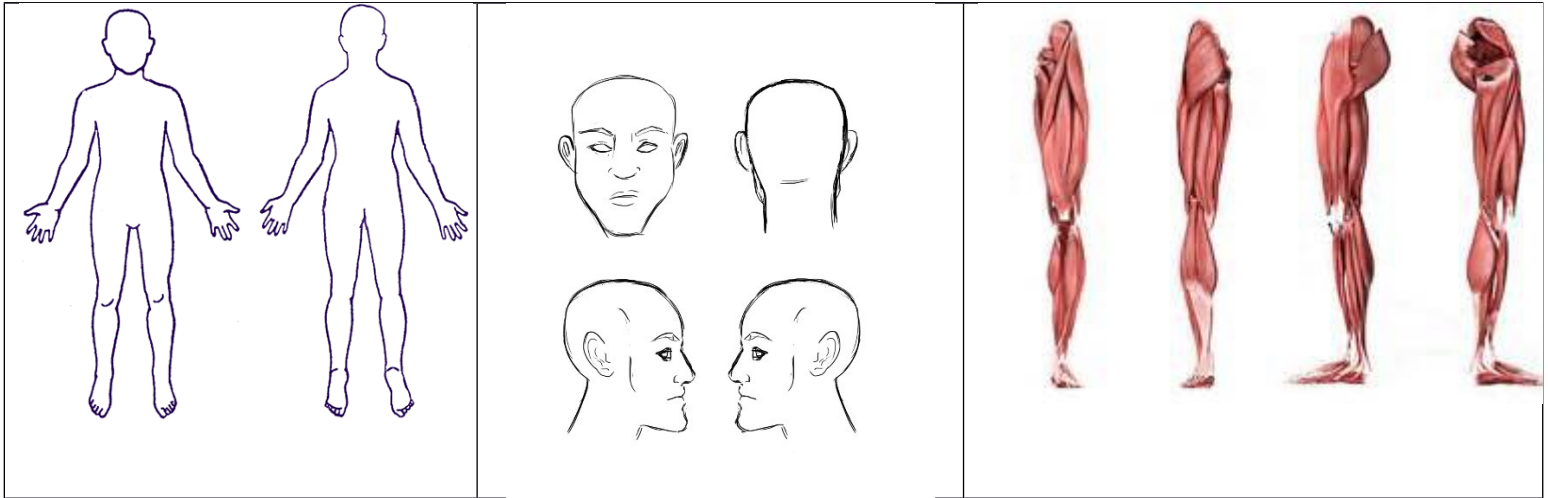
Have you been diagnosed for the problem by a physician? If yes, what is the diagnosis?

If yes, please provide physician's name and telephone.

Is the condition relieved by medication/treatment/rest/other?

What makes the condition worse? Exacerbated by moving/standing/walking/lying down/other?

Please Mark Painful or Distressed Areas Below



Medical History

What medications are you taking and for what conditions?

Medication	Condition

Major Surgeries and Hospitalizations, please list most recent first.

Year	Operations/Hospitalizations

Please list diagnostic tests done. (MRI, CT Scan, XRAYs. Etc.)

Do you have any of the following? Please circle.

Pace Maker Surgical Implants Bleeding Disorders

Are you allergic to any of the following? Please circle.

Medicine Food Herbs Latex Others

Please check off if you have the following conditions:

CANCER	Birth Trauma
SEIZURES	Hepatitis
High Blood Pressure	Heart Disease
Low Blood Pressure	Diabetes
Rheumatic Fever	Venereal Disease
Thyroid Disease	Asthma
Stroke	Other

Lifestyle

Do you smoke? If yes, how many packs a day?
Do you drink coffee or tea? If yes, how many cups a day?
Do you drink alcohol? If yes, how many drinks do you have per day? Per week?
Do you use recreational drugs? If yes, what?
Do you have dietary restrictions? If yes, what?
Do you have food or sugar cravings? If yes, what?
Do you take vitamins or herbs? If yes, what?
Do you have problems with sleeping?
What are your sleeping patterns?
What is your exercise routine?
What leisure activities do you enjoy doing?

Family History: please write down: self, mother, father, sibling, spouse, child

Allergies	Asthma
Cancer	Migraine
Diabetes	Arthritis
Blood/Bleeding Disorder	Anemia
High Blood Pressure	Heart Disease
Strokes	Seizure/Epilepsy
Depression	Mental Illness
Glaucoma	Hepatitis
Gall Stones	Kidney Disorders
Parkinson's Disease	Thyroid Disorders
Other	

PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN **THE LAST THREE MONTHS**.

GENERAL		
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fever
<input type="checkbox"/> Disturbed Sleep	<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Chills
<input type="checkbox"/> Localized Weakness	<input type="checkbox"/> Sweating Easily	<input type="checkbox"/> Sudden Energy Drop
<input type="checkbox"/> Cravings	<input type="checkbox"/> Tremors	<input type="checkbox"/> Strong Thirst
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Poor Balance

SKIN AND HAIR		
<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Recent Moles
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Pimples	<input type="checkbox"/> Changes in Texture of Hair
<input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Changes in Texture of Skin
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Acne	<input type="checkbox"/> Itching

HEAD, EYES, EARS, NOSE,		THROAT	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Recurrent Sore Throats	
<input type="checkbox"/> Concussions	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Nose Bleeds	
<input type="checkbox"/> Migraines	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Grinding Teeth	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores On Lips Or Tongue	
<input type="checkbox"/> Spots In Front Of Eyes	<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Facial Pain	
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Teeth Problems	
<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Jaw Clicks	

CARDIOVASCULAR		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Swelling Of Feet
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Hands Or Feet	<input type="checkbox"/> Difficulty In Breathing
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Swelling Of Hands	<input type="checkbox"/> Phlebitis

RESPIRATORY		
<input type="checkbox"/> Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Excessive Phlegm
<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Pain With Deep Inhalation	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Difficulty Breathing When Lying Down	

DIGESTIVE		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Belching	<input type="checkbox"/> Rectal Pain
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Black Stools	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood In Stools	<input type="checkbox"/> Abdominal Pain or Cramps
<input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Chronic Laxative Use
<input type="checkbox"/> Gas	<input type="checkbox"/> Bad Breath	<input type="checkbox"/>

GENITOURINARY		
<input type="checkbox"/> Pain On Urination	<input type="checkbox"/> Urgency To Urinate	<input type="checkbox"/> Decrease In Flow
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Unable To Hold Urine	<input type="checkbox"/> Impotence
<input type="checkbox"/> Blood In Urine	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Sores On Genitals
<input type="checkbox"/> Urge To Void At Night	<input type="checkbox"/> Elevated PSA	

Any particular color to your urine? _____

GYNECOLOGIC		
<input type="checkbox"/> Premenstrual Changes	<input type="checkbox"/> Heavy Menstrual Flow	<input type="checkbox"/> Premature Births
<input type="checkbox"/> Menstrual Clots	<input type="checkbox"/> Light Menstrual Flow	<input type="checkbox"/> Miscarriages
<input type="checkbox"/> Painful Menses	<input type="checkbox"/> Irregular Menses	<input type="checkbox"/> Unusual Menses
<input type="checkbox"/> Abortions	<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Fibroids

Age of first menses: _____ Age at menopause: _____

Time between cycles: _____ Duration of bleeding: _____

First day of last menses: _____ Number of pregnancies: _____

Do you practice birth control, if so what and how long? _____

Other gynecologic problems? _____

ARE YOU PREGNANT: YES NO

MUSCULOSKELETAL		
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hand/Wrist Pain
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Foot/Ankle Pain	<input type="checkbox"/> Hip Pain

NEUROPSYCHOLOGICAL		
<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lack Of Coordination	<input type="checkbox"/> Bad Temper
<input type="checkbox"/> Loss Of Balance	<input type="checkbox"/> Concussion	<input type="checkbox"/> Susceptible To Stress
<input type="checkbox"/> Areas Of Numbness	<input type="checkbox"/> Depression	<input type="checkbox"/>

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

Please list any other problems you would like to discuss?

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ACUPUNCTURE INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to the performance of acupuncture and other related treatments and procedures on me or my son/daughter (name) _____ who is currently under my legal guardianship by the practitioner now and in the future.

I understand that acupuncture and related treatments and procedures may include, but are not limited to, needle acupuncture, acupressure, moxabustion, heat therapy, electric stimulation and the use of lasers, magnets or metal beads to stimulate acupuncture points. I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including but not limited to bruising, numbness at the need site, dizziness and fainting. Moxabustion and the use of heat therapies may in rare instances cause burning and scarring. I understand that although it is rare, acupuncture during pregnancy can result in induction of premature labor. I will notify a staff member if I become or suspect I or my legal minor am/are pregnant. I will also notify a staff member of any drugs (medicinal or recreational) and supplements I or my legal minor am/are taking and if there has been any change to them. I understand that I may choose to stop the treatment at any time at my discretion. I will immediately notify a staff member of any unanticipated or unpleasant effects of my treatment. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand results cannot be guaranteed.

I understand the practitioner clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand that the practitioner may from time to time send me information via mail or e-mail but that my name and contact information will never be released to any business or organization.

By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my or my legal minor's present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____ Relation To Patient If Not Self _____

Practitioner _____ Date _____

**NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

I, _____ have read and understand these guidelines above.

Patient Signature: _____

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal policy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Hollenbach.

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Please Print)

Signature

Date

If you are a minor or if you are being represented by another party:

Personal Representative Name

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient.