Dr Chu Acupuncture Clinic
1615 Maxwell Dr. Suite D. Hudson, WI 54016

Patient Notes

Patient Name		Gender	F M	DOB	
Address					
Phone	Work:	Home:		Cell:	
Email					

Chief Complaint	
How long has it been:	
Secondary complaint	
How long has it been	

Please make a check mark in front of the conditions if you have a history of any of the following

	Diabetes		Peripheral neuropathy		Cough
	Hypertension		Dizziness		Shortness of breath
	Stroke		Tinnitus		Hepatitis
	Palpitation		Constipation		Gallstone
	Nausea		Diarrhea		Kidney stone
	Vomiting		Sinus infection		Urinary infection (UTI)
	Edema		Poor appetite		Irregular menstruation
	Insomnia		HIV infection		Cancer
	Colitis		Thyroid problems		Infertility
	Prostatitis		Anxiety		Depression
	Bi-polar		Epilepsy		Obesity
	Polycystic Ovary Syndrome		Menopause		Acid reflux
	Asthma		Emphysema		Sinusitis
	Migraine		Fibromylgia		Arthritis
	Night sweat		Skin problems		Eye problems

Please list other conditions (symptoms) not included above

1. ____ 2. ____

3.____ 4. ____

Do you have anything you are allergic to? If you have, please list the allergens in the following:

1. ____ 2. ____

3. ______________________________________ 4. ____

Please list the medications and their dosage you are taking currently for your condition (if any)

1. _______________________________________ 3. ____

3.____ 4. ____

Family History

	Relationship to you		Relationship to you
Diabetes	______________________	Alcoholism	_______________________
Heart disease	______________________	Depression	______________________
Hypertension	______________________	Bleeding disorders	_______________________
High cholesterol	______________________	Strokes	_______________________
Prostate cancer	______________________	Arthritis	_______________________
Breast cancer	______________________	Thyroid disease	_______________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMTION.

The Dr Chu Acupuncture Clinic is dedicated to providing service with respect and dignity. It is fundamental to protect your privacy and healthcare information during our relationships. We are required by laws to tell you how we will be keeping your protected health information confidential. We are asking every patient to sign an acknowledgment form that they have received this notice. This notice will remain effect until it is replaced or amended by changes in the laws.

How We Gather Your Personal and Health Information
Information we received from you.
Information we receive from other healthcare providers.
Information we receive from third party payers.

How We May Use Your Health Information
Your health information may be used for the following purposes
1. During the course of our relationship with you, your health information may be used and disclosed for treatment, payment and healthcare operations.
2. We may use your health information to provide, coordinate and manage healthcare treatment or service. We may disclose health information about you to health professionals who are involved in taking care of you.
3. We may use information to receive payment from you, an insurance company, or a third party for services we provide.
4. We may use and disclose health information to contact you as a reminder that you have an appointment or we may need to reschedule your appointment.
5. We may use information for certain activities related to business functions of this office.
6. Unless you object, we may disclose your information directly as it relates to such person’s involvement in your health care or payment for such health care.
7. We may use and disclose health information to inform you about recommended possible treatment aftercare options that will benefit you.
8. We may use or disclose minimally necessary health information for other special situations such as public health activities, for averting a serious threat or safety, or for worker’s compensation purposes.
9. We will disclose minimally necessary health information about you when required to do so by federal, state or local laws.

Right to Request Confidential Communications
You may specifically authorize us to protect health information for any purpose or to disclose your health information by submitting the authorization by writing. Such disclosure will be made to any representative with whom you choose to share your protected health information.

Marketing
This office will not use your health information for marketing communication without your written authorization. We may send you birthday cards, newsletters, post cards, letters or calls.

Patient Rights
Upon written request you have the right to access, review or receive copies of your healthcare records.
Upon written request you have the right to receive a list of the items this office has disclosed about your healthcare information.
You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
You have the right to request that we amend your Protected Health Information. The request must be in writing.
You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office. Complaints about your privacy rights or how your privacy is handled at this office can be directed to the office manager by phone or in writing.

If you are not satisfied with how this office handles your complain you may submit a formal complaint to US Department of Health and Human Services at the following address:

DHHS (Office of Civil Rights)
200 Independent Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Acknowledgment of

Receipt of Notice of Privacy Practices

I, ______________________________, have read, reviewed, understood and agreed to the statement in the Notice of Privacy Practices for healthcare services.

This practice has attempted to provide each patient with a statement of Privacy Practices.

____________________________________	____________________________________
Patient Signature	Date of Birth
____________________________________	____________________________________
Printed Name	Date (MM/DD/YY)

CONSENT FORM

I voluntarily consent to be treated with acupuncture by **Qin Chu, Licensed Acupuncturist at Dr Chu Acupuncture Clinic**.

I understand that methods of treatment may include, but not limited to, acupuncture, moxibustion, cupping, electric stimulation, Tuina, Chinese herbs and nutritional counseling. I have been informed that acupuncture and other Chinese medical procedures may have the following potential risks and side effects, local bruising, needling sickness, pain or discomfort, minor bleeding, bending or breaking of needles, burning or scarring, fainting, the possible temporary aggravation of symptom existing prior to acupuncture treatment, and abdominal discomfort. Other unusual risks include pneumothorax, miscarriage, infection or nerve damage.

I understand that no guarantees concerning the use and effects of acupuncture treatment are given to me, and I am free to stop acupuncture treatments at any time.

Record Release Authorization

I understand that I am responsible for my bill
I authorize the use of this form for all my insurance submission.
I authorize release of information to to all my insurance companies.
I permit a copy of this authorization to be used in place of the original.
I direct my previous health care providers to release medical record to this clinic.
I authorize the staff of Dr Chu Acupuncture Clinic to act as my agent to obtain payment from my insurance companies.

Patient Signature ________________________________ Date ____________________________
Patient Printed Name _____________________________ Date of Birth ____________________

Consent to Treat a Minor Child

I authorize the acupuncturist and/or whoever they designate as assistants to administer acupuncture care as deemed necessary to my __________________________(relationship).
Patient's Name ________________________________ Date ________________________________
Patient or Guardian's Signature ________________________________ Date __________________