Smithtown Acupuncture and Wellness Center

20 Gilbert Avenue, Suite 202, Smithtown, New York 11787
631.265.5656

Medical and Health History

IDENTIFICATION

Name: _____ Age: _____ Birthday: ___ / ___ / ___ Sex: M F

Address: _____ City: _____ State: ____ Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Occupation: _____

Status: Single / Married / Divorced / Widow(er) Social Security #: _____

Emergency Contact: _____ Phone: _____

How did you hear about us?

_____

INSURANCE INFORMATION

Insurance Company: _____

Policy #: _____ Group #: _____

Insured's name: _____ Insured's SS#: _____

I authorize the release of medical information necessary to process this and related claims. I request payment to myself or to the party who provided the care.

Signature: _____ Date: _____

CHIEF COMPLAINTS

Please list your main complaints / symptoms in the order of importance. Give us the approximate date symptoms started.

1. _____ Started: _____
2. _____ Started: _____
3. _____ Started: _____
4. _____ Started: _____
5. _____ Started: _____

List all practitioners you have seen for these problems and indicate the results: _____

_____

Are you a vegetarian? No Yes If yes, how long? _____

SYMPTOM CHECKLIST

Circle all symptoms that you are currently experiencing:

Abdominal pain	Acne	Allergies	Anxiety / nervous
Arthritis	Back pain	Belching	Black stools
Blackouts / fainting	Bleeding gums	Bloating	Bloody noses
Bloody stools	Blurry vision	Bruising	Cataracts
Chest colds	Chest pain / pressure	Chills	Cold sores
Constant hunger	Constipation	Coughing	Continuous urge to urinate
Coughing blood	Dandruff	Dental problems	Decreased force of urine
Depressed	Difficulty starting urination	Diarrhea	Difficulty swallowing
Digestive problems	Diverticulitis	Dizziness	Double vision
Dry skin	Ear aches	Ear infections	Ear ringing
Eczema	Eye pain / itching	Fatigue	Feel very cold
Feel very warm	Fevers	Frequent colds	Frequent urination
Headaches	Hearing difficulty	Heart murmur	Heart palpitations
High blood pressure	Hives	Hoarse voice	Indigestion
Intestinal gas	Itching / burning skin	Jaundice	Involuntary escape of urine
Joint aches / pains	Joint stiffness	Leg cramps	Kidney / bladder infections
Loose stools	Loss of appetite	Loss of balance	Loss of taste / smell
Low blood sugar	Muscle aches / pains	Nasal congestion	Nasal polyps
Nausea / vomiting	Neck pain	Night sweats	Numbness / tingling
Painful feet	Phlebitis	Psoriasis	Rectal itching
Rectal pain	Red eyes	Runny nose	Seizures
Shortness of breath	Skin problems	Skin rashes	Skipped heartbeats
Sore throat	Sore tongue	Suicidal thoughts	Swollen feet / ankles
Swollen glands	Trembling / shaking	Urine brown / red	Urination difficult
Varicose veins	Vertigo	Watery eyes	Weakness

Please circle in the chart below with information about your bowel movements:

A. Frequency	**B. Color**	2-3x per week
More than 3x/day	Very dark or black	Varies a lot
1-3x per day	Medium brown consistently	1 or fewer times per week
4-6x per day	Blood is visible	
	Dark brown consistently	

C. Consistency

Soft and well formed

Often floats

Difficult to pass

Diarrhea

Thin, long and narrow

Small and hard

Loose but not watery

Alternating between hard and loose and watery

For Men Only

Circle all symptoms that you are currently experiencing:

Painful testicles	Sexual dysfunction	Prostate problems	Hernia
Always feel cold	Fatigue	Depression	Low motivation

Date of last prostate exam: _____

Results: _____

WOMEN ONLY

Circle all symptoms that you are currently experiencing:

Ovarian cysts	Low libido	Fibroids	Myomas
Hormone replacement	Frequent yeast infections	Night sweats	Hot flashes

Age of first period: _____

Are you currently on birth control? If yes, reason: _____

Were you previously on birth control? How long and when did you stop? _____

_____

Is your menstrual cycle: regular irregular

How many days do you bleed: _____ How many days is your cycle: _____

During your cycle, or right before it starts, do you experience the following:

PMS / irritable	Dark blood clots	Abdominal cramps	Back pain
Breast tenderness	Spotting between periods	Light blood flow	Heavy blood flow

How many times have you been pregnant? _____ How many children do you have? _____

Have you had any miscarriages? How many and when? _____

Are you pregnant now? Yes No Are you seeking help for fertility? Yes No

Number of IUI's and dates: _____

_____

Number of IVF's and dates: _____

_____

Are you currently, or were you previously, on fertility medication? _____

If you are working with a Reproductive Endocrinologist or an ObGyn for help with fertility:

Practice name: _____

Doctor: _____ Phone: _____

Address: _____

I authorize Smithtown Acupuncture and Wellness, PC to share information regarding my case with my medical doctor.

Signature: _____ Date: _____

Date / results of last breast exam: _____

Date / results of last PAP smear: _____

Are you In menopause or perimenopause? How long? _____

Did you have a hysterectomy? When?

_____

Do you have a history of HPV, cervical cancer, breast cancer? _____

YOUR MEDICAL HISTORY

Circle all problems that are current and/or from the past:

Alcoholism	Crohn's Disease	Herpes	Kidney disease
Colitis	HIV	Lupus	Venereal disease
Anemia	Depression	Hypoglycemia	Lyme disease
Arthritis	Diabetes	Hepatitis	Mental illness
Asthma	High cholesterol	Migraines	Thyroid disease
Epilepsy	Eating disorders	High blood pressure	Multiple Sclerosis
Heart disease	Irritable bowel	Pneumonia	Rheumatoid arthritis
Polio	Rheumatic fever	Stroke / TIA	Stomach ulcers
Tuberculosis	Kidney stones	Osteoporosis	Pancreatitis

Cancer (type): _____

Other conditions: _____

Please list all hospitalizations and surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Approximate when the following tests were done:

Physical exam: _____ Chest x-ray: _____

Blood test: _____ EKG: _____

Urine test: _____ Rectal exam: _____

Approximate when the following immunizations were done:

Smallpox: _____ Polio: _____ MMR: _____

Pertussis: _____ Diptheria: _____ Tetanus: _____

DTAP: _____ Influenza: _____ Hepatitis B: _____

Chicken pox: _____ Others: _____

Primary care physician

Name: _____ Phone: _____

Address: _____

I authorize Smithtown Acupuncture and Wellness, PC to share information regarding my case with my medical doctor.

Signature: _____ Date: _____

FAMILY MEDICAL HISTORY

For each family member write current age and any medical problems they have.

Mother: _____ Grandmother: _____

Father: _____ Grandfather: _____

Siblings: _____

Children: _____

CURRENT PRESCRIBED MEDICATIONS

List all medications, reason for taking them and current dosage:

1. _____

2. _____

3. _____
4. _____
5. _____

OVER-THE-COUNTER MEDICATIONS

List all over-the-counter medications you are taking: _____

_____

NUTRIENT SUPPLEMENTS

List all vitamins, minerals, herbs, homeopathics or other supplements that you take:

_____

_____

_____

ALLERGIES

List all medications, substances or foods that you are allergic to.

_____

_____

LIFESTYLE AND HABITS Tobacco:

Do you currently smoke / chew? Yes No If yes, how much per day? _____

Did you ever smoke? Yes No If yes, for how long and when did you stop? _____

Alcohol (wine, beer, liquor):

How often do you drink? _____ Was drinking ever a problem? _____

Caffeine:

How much of the following to you consume daily?

Coffee: _____ Black tea: _____ Green tea: _____

Decaf coffee: _____ Cola: _____ Diet cola: _____

Energy drinks: _____ Chocolate: _____

Recreational drug use:

What type and how often do you use drugs? _____

Stress:

Life changing events and stress at work or at home play a major role in our health. Please tell us about your current level of stress, anxiety, worry and depression: _____

_____

Energy:

How is your energy in the morning? _____

How is your energy in the afternoon, 1-3pm?_____

How is your energy in the evening, 5-7pm?_____

How is your energy before bed?_____

DIET SURVEY

Place a check mark to indicate if you consume a product frequently, occasionally or never:

	Frequently	Occasionally	Never
Fast food			
Pastries, cookies, cakes			
Add sugar to coffee, tea, food			
Artificial sweeteners			
White bread, white flour products			
Ice cream			
Processed meat, deli meat			
Add salt to food			
Colas and soft drinks			
Instant breakfasts, cereals, muffins			
Deep fried foods			
Cheese, milk, heavy cream			
Whole grain hot cereals			
Meat (beef, veal, pork, ham, lamb)			
Chicken, turkey			
Eggs			
Fresh fish			
Fresh vegetables			
Fresh fruits			
Yogurt			
Beans, legumes			
Nuts, seeds			
Water			

LIFE CHANGE INDEX

This index, developed by Drs. Holmes and Rahe, indicates degree of stress related to changes in life. Even enjoyable events can be stressful. Life change scores that are high are related to more illness. In studies, many people who scored over 300 became ill within a three to six month period. If an event has been true for you in the past year, or is

about to happen, circle the associated point value. If and unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of a spouse or partner…….100
Divorce ……..73
Separation from spouse or partner ……65
Jail time ……63
Death of a close family member ……..63
Personal injury or illness……..53
Marriage/commitment to a partner ……..50
Fired at work ……47
Reconciliation with spouse/partner ……..45
Retirement ……..45
Change in health of family member ……..44
Pregnancy ……..40
Sex difficulties ……39
Addition of new family member ……..39
Business readjustment ……39
Change in financial state ……38
Death of a close friend ……..37
Change to a different line of work ……35
arguments with spouse/partner …….31
Mortgage over $50,000……..30
Foreclosure of mortgage or loan ……..30
Change in work responsibilities ……29
Child leaving home ……29
Trouble with in-laws ……29
Outstanding personal achievement ……28 Spouse/partner
begins/stops work ……26
Begin or end school ……..26
Change in living conditions ……..25
Revision of personal habits ……24
Trouble with boss or employee ……23
Change in work hours or conditions …… 20
Change in residence ……..20 Change
in schools ……19
Change in recreation ……19
Change in social activities ……18
Change in sleeping habits ……16
Change in eating habits ……15
Vacation ……..13
Christmas approaching ……12
Minor violations of the law ……11
Other ……_____
TOTAL ALL THE POINTS _____

ACUPUNCTURE CONSENT

I hereby request and consent to the performance of acupuncture treatment and other oriental medicine procedures by the licensed acupuncturists at Smithtown Acupuncture and Wellness, PC who will now, or in the future, treat me. Acupuncture has the effect to normalize physiological functions, to decrease the perception of pain, and to treat certain dysfunctions in the body. This therapy is indicated for functional disorders of the musculoskeletal, respiratory, gastrointestinal and neurological systems or even trauma, to name a few. According to the Oriental Medical Theory, the body has twelve main meridians through which the energy or Qi flows. Blockages in the flow of this energy cause obstruction in the meridians, prohibiting the energy to flow freely. Pain or illnesses are the manifestations of meridian obstruction or imbalance. Acupuncture treatment balances and moves the energy, thereby reinstating the flow of Qi in the body. The office uses only pre-sterilized, individually packaged and disposable needles. All acupuncturists employed by Smithtown Acupuncture and Wellness, PC are certified in Clean Needle Technique to assure that infectious organisms are not transmitted during treatment. I have discussed acupuncture and other procedures with the acupuncturists. I do not expect the acupuncturist to be able to explain all the risks or complications, so I wish to rely on the acupuncturist to exercise their judgment, based on their knowledge, during the course of the procedure. I have read the above consent and I have also had an opportunity to ask questions about its contents. By signing below I agree to acupuncture treatments. I intend for this consent form to cover the entire course of treatment for my conditions and any future conditions for which I may seek treatment.

I _____, do affirm that I have been advised by Smithtown Acupuncture and Wellness, PC
Patient Name
(Kenneth Moss, L.Ac. or other licensed acupuncturists at Smithtown Acupuncture and Wellness, PC) to consult a physician regarding the condition for which I am seeking treatment.

Patient Name : _____ Patient Signature : _____

Date: _____ Parent or Guardian : _____

I have received a copy of the Acupuncture consent for insertion of needles during my acupuncture treatment.

Patient Name: _____ Patient Signature: _____

Date: _____ Parent or Guardian : _____

NAET CONSENT

I understand that all acupuncturists at Smithtown Acupuncture and Wellness, PC do not claim to cure any illness or disease with NAET. I understand that NAET is not a medical diagnostic procedure and therefore it does not diagnose a disease. NAET gives the practitioner an indication as to the substances to which the patient may have a sensitivity to. NAET uses standard diagnostic procedures and modalities to understand and treat the patient's condition. The premise behind NAET is to desensitize a patient to substances using allopathic, acupuncture, nutritional and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them. I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours of treatment or after, if I get a lifethreatening reaction from the allergen I was treated for, or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments or by calling 911 or by attending an emergency room in a local hospital. If I am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication to keep my symptoms under control while I am getting treated with NAET. I understand that I may need to continue pharmaceutical drugs indefinitely. I understand that for 25 hours after the treatment I am to avoid eating, touching, breathing near and coming within three feet of the substance that I have received treatment for. If I come into contact with the substance for which I am being treated, I realize that the treatment may not work and I may have a sensitivity reaction. I understand that I must return after the 25 hour avoidance period to see if I have cleared for the substance. I fully understand that I may still experience a reaction to the substance of unknown severity if I come in contact with it if I did not energetically clear the treatment completely. If I did not clear the treatment completely, I may be required to repeat the procedure (additional office visits at my cost) until I clear the treatment satisfactorily.

I have read, or have been read, the above statements and have had the opportunity to ask questions about its content. By signing below I agree to the terms and procedures.

Print Name: _____ Patient Signature: _____

Date: _____ Parent or Guardian : _____

NUTRITIONAL AND HERBAL CONSENT

By signing below, I acknowledge that any dietary or supplemental suggestions made by Smithtown Acupuncture and Wellness, PC are entirely nutritional in nature and are not intended as the diagnosis, cure or treatment for any disease or ailment. I also acknowledge that your medical doctor is your primary health care provider and is responsible for supervising all changes in diet and nutrients that you are taking.

Print Name: _____ Patient Signature: _____

Date: _____ Parent or Guardian : _____

PAYMENT RESPONSIBILITY

I fully understand that I am directly and fully responsible to Smithtown Acupuncture and Wellness, PC for service rendered to me and that this agreement is made solely for Smithtown Acupuncture and Wellness, PC's additional protection and in consideration of the practitioner's awaiting payment. If my insurance fails to compensate the practitioner for services rendered to me, I am fully responsible for payment of service. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Print Name: _____ Patient Signature: _____

Date: _____ Parent or Guardian : _____

HIPPA NOTICE PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – in order to provide you with the health care you require, the Practice will provide your PHI to those healthcare professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment- In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written consent from you, in the following additional instances:

(a) De-identified information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard you PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your consent as soon as possible; or

- (ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – if, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such a disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was a result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

<u>Appointment Reminders</u>

- Your health care provider or staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide you appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

<u>Sign-in-log</u>

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and if so, disclosure only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with written Authorization.

Your Right To Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, your must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with an emergency treatment.

You Have a Right to

Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer.

You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice.

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, (202) 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE REQUIREMENTS

1. The Practice:

   - Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
   - Is required to abide by the terms of this Privacy Notice.
   - Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
   - Will distribute any revised Privacy Notice to your prior to implementation.
   - Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____

Dr. Kenneth Moss, DCN, L.Ac. • Chris Wilkinson DPM, CNS • Kaitlynn McGlone, L.Ac., MS
20 Gilbert Ave • Suite 202 • Smithtown, NY 11787 • SmithtownAcupuncture.com • Phone : (631) 265-5656 • Fax : (631) 265-5660

Please be advised of our office procedure. Any balances over 30 days past due for treatments, copays, outstanding insurance payments, or supplements will be automatically billed to your credit card.

Credit Card on File Agreement

I authorize Smithtown Acupuncture and Wellness to charge my credit card on file for any balance that is over 30 days.

Name: _____

Address: _____

Credit Card # _____ Exp date _____ CVC _____

Signature: _____

A copy of the credit card receipt, and bill will be sent to you once the payment is made.

Thank you,

Dr. Kenneth Moss, DCN, L.Ac. • Chris Wilkinson DPM, CNS • Kaitlynn McGlone, L.Ac., MS
20 Gilbert Ave • Suite 202 • Smithtown, NY 11787 • SmithtownAcupuncture.com • Phone : (631) 265-5656 • Fax : (631) 265-5660

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your personal health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have the right to agree to those restrictions.
- The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If Yes, please name the members allowed:

This consent was signed by: _____

(Print Name Please)

Signature: _____ Date: _____

Smithtown Acupuncture & Wellness P.C.
Bringing Your Health Back to Balance!

Dr. Kenneth Moss, DCN, L.Ac. • Chris Wilkinson DPM, CNS • Kaitlynn McGlone, L.Ac., MS
20 Gilbert Ave • Suite 202 • Smithtown, NY 11787 • SmithtownAcupuncture.com • Phone : (631) 265-5656 • Fax : (631) 265-5660

CANCELLATION POLICY

ACUPUNCTURE: Due to the high demand for appointments the following will apply.

1. Please note we do require 24-hr notice to cancel an appointment, if you do not cancel within 24 hours there will be a $35 cancellation fee.
2. If you confirm your appointment and do not show up for your appointment your credit card will be charged $35 for the missed appointment. Int: _____
3. If you miss three (3) consecutive appointments, you will be discharged from the practice.

NUTRITION:

1. Please note we do require 48-hr notice to cancel an appointment, if you do not cancel within 48 hours there will be a $75 cancellation fee.
2. If you do not show up for your appointment, your credit card will be charged $75 for the missed appointment. Int: _____

Please provide us with the following information for our records.

Email address: _____

Best phone number to reach you at: _____ is this a cell # Y N

I _____ have read the above notice and acknowledge I understand the cancellation policy.

Signature: _____ Date: _____