UYAYI

ACUPUNCTURE

New Patient Registration/Personal History Form

I'm very excited to help you get on the path to optimal health. To help me understand your condition, please fill out this form completely and be as neat and accurate as possible. All information is strictly confidential. Thank you!

PATIENT INFORMATION (Please Print and complete in full)

Name: _____ Today's Date: _____

Address: _____

City_____ State_____ ZIP _____

Home Telephone #: _____Work Telephone #: _____Cell #: _____

May we leave a message at these phone numbers? _____

Would you like to receive E-Newsletters or special clinic offers? Circle If Yes or No

Email Address: _____ _____

Patient Status:

Birth Date: ____/____/_____ Age: _____ Gender: M____ F____

How would you like to be addressed? _____

Married ___ Single ___ Divorced ___ Widowed ___ Partnered ____ Other _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #: _____

How did you hear about Acupuncture at this clinic? _____

Family:

Name of Spouse or Parent: _____ Phone#_____

Primary Health care source

Physician's Name: _____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for a medical condition? Please describe

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Date of Injury or Onset of Illness:

Please briefly describe any chronic pain:

What health issue do you want treated? Please describe as fully as possible.

What treatment have you been using for relief of this issue?

Other health concerns you would like to be treated for, in order of significance:

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

What are your treatment goals?

Exercise:

Do you exercise regularly? Yes ____ How often? ____ No ____

What type of exercise do you do? _____

Patient Health/Family History: Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sibling	Grandparent	Spouse	Child
Allergies							
Blood Disorder/Anemia							
Autoimmune diseases							
Hepatitis (type)							

HIV+/AIDS							
Diabetes							
Cancers or Tumors							
HPV+							
Seizures							
High Blood Pressure							
High Cholesterol							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug/Alcohol Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at Death							

Major Hospitalizations (if you have ever been hospitalized for any serious medical illness or operation):
Please write in your most recent hospitalizations below.

Operation/Illness/Procedure	Year	Name of Hospital	City & State

Pregnancy History:
Currently pregnant?_____ If yes, for how long?_____
Total Pregnancies_____ Living_____ Ectopic_____ Miscarriages_____ Induced Abortions_____

Medicines- Mark an X in the box next to any of the following that you are now taking:

aspirin	ibuprofen	acetaminophen (Tylenol)	Other:__PLEASE LIST ALL___
antacids	laxatives	cold tablets	____MEDICATIONS____
oral contraceptives	diet pills	tranquilizers	_____ON PAGE 6_____
fiber supplements	sleeping pills	hay fever pills	_____
blood pressure pills	blood thinners	insulin, diabetic pills	

Drug Allergies_____
Latex Allergy?_____

Mark an X in the box next to all of the symptoms you currently have or have had in the past.

GENERAL

Past	Current	
		Poor appetite
		Excessive appetite
		Insomnia
		Fatigue
		Fevers
		Nights sweats
		Sweat easily
		Chills
		Localized weakness
		Poor coordination
		Change in appetite
		Strong thirst
		Other_____

CARDIOVASCULAR

Past	Current	
		High Blood Pressure
		Low Blood Pressure
		Blood clots
		Palpitations
		Fainting
		Phlebitis
		Chest pain/Angina
		Irregular heartbeat
		Cold hands/feet
		Swelling of hands/feet
		Pacemaker
		Other_____

FEMALE

Past	Current	
		Frequent urinary tract infections
		Frequent vaginal infections
		Pain/itching of genitalia
		Genital lesions/discharge
		Pelvic inflammatory disease
		Abnormal pap smear
		Irregular periods
		Painful menstrual periods
		Premenstrual syndrome
		Abnormal bleeding
		Menopausal syndrome
		Breast lumps

SKIN & HAIR

Past	Current	
		Rashes
		Hives
		Itching
		Eczema
		Pimples
		Dryness
		Tumors/Lumps
		Other_____

RESPIRATORY

Past	Current	
		Asthma
		Bronchitis
		Frequent colds
		Pneumonia
		Cough
		Coughing blood
		Production of phlegm
		Emphysema
		Shortness of breath
		Chronic obstructive pulmonary disease
		Other_____

NEUROLOGICAL

Past	Current	
		Seizures
		Tremors
		Numbness/Tingling of limbs
		Concussion
		Pain
		Paralysis
		Other_____

HEAD & NECK

Past	Current	
		Fainting
		Neck stiffness
		Enlarged lymph glands
		Headaches
		Concussions
		Dizziness
		Other_____

EARS

Past	Current	
		Infection
		Ringing
		Decreased hearing
		Discharge
		Other_____

GASTRO-INTESTINAL

Past	Current	
		Nausea
		Vomiting
		Diarrhea
		Belching
		Bloody/black stools
		Bad breath
		Rectal Pain
		Hemorrhoids
		Constipation
		Pain or cramps
		Indigestion
		Gall Bladder disorder
		Gas
		IBS
		Heartburn
		Other_____

PSYCHOLOGICAL

Past	Current	
		Depression
		Anxiety/stress
		Irritability
		Emotional/Psychological issues
		Mania/Bipolar
		PTSD
		Other_____

MALE

Past	Current	
		Pain/Itching of genitalia
		Genital lesions/discharge
		Impotence
		Weak urinary stream
		Lumps in testicles
		Prostatitis
		Other_____

EYES

Past	Current	
		Blurred vision
		Visual changes
		Poor night vision
		Spots/Floaters
		Cataracts
		Glasses/Contacts
		Eye inflammation
		Conjunctivitis (pink eye)

GENITO-URINARY

Past	Current	
		Kidney stones
		Painful urination
		Frequent urination
		Blood in urine
		Urgency to urinate
		Unable to hold urine
		Other_____

NOSE, THROAT & MOUTH

Past	Current	
		Nose bleeds
		Sinus infection
		Hay fever or allergies
		Recurring sore throats
		Grinding teeth
		Difficulty swallowing
		Other_____

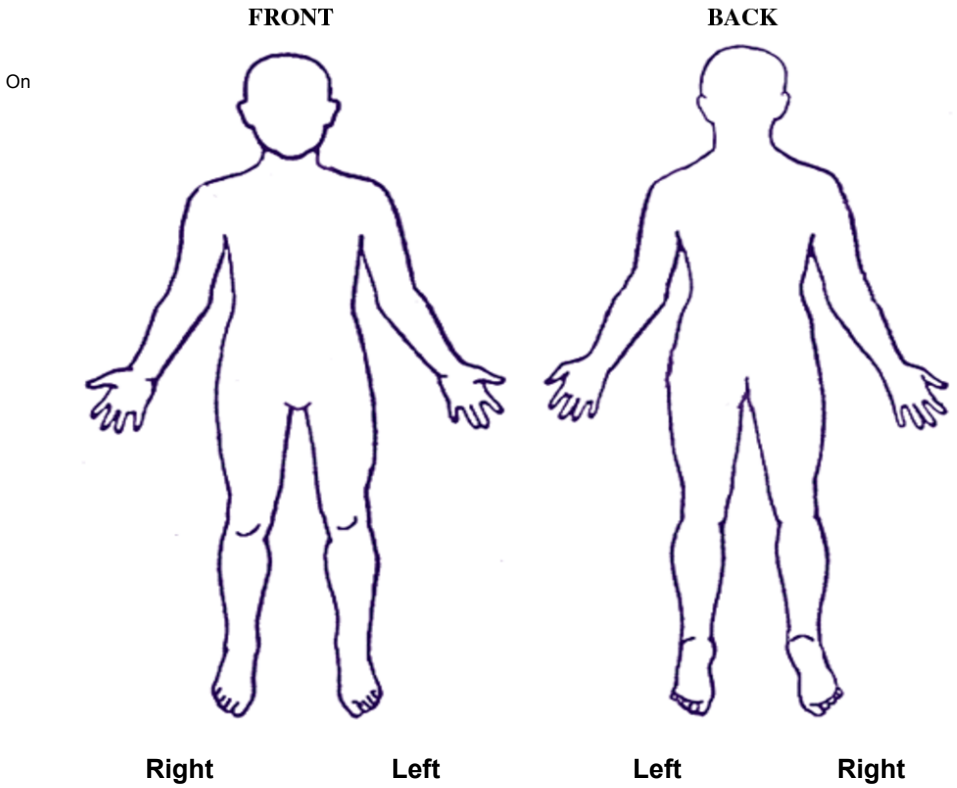
Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiating pain. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	0 0 0 0 0 0 0 0	x x x x x x	* * * * *	/ / / / / / / /
- - - - - - - - -	0 0 0 0 0 0 0 0	x x x x x x	* * * * *	/ / / / / / / /

Please mark on the pain scale from 0 to 10 the pain you feel with this condition. Zero being no pain and 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm Pain
a scale from 0-10, I rate my discomfort as follows:

(_____)
0 10
No pain Severe

Mid Back Pain
On a scale from 0-10, I rate my discomfort as follows:

(_____)
0 10
No pain Severe

Low Back & Leg Pain
On a scale from 0-10, I rate my discomfort as follows:

(_____)
0 10
No pain Severe

Date: _____ Signature: _____

Patient Medication Chart

Please list all medications that you are currently or have recently taken, including prescriptions drugs, vitamin supplements and herbs.

	Medication Name	Dosage e.g. 25 mg B.I.D	Date Started	Date Stopped
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				

Fee and Payment Agreement for Acupuncture/Traditional Chinese Medical Care

- Initial History, Evaluation & Acupuncture Treatment: $100
- Established Patient Follow Up Acupuncture Treatment: $80
- Family Acupuncture: 2 People: $50 each 3+ people: $45 each
- Re-evaluation Fee for Herbs (NO Acupuncture Treatment): $45
- **Cost of herbs or other items are extra. Depending on the herbal formula, the price varies according to each patient's individual TCM (Traditional Chinese Medicine) diagnosis. The patient is responsible to pay for herbs even if the patient must return to pick them up and even if the patient changes his/her mind about taking them, once they are made. No refunds will be made for the herbs under any circumstances.**
- ***No Show* and *Failure to Cancel Scheduled Appointment 24 hours in advance Fee*: The patient/responsible party will be charged for the full treatment fee for the missed appointment and agrees to pay it.**

Consultations and treatments are paid for at the time of the visit. Venmo, Paypal, MasterCard and Visa credit cards, cash are accepted.

Insurance Claims: We do not deal with Insurance or offer any Super Bill options. Sorry for this inconvenience.

We reserve the right to change the fees at any time without notice. The undersigned/patient/responsible party understands that there may be times of waiting for an appointment due to the acupuncturist being with other patients. The acupuncturist is doing his best to treat, honor, and respect each patient's problems and time. (Wait times are not usually greater than 30 minutes, although it may occur.)

I, the undersigned, have read and understand the fee schedule and financial policies and financial obligations to Uyayi Acupuncture & Herbal Medicine (*acupuncturist Francis Marlon Bugarin LAc.)*. I understand that health and accident policies are an arrangement between me and the insurance company. I understand that all services rendered to me by *Acupuncturist Francis Marlon Bugarin L.Ac.* are charged directly to me and that I am personally responsible for such charges. I understand and agree to the above terms.

_____ _____

Signature of Person Responsible for Payment **Date**

_____

Print Name of Person Responsible for Payment

_____ _____

Signature of Patient (if different from person responsible for payment) **Print Name of Patient** (if different from person responsible for payment)

Informed Consent to Acupuncture and Traditional Chinese Medical Treatment and Care

Name of Acupuncturist Treating this Patient: Francis Marlon Bugarin, L.Ac., M.S. in Traditional Chinese Medicine

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and Traditional Chinese Medicine including, but not limited to, acupuncture, moxibustion, cupping, electro-acupuncture, herbology, or various modes of physiotherapy, on me (or on the patient named below, for whom I am legally responsible) by the acupuncturists named above, and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for the acupuncturist named above, including those working at the clinic or office listed above whether signatories to this form or not.

I understand and am informed that there are some risks to acupuncture and Traditional Chinese Medicine treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, and blisters. There have been instances reported of fainting, vomiting, infections, and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. **I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist.** If I experience any gastrointestinal upset or allergic reaction to the herbs, I will inform the acupuncturist. I do not expect the acupuncturist to anticipate or explain all possible complications and risks, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I also understand that I may ask questions about its content if so I wish. By signing below, I agree to acupuncture or any modalities within the scope of practice of acupuncture procedures. I intend this consent form to cover the entire course of treatment for my past or present condition and for any future conditions for which I seek treatment.

_____	_____
Signature of Patient or Patient's Representative	Date
_____	_____
Print Representative's Name	Print Patient's Name (If different from person responsible for payment)

Notice of Privacy Practices

I. Understanding Your Health Record/Information
Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, 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:
a) basis for planning your care and treatment
b) means of communication among the many health professionals who contribute to your care
c) legal document describing the care you received
d) means by which you or a third-party payer can verify that services billed were actually provided
e) a tool for educating heath professionals
f) a source of data for medical research
g) a source of information for public health officials charged with improving the health of the nation
h) a source of data for facility planning and marketing
i) 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:
a) ensure its accuracy
b) better understand who, what, when, where, and why others may access your health information
c) make more informed decisions when authorizing disclosure to others

II. Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:
a) request a restriction on certain uses and disclosures of your information
b) obtain a paper copy of this Notice of Privacy Practices upon request
c) inspect and obtain a copy of your health record
d) amend your health record under certain circumstances
e) obtain an accounting of disclosures of your health information
f) request communications of your health information by alternative means or at alternative locations
g) revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities
This organization is required to:
a) maintain the privacy of your health information
b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
c) abide by the terms of this notice
d) notify you if we are unable to agree to a requested restriction
e) 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 supply to us.

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

IV. For More Information or to Report a Problem
If you have questions and would like additional information, ask your provider for clarification. If you believe your privacy rights have been violated, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. You can find the Office for Civil Rights for your state at: http://www.hhs.gov/ocr/regmail.html.There will be no retaliation for filing a complaint.

V. Examples of Disclosures for Treatment, Payment and Health Operations
Needless-to-say, we will disclose your protected health information in communications with you. For example, we may use and disclose health information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefits or services that might be of interest to you. Other reasons to disclose your health information include the following.

1) We will use your health information for treatment.
For example: Information obtained by your practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his or her expectations of any other members of your healthcare team. Those team members will then record the actions they take and their observations. In that way, the practitioner will know how you are responding to treatment.

2) 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 clinic operations.

For example: Members of the clinic 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 service we provide.

3) Business associates
There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered, if appropriate. To protect your health information, however, we require the business associate to appropriately safeguard your information.

4) Directory
Unless you notify us that you object, we may use your name, general condition, and religious affiliation for directory purposes.

5) 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.

6) 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.

7) 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.

8) Coroners, medical examiners and funeral directors
We may disclose health information to coroners, medical examiners and funeral directors consistent with applicable law to carry out their duties.

9) 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.

10) 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.

11) 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.

12) 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.

13) 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.

14) 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.

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

16) Health oversight
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 work force 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.

17) As required by law
We will disclose health information about you when required to do so by federal, state, or local law. For example, information may need to be disclosed to the Department of Health and Human Services to make sure that your rights have not been violated.

18) Suspicion of abuse or neglect
We will disclose your health information to appropriate agencies if relevant to a suspicion of child abuse or neglect, or, if you are not a minor, if you are a victim of abuse, neglect or domestic violence and either you agree to the disclosure or we are authorized by law to disclose this and it is believed that disclosure is necessary to prevent serious harm to you or others.

19) To avert a serious threat to health or safety
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone who we believe would be able to prevent the threat or harm from happening.

20) For special government functions
We may use or disclose your health information to assist the government in its performance of functions that relate to you. For example, if you are a member of the armed forces, this might include sharing your information with appropriate military authorities to assist in military command.

Acknowledgement of Receipt of Notice of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.

b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____ _____
Signature of patient or representative Today's Date

_____ _____
Print patient name Patient Birth Date