windhorse acupuncture

Windhorse Acupuncture
Christina Windhorse Lic. Ac
PO Box 1624, Lake Placid NY 12946
518-524-1141

Name (last, first) _____ Date _____

Address _____

City / State / Zip _____

Home phone _____ Work Phone _____

Cell Phone _____ Email _____

Occupation _____Birth Date _____

Emergency contact _____
(name & phone)

Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed

___ Caregiver for dependent Number of Children _____

Have you ever had acupuncture? _____ If yes, when? _____

For what condition? _____

Are you currently under the care of a physician? _____If so, who,_____

For what condition(s)? _____

Main reason(s) for seeking acupuncture

_____

_____

How long have you experienced symptoms? _____

Your condition is improved by_____
_____
_____

Your condition is aggravated by_____
_____
_____

List all current medications, prescribed or over the counter _____
_____
_____
_____
_____

List all current vitamins, herbs and other supplements _____
_____
_____
_____

Significant illnesses (please check all that apply)

___ Cancer	___ Pneumonia	___ Depression
___ Diabetes	___ Tuberculosis	___ Shingles
___ Hepatitis	___ Multiple sclerosis	___ Chronic Fatigue
___ Heart Disease	___ Thyroid	___ Rheumatic Fever
___ Stroke	___ Asthma	___ High Blood Pressure
___ Seizures	___ Stomach Ulcers	___ Sexually Transmitted Diseases
___ HIV / Aids	___ Obesity	___ Other _____

Please list any surgeries you've had including dates _____
_____
_____
_____
_____

Please list any Allergies _____
_____
_____
_____
_____

Please list any major emotional or physical traumas you've experienced
_____
_____
_____
_____
_____

Lifestyle (please check all that apply, and note frequency of use)

___ Tobacco
___ Alcohol
___ Recreational drugs
___ Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency
_____
_____
_____

Dietary preferences

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners
___ Fast food
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___Ice chewing
___Extreme thirst
___Thirst with no desire to drink

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General symptoms

___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion

___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ Nausea
___ Vomiting
___ Bulimia
___ Irritability or low energy between meals
___ Other _____

How many meals per day? _____ How many snacks per day? _____

Intestinal

___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Anal fissures
___ Intestinal pain/cramping
___ Incomplete evacuation
___ IBS
___ Colitis
___ Gout
___ Gallstones
___ Other _____

Sleep

___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake at specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or frightening dreams
___ Need drugs or supplements to fall asleep

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Head, Eyes, Ears, Nose and Throat

___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth
___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing
___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other
_____

Cardiovascular / respiratory

___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough (color of phlegm?)
___ Other _____

Skin / hair

___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

Musculoskeletal

___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Vertebral disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other _____

Neuropsychological

___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10

no stress moderate extremely stressed

Rate your stress level regarding

Work _____
Health _____
Love _____
Money _____
Family _____
The future _____
General _____

Genito-urinary

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Decreased libido / sexual desire
___ Impotency
___ Infertility
___ Other _____

Men only

___ Prostate problems
___ Erectile dysfunction
___ Herpes

Women only

Age menses began _____

Age menses ended (if applicable)_____

Date of last ob/gyn exam _____

Hysterectomy? ___ partial ___ full

___ hormone replacement therapy

Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

___ Abortion(s)
___ Miscarriage
___ Live births
___ Birth control pills
___ Breast cancer
___ Ovarian cysts
___ Fibroids
___ Candida / yeast
___ Vaginal discharge
___ Vaginal odor
___ Vaginal sores
___ Herpes
___ Human Papilloma Virus positive
___ STD history (chlamydia, PID, etc)
___ Fibrocystic breast
___ Pain at ovulation
___ Cramps / low back pain
___ Acne associated with period
___ Constipation or diarrhea associated with period
___ Emotional irritability or depression associated with period
___ Bleeding outside of regular menstrual cycle
___ No period / skipped cycles
___ Irregular cycle

Period lasts _____ days Usual number of days between periods _____

Menstrual flow

___ Clotting
___ Brownish
___ Watery, thin and bright red
___ Normal red
___ Flooding and trickling
___ Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?

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INFORMED CONSENT

Acupuncture is NOT a substitute for conventional medical diagnosis and treatment. Techniques commonly employed in the application of acupuncture:

· Acupuncture needling – treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself.

· Auxiliary / Associated therapies – massage, assisted stretching, topical application of liniments

There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psychopharmaceuticals and illegal drugs.

I, _____, certify that I have read and understood the statements above. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.
I hereby give my consent to the recommended treatment as explained to me.

Signature: _____
Date:_____

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PAYMENT AGREEMENT

Payments can be made by cash, check, credit or debit card. Full payment is expected at the time the services are rendered.

Explanation of Insurance Coverage: Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

If you must cancel your appointment, call as soon as possible to give Iris a chance to rebook your time slot. You must call before 3:00 pm the day before your appointment or else you will be charged in full for your cancelled appointment. Exceptions can be made for medical emergencies.

If you miss an appointment, you will be charged for it.

I, _____, certify that I have read and understood the statements above and agree to abide by them.

Signature: _____

Date:_____

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Notice of Privacy Practices

This *Notice* together with the *Practices Regarding Disclosure of Health Information*, describe how health information about you may be used and disclosed. They also describe how you can gain access to your health information.
Please review this information carefully.

Understanding Your Health Record

A record is made each time you visit the office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

Your Health Information Rights

This office owns your health record, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to you record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals of entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of you health information at any time. This revocation must be provided to this office in writing.

Our Responsibilities

We are required to maintain the privacy of your health information and to provide you with a copy of the *Notice* of our privacy practices. We will follow the terms of this *Notice* and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this *Notice*, we will not use or disclose your health information without your consent.

I, _____, have received a copy of the *Notice of Privacy Practices* and a copy of the *Practices Regarding Disclosure of Patient Health Information*. I understand my health information will be used and disclosed consistent with these *Notices*.

_____	_____	_____
NAME PRINTED	SIGNATURE	DATE

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STANDARDS AND PRACTICES IN PRIVACY OF PATIENT INFORMATION

Christina Windhorse, L.Ac. is committed to treating all patients with appropriate care and respect. Information that patients provide to use in connection with their treatment, Protected Health Information (PHI), is subjected to standards of security and confidentiality as defined under Federal Law, the Health Information Portability and Accountability Act (HIPAA). These Standards and Practices set forth the procedures in insure compliance with the requirements of HIPAA.

Practices

1. Written or electronic files containing PHI must be stored in secure facilities. Written files will be maintained in locked file cabinets and electronic files will be stored in secure databases only accessible through password- protected codes. Computer screens will be positioned so that they are not viewable by persons other than personnel authorized to access that information. All personnel shall use discretion when discussing PHI in conversations.

2. A Notice of Privacy Practices together with the statement of Practices Regarding Disclosure of PHI will be provided to all patients at the time of their initial visit. All patients will be requested to sign a statement acknowledging receipt of this information. The acknowledgement will be kept on file for seven years.

3. Patients will be requested to advise the office whether it may contact them by phone or in writing regarding their care. It is our practice to call to remind patients of their appointments and to send billing and related information to patients homes.

4. PHI may be routinely used for treatment, billing, payment and quality control purposes. PHI may also be used without the patients consent for the following purposes:
   a. uses and disclosures required by law
   b. uses and disclosures for public health activities
   c. disclosures about victims of abuse, neglect or domestic violence
   d. disclosures for judicial and administrative proceedings
   e. disclosures for law enforcement purposes
   f. uses and disclosures about decedents
   g. uses and disclosures for cadaver or organ donation purposes
   h. uses and disclosures to avert a serious threat to health or safety
   i. disclosures for workers compensation
   j. disclosures to a State Licensing Board or other professional oversight entity

5. Patients have the right to request restrictions on the use of their PHI although, we are not always able to abide by such requests. All such requests must be submitted in writing on our Restriction Request Form. We will take all such requests under advisement and notify the patient in writing of our determination. A copy of the determination will be maintained in our files. If the request is granted then it will be observed, except in the event of an emergency or in the event we terminate the agreement.

6. State law pertaining to parent/guardian authorization will apply in the case of a minor. When state law is silent, we reserve the right to use our professional judgment.

7. Non-routine requests for PHI will be reviewed in the normal course and may require specific patient authorization.

8. Patients may request an account of all PHI disclosures made in the prior six years. Such an accounting will not include disclosures:
   a. for treatment, payment and healthcare operations b. to the patient
   c. to persons involved in the patients care
   d. for national security or intelligence purposes
   e. to correctional institutions of law enforcement agencies f. disclosures made prior to the enactment of HIPAA

In some instances PHI may be used once it has been stripped of all elements of personally identifying information. Identifiers that may be stripped include:

a. name
b. all address information
c. email addresses
d. dates (other than year)
e. Social Security number
f. medical record numbers
g. health plan beneficiary numbers
h. account numbers
i. certificate numbers
j. license numbers
k. vehicle identification numbers
l. facial photographs
m. telephone numbers
n. device identifiers
o. url's
p. ip addresses
q. biometric identifiers
r. zip code, if the geographic unit includes less than 20,000 persons
s. any other unique data which when used alone or in combination with other information might identify the individual who is the subject of the information

9. We are required to act on written requests for onsite review of PHI within thirty days of our receipt of the request. If copies are requested we may charge a reasonable copying fee. Patients do not have the right to access:

    a. psychotherapy notes

    b. information relating to criminal, civil or administrative procedures

    c. PHI lawfully prohibited from release because it is subject to or exempted from Clinical Laboratory Improvements Amendments (CLIC)

    d. information created by someone other than us given to use under a promise not to release

10. Patients have a right to request amendments to their PHI. Requests to amend must be made in writing, clearly stating the requested amendment and the reason for the request. We will provide a written response within 60 days. If un-amended information had previously been provided to third parties, we will undertake to advise any such person of the amendment. If the request is denied we will provide a written statement setting forth the basis for the denial.

11. Amendment Rights do not apply in the following circumstances:
    a. the information is not part of the patient file
    b. the information is accurate and complete
    c. the information was not created by us

12. We shall designate a person who shall be responsible for developing and implementing out HIPAA policies and procedures. This person shall also be responsible for training all staff in these policies and procedures. All employees will be required to sign an Employee Agreement Form acknowledging that they have been trained and they understand their obligations. Employee infractions of HIPAA will result in discipline and may result in termination of employment. Similarly, any third party vendor who has access to PHI will be required to acknowledge that they are HIPAA compliant in all services provided to our business.

13. We shall not adversely treat any patient who exercises his/her rights under HIPAA. The staff is expressly prohibited from intimidating, threatening, coercing, discriminating, or retaliating against any patient who exercises their HIPAA rights.

14. Any patient wishing to appeal a determination or to file a complaint regarding HIPAA should contact the Secretary of DHHS within 180 days of the alleged violation. All personnel shall fully cooperate with any resulting investigation. Complaints are to be filed with:
    Office for Civil Rights
    U.S. Department of Health and Human Services
    200 Independence Avenue, SW
    Washington DC, 20201 800-368-1019 Hotline

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PATIENT COMMUNICATION CONSENT FORM

I hereby consent to have Christina Winhorse Lic. Ac communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, appointments and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Phone message at the following number ( )_____

Email messages at the following email address _____

Text messages at the following phone number ( )_____

Dated: _____

_____ Patient's Name

_____ Signature

_____ Signature of Parent or Guardian (if a minor)