HEALING ARTS HEALTH CENTER

Acupuncture

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NOTICE OF PRIVACY PRACTICES

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.

This Notice explains how our office may collect, use and disclose your protected health information. It also explains your rights regarding your protected health information and the steps we take to keep your protected health information secure. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of care to you or the payment for that care.

Our office is required to provide you with this Notice by state and federal law. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent then federal standards. Our office is legally required to maintain the privacy of protected health information and to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to all of the protected health information that we maintain, including any information we have created or received prior to issuing any new Notice. When we make an important change to our privacy policies, we will promptly change this Notice and post a new Notice in the office. You may also obtain any new Notice by asking for one at any time. This Notice goes into effect April 14, 2003.

USES AN DISCLOSURES

Our office uses and discloses your protected health information for different reasons. We may collect and disclose protected health information from you and your other healthcare providers for the purposes of coordinating treatment, payment or operating your heath care plan.

- **Treatment**: We may use and disclose your protected health information to assist in your diagnosis and treatment. For example, 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.
- **Payment**: We may use and disclose your protected health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide you protected health information to our billing department and your health plan to get reimbursed for health care services. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that participate in claims payment process.
- **Health Care Operations**: We may use and disclose your protected health information for activities necessary to operate your health care plan including quality management, utilization review, and anti-fraud and claims payment, provider credentialing activities, underwriting or determining premiums, We may also collect and disclose your protected heath information as required by industry or government regulators such as the state licensing boards and insurance regulatory agencies.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes. As required, we

may also disclose protected health information to the sponsor of your health plan (usually your employer). Our office must disclose protected health information about you when required by law. Examples of such disclosures include the following:

- **Avoid Threat to Health or Safety**. We may disclose protected health information to law enforcement personnel or persons able to prevent or lessen a serious threat to the health or safety of a person or the public.

- **Coroners, Funeral Directors, Organ Donation**. We may disclose protected health information to coroners, medical examiners, and funeral directors as is necessary for such persons to carry out their duties. Additionally, we may disclose protected health information relating to organ, eye, or tissue donations and transplants.

- **Health Oversight Activities**. We may disclose protected health information to assist the government agencies for activities allowed required by law such as when it conducts an investigation or inspection of a health care organization.

- **Health-Related Benefits or Services**. We may disclose protected health information to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits that may be of interest to you.

- **Law Enforcement, Judicial and Administrative Proceedings**. We may disclose protected health information when ordered to do so in a judicial or administrative hearing. We may disclose protected health information in response to a subpoena, discovery request or other lawful process. Finally, we may disclose protected health information in response to a warrant, to identify or locate a suspect, or to provide information about the victim of a crime.

- **National Security and Intelligence**. We may disclose protected health information as required by military officials for national security and military intelligence purposes.

- **Public health Activities**. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

- **Research**. In certain circumstances, we may disclose protected health information in order to conduct medical research. Such circumstances include taking steps to protect your privacy.

- **Victims of Abuse, neglect or Domestic Violence**. We may disclose protected health information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence.

- **Workers' Compensation**. We may provide protected health information in order to comply with workers' compensation laws.

AUTHORIZATION

Any uses or disclosures other than those described in above will be made ONLY with your prior written authorization, unless otherwise permitted or required by law. In the event you authorize us to use or disclose your protected health information in ways other than those described above, you have the right to revoke authorization at any time by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

PATIENT RIGHTS

Right to Request Restrictions On Uses and Disclosures of Protected Health Information: You have the right to request restrictions on the use and disclosure of your protected health information. To request a restriction please speak to the Office Manager. Please note that while you may request a restriction, we have a right to refuse that request. If we accept your request, we will put the limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right To Receive Confidential Communications: You have the right to receive confidential communications, including the right to direct where communications containing protected health information are sent. For example, you may request that information be sent to your work address rather than your home address or via alternative means such as email rather than regular mail. To verify or modify where or how you would like such communications be sent, contact the Office Manager. We will accommodate all reasonable requests. Unless requested otherwise, we will direct mailings and telephone messages containing protected health information to the address and telephone number we have on record for the subscriber of the health plan.

Right To Inspect And Copy Protected Health Information: In most cases, you have the right to see and get copies of your protected health information that we maintain. If you want to see or get copies of your protected health information you must submit your request in writing to the Office Manager. If we do not have your protected health information but knows who does, we will tell you where you can get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do deny your requests, we will tell you, in writing, the reasons for the denial and explain your right to heave the denial reviewed. If you request copies of your protected health information, we will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance. Instead of providing the protected health information you requested, we may provide you with summary or explanation of the protected health information as long as you agree to the summary and any applicable charges in advance.

Right To Amend Protected Health Information: If you believe that there is a mistake in your protected health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing to the Office Manager. We will respond within 60 days of receiving your request. We may deny your request in writing if the protected health information is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a rebuttal, you have the right to request that copies of your initial request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, inform you when the change is complete, and inform others that need to know about the change to your protected health information.

PATIENT RIGHTS (continued)

Right to Receive An Accounting Of Disclosures Of Protected Health Information: you have a right to receive an accounting to any disclosures of your protected heath information that were made

for purposes other than coordinating treatment, payment or other health care services plan operations. The accounting will not include uses and disclosures made for treatment, payment, or health care operations, disclosures made directly to you or your family, or disclosures that you have already authorized. Additionally, the accounting will not include uses and disclosures made for national security purposes, or to corrections or law enforcement that has lawful custody over you. We will respond within 60 days of receiving your written request. The accounting will include the date of the disclosure to whom protected health information was disclosed (including their address, if known), a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting you request within a 12-month period at no charge. For additional accounting within the same time period, we may charge you a fee for each additional request but will inform you of that fee in advance. To request an accounting of any such disclosures submit your request in writing to the Office Manager stating the time period for which you want the accounting. This time period may not be longer than six years and may not include dates before April 14, 2003.

Right To Get A Paper Copy Of This Notice: You have the right to get a paper copy of this Notice at any time if you previously agreed to receive an electronic copy.

Right to File A Complaint: If you believe that your protected health information has been improperly used or disclosed, or that your privacy rights have been violated you may file a privacy complaint with us. To file such a complaint you should contact the Office Manager. You also have the right to file a complaint with the Secretary of the U S. Department of Health and Human Services (DHHS). We will take no retaliatory action against you if you file a complaint with us or with the DHHS.

I acknowledge having received a copy of this Notice of Privacy Practices.

Patient Name:

_____

Signature: _____ **Date of Signature:** _____

Relationship to Patient (if other than self):

_____

Note: If a patient's legal representative is signing this acknowledgement, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

PATIENT CONFIDENTIAL INFORMATION

This confidential questionnaire will help us to determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you.

PERSONAL INFORMATION (Please print legibly) Date: _____

Name: _____ (Required)

Home Address: _____ (Required)

City: _____ State: _____ (Required) Zip: _____ (Required)

Home Phone: _____ (Required) Work Phone: _____

Social Security No.: _XXX-XX-_____ (Required) Driver's License No.: _____ (Required)

E-mail Address: _____

Occupation: _____ Employer: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Number of Children _____ (Required)

In Case of Emergency Call:

_____

(***Please write phone # beside name***)

Who should we thank for referring you to this office?

_____

Have you received acupuncture therapy before? ☐ Yes ☐ No

If Yes, Where?

_____

Person responsible for your account: _____

(Name and phone #)

Insurance – Carrier name/ Subscriber ID# & name shown on card:

_____

_____

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5222 BALBOA AVE., SUITE 43, SAN DIEGO, CA 92111

SHAHEED K. ABDULLAH L.AC.
TEL: 858-467-9693 FAX: 858-467-9900

What are the main health problems (include 1st occurrence date of problem/injury for which you seek treatment)?

_____

_____

_____

List any other health problems you now have:

_____

_____

_____

List any allergies, food sensitivities or food cravings that you have:

_____

_____

List any accidents, surgeries, or hospitalizations (include dates):

_____

_____

CLINICAL NOTES(This section reserved for doctor's use):

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark: Never experience ✓: Sometimes experience +: Frequent experience

___ Lack of Appetite
___ Excessive Appetite
___ Digestion problems, indigestion
___ Vomiting
___ Belching or burping
___ Heartburn
___ Feeling of retention of food in stomach
___ Difficulty digesting oily foods
___ Abdominal pain
___ Loose stool or diarrhea
___ Light colored stool
___ Blood in stool
___ Black "tarry" stool
___ Constipation
___ Colitis or diverticulitis
___ Hemorrhoids

___ Insomnia, difficulty sleeping
___ Heart palpitations
___ Cold hands and feet
___ Nightmares
___ Mentally restless
___ Laughing for no apparent reason
___ Angina pains

___ Tendency to catch colds easily
___ Intolerance to weather changes
___ Allergies
___ Hay fever
___ Cough
___ Shortness of breath
___ Bronchitis
___ Asthma
___ Chest pain
___ Decrease sense of smell
___ Nasal problems
___ Skin problems
___ Feeling of claustrophobia
___ Recent use of antibiotics

___ Eye problems
___ Jaundice (yellowish eyes or skin)
___ Hepatitis
___ Gall stones
___ Soft or brittle nails
___ Easily angered or agitated

___ Difficulty making plans or decisions
___ Spasm or twitching of muscles

___ Low back pain
___ Knee problems
___ Sciatic pain
___ Hearing impairment
___ Ear ringing
___ Decreased sex drive
___ Hair loss
___ Kidney stones
___ Urinary problems

___ Fatigue
___ Edema
___ Easily bruised
___ Difficult to stop bleeding
___ Headaches
___ Dizziness
___ Tendency to faint easily
___ High blood pressure
___ High cholesterol levels
___ Sudden weight loss
___ Tendency to become obsessive your work, relationships...

FOR MEN ONLY:
___ Prostate problems
___ Painful or burning urination
___ Pain or coldness in the genital area

OTHER:

_____

FOR WOMEN ONLY:
___ Pre-menstrual pain or discomfort
___ Menstrual pain or discomfort
___ Irregular menstrual cycle
___ Swelling or pain in breasts

OTHER:

_____

Are you pregnant? ☐ Yes ☐ No
Date of last menstrual period: _____
Last gynecology exam:

_____

Results:

_____

Indicate any significant illnesses you have had (please include date):

Cancer _____ Diabetes _____ Hepatitis _____ Heart Disease _____

Hypertension _____ Seizures _____ Rheumatic Fever _____

Emotional Disorders _____ Infectious Diseases _____ Others _____

List any major diseases or health problems in your FAMILY:

_____

_____

List any medications and supplements you are currently taking (indicate reason):

_____

_____

Please indicate the use and frequency of the following:

Tobacco:_____

Coffee / Black Tea: _____

Alcohol:_____

Non-medical-drugs: _____

Exercise: _____

How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Spouse or Significant other						
Family						
Diet						
Sex						
Self						
Work						

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OFFICE POLICY

INSURANCE

Should we agree to bill your insurance for you, please understand that this is done as a courtesy and it is not our responsibility to pursue payment of your account. **YOU HOLD THE CONTRACT WITH YOUR INSURANCE COMPANY AND IT IS YOUR RESPONSIBILITY TO COLLECT AND/OR NEGOTIATE SETTLEMENT OF YOUR CLAIMS.** We will be happy to furnish information and answer all inquiries directed to us from your insurance company.

INSURANCE ACCEPTANCE

We will be happy assist you in billing you insurance and will accept payment directly to the doctor. **IT IS THE PATIENT'S RESPONSIBILITY TO UNDERSTAND THEIR POLICY AND THE BENEFITS PERTAINING TO THEIR ACUPUNCTURE TREATMENT.** Please provide us with an original completed claim form. If for any reason the claims are denied, the patient or responsible party will satisfy the account in full. If there is a deductible or co-payment, that portion will be due at the time of each service. **IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US WITH ANY CHANGES IN COVERAGE.**

CANCELLATION OR NO-SHOW APPOINTMENT

Regarding cancellations, our policy states that there must be a 24-hour notice between when you cancel an appointment and the actual time of your appointment. If you have cancelled treatment without 24-hours notice, you will be given a verbal warning. On your second cancellation, you will be charged a **$25.00** fee before you may be treated again.

Regarding no-show appointments, a no-show appointment is when a patient misses his or her appointment without any notice. A **$25.00** charge will be incurred before treatment may be rendered again.

Please try to be on time for your appointment, because it affects all patients after you if you are late. We respect your time as well, and will do our utmost to stay on schedule.

In order to render a high standard of care, this policy was developed to insure each patient's treatment time.

I understand and accept the above policy

(Signature of Patient or Parent of Minor) **(Date)**