AUSTIN FAMILY CLINIC

Confidential Patient Intake Form

4131 Spicewood Springs Road, Bldg. D-6, Austin, Texas 78759, Phone: 512 502-1293

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have a question, please ask.

Last Name	First Name	Preferred Name/Nickname	Date

Gender	Date of Birth	Age	Marital Status
☐ M ☐ F			☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address		
City	State	Zip

Daytime Phone# (home, work, cell – circle one):	Alternate Phone# (home, work, cell – circle one):
( )	( )
Other Phone Number (home, work, cell – circle one):	Email
( )	
Occupation	
Emergency Contact & Relation ship	Phone Numbers of Emergency Contact
	( )

Insurance ☐ None ☐ PPO ☐ HMO ☐ TWC ☐ Others: _____

Primary	**Secondary**
Ins. Name:_____	Ins. Name:_____
Policy Holder:_____	Policy Holder:_____
Policy Number:_____	Policy Number:_____
Group Number:_____	Group Number:_____
Phone Number:_____	Phone Number:_____

Primary Care Physician (if applicable):	
Other Doctors You See	Specialty
Other Doctors You See	Specialty
Is your injury work related? ☐ Yes ☐ No	Is your injury auto accident related? ☐ Yes ☐ No
How did you hear about us?	Who REFERRED YOU to our clinic?

Under 18 years of age
Last Name First Name

Guarden's Name: _____ Contact Number:_____

Medical Information

Please describe current health problem(s) for which you are seeking treatment: _____

Date problem(s) began (mm/dd/yy): _____

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Indicate any significant illness(es) you have:

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Seizures ☐ Emotional Disorders
☐ High Blood Pressure ☐ Rheumatic Fever ☐ Heart Disease
☐ Infectious Diseases ☐ Others _____
☐ Sexually Transmitted Diseased (Gonorrhea, Syphilis, AIDS, ARC) _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

_____

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 date): _____

LIST MEDICATIONS YOU ARE NOW TAKING _____

DRUG ALLERGIES _____

Please indicate the use and frequency of the following:

☐ Tobacco _____ ☐ Coffee/Black tea _____ ☐ Alcohol _____
☐ Non-Medical Drugs _____ ☐ Exercise _____ ☐ Street Drugs _____

If a family member has had any of the following, please mark the appropriate box and explain:

☐ Arthritis ☐ Cancer ☐ DIABETES ☐ Lupus ☐ Hypertension ☐ Heart disease ☐ Mental disorders
☐STROKE ☐ TUBERCULOSIS ☐ Others _____

MEDICAL HISTORY

Mark ☐ for current problems.

☐Decreased Hearing
☐Ringing in ear
☐Ear infections - frequent
☐Dizzy Spells
☐Failing Vision
☐Double or Blurred Vision
☐Eye Pain
☐Eye Infections - frequent
☐Nose Bleeds - recurrent
☐Sinus Trouble
☐Sore Throats - frequent
☐Hay fever/Allergies
☐Hoarseness - prolonged
☐Pneumonia/Pleurisy
☐Bronchitis/Chronic Cough
☐Asthma/Wheezing
☐Shortness of Breath
☐on Exertion
☐Chest Pain
☐High Blood Pressure
☐Heart Murmur
☐Palpitations
☐Irregular Pulse
☐Swollen Ankles
☐Fainting Spells

☐Leg Pain when walking
☐Varicose Veins/Phlebitis
☐Loss of Appetite - recent
☐Difficulty Swallowing
☐Indigestion or Heartburn
☐Persistent Nausea/Vomiting
☐Peptic Ulcers
☐Abdominal Pain - chronic
☐Change in Bowel Habits - recent
☐Diarrhea ☐Constipation
☐Diverticulosis
☐Bloody or Tarry Stools
☐Hemorrhoids
☐Gall Bladder Trouble
☐Jaundice/Hepatitis
☐Hernia
☐Urinary Infections - frequent
☐Lying Flat ☐Painful Urination
☐Blood in Urine
☐Overnight Urination-More Than 2
☐Control in Urination
☐Decrease in Force of Urination
☐Kidney Stones
☐Venereal Disease
☐Urethral Discharge

☐Chronic Fatigue
☐Weight Loss - recent
☐Anemia ☐Bruise easily
☐Mumps

☐Thyroid Disease
☐Convulsions/Seizures
☐Stroke
☐Tremor/Hands Shaking
☐Muscle Weakness
☐Numbness/Tingling Sensations
☐Headaches - frequent
☐Arthritis/Rheumatism
☐Back Pain - recurrent
☐Bone Fracture/Joint Injury
☐Gout
☐Foot Pain ☐Cold Numb Feet
☐Rashes ☐Hives
☐Psoriasis ☐Eczema
☐Sleeping Difficulty
☐Nervousness ☐Depression
☐Memory Loss
☐Moodiness - excessive
☐Phobias
☐Mental Illness

☐Chicken Pox ☐Polio
☐Measles ☐Germ. Measles
☐Rheumatic ☐Scarlet Fever

FEMALES - Menstrual History
Age at Onset_____☐Reg ☐Irreg
Flow ☐Heavy ☐Mod ☐Light
☐Pain/Cramps with Mens. Flow
_____ Days of Flow
_____ Length of Cycle
☐Pain/Bleeding After Sex
No. of Pregnancies_____
No. of Live Births_____
No. of Miscarriages_____
Birth Control Method_____
B.C. Pill (name)_____
☐Flushing/Menopause
☐H.I.V.
Other Symptoms of Diseases
☐_____
☐_____
☐_____

REQUEST AND CONSENT FOR TREATMENT

I hereby request the Acupuncturist to treat me. I also authorize him/her to perform on me the treatment known as Acupuncture as his/her judgment may indicate and authorize him/her to use whatever therapeutic methods he/she may see fit, whether or not such methods are commonly and generally accepted and practiced in this community.

The Acupuncturist has frankly and fully explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards and possibilities of complications during or as a result of the treatment. I understand what the term "complication" means, and in giving my consent to the treatment, I have in mind his/her frank and full explanation. If any unforeseen condition arises in the course of the treatment and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different form those now contemplated, I also request and authorize him/her to do whatever he/she deems advisable.

The Acupuncturist has made no guarantee as to the results that may be obtained.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this office. This practice has attempted to provide each patient with a Notice of Privacy Policies.

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I give consent to Austin Family Clinic for the use and disclosure of my individually identifiable health information or protected health information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the services this office has rendered to me;
C. The general healthcare operations of this practice.

The Purpose of This Consent: Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

If you are suffering from any of the following diseases/ conditions, please notify the acupuncturist at this time:

1. Heart condition _____
2. Stroke _____
3. Water retention from diabetes _____
4. Fainting from needles _____
5. Bruise easily _____
6. Please confirm that the acupuncturist has shown you the disposable needles. Yes _____ No _____

In the event that my condition is such that treatment is beyond the normal capabilities of the clinic, I understand that I may be referred to other competent practitioners including, but not necessarily limited to, medical physicians or other acupuncturists. **I also agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I may be charged the regular treatment fee if I miss an appointment without giving 24 hours notice.**

I have been given no guarantee as to the results that may be obtained.

_____ _____

Signature of Patient Date

AUSTIN
FAMILY
CLINIC

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirements of section183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (patient's name) _____
am notifying AUSTIN FAMILY CLINIC, John McMillian LAC of the following:

___ Yes ___ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. _____After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

OR

___ Chronic Pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____
Patient Signature Required Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____ _____
Patient Signature Required Date

_____ _____
Acupuncturist's Signature Date

AUSTIN FAMILY CLINIC

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/01/13 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights law.

Judicial and Administrative Proceedings, If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: John McMillian DOM

Address: 4131 Spicewood Springs Rd., Bldg. D-6 Austin, Texas

Telephone: 512 502-1293