1. Medical History Form 2. Consent Form 3. Notice of Privacy Practices

Medical History Form

Lake Bluff Acupuncture, LLC

49 Sherwood Terrace, Evergreen Office Building, Suite J, Lake Bluff, IL 60044

Phone: 847-533-3621 www.lakebluffacupuncture.com

Today's Date_____/_____/_____

Patient Name_____ Male/Female Age_____ Date of Birth____/____/_____

Height_____ Weight_____ Marital Status_____ Occupation_____

Phone (H) (_____)_____-_____ (W) (_____)_____-_____ Employer_____

Address_____City_____State____ Zip _____

Spouse's Name_____ Phone (_____)_____-_____ 2nd Phone (_____)_____-_____

Primary Physician_____ Phone (_____)_____-_____ Referred by _____

Emergency contact information: The name of the person you would like to contact in emergency_____

Phone (H) (_____)_____-_____ 2nd Phone (_____)_____-_____ Relationship_____

Insurance _____ 2nd Insurance_____

Subscriber's Name_____ Subscriber's Name_____

Date of Birth_____/_____/_____ Date of Birth_____/_____/_____

I. D#_____ I. D# _____

Please List things you are allergic to:

( ) Medicine_____

( ) Food _____

( ) Herb _____

( ) Others _____

Please list medications you are currently taking:

_____ _____

_____ _____

Do you use or are you any of the following ?

( ) Pacemaker ( ) Electric Implants ( ) Metal Implants ( ) Severe Bleeding Disorders ( ) Pregnant
( ) HIV Positive ( ) Hepatitis A/B/C ( ) Blood Thinning Pills

Your main complains today: (indicate the pain level 0-10, if you have pain)

_____

_____

_____

_____

Please check if you have had any of the following conditions:

General

[ ] Anemia
[ ] Fatigue
[ ] Fever
[ ] Weight Loss
[ ] Sweats
[ ] Chills
[ ] Drug Addiction
[ ] Poor Appetite
[ ] Localized Weakness
[ ] Bleeding or Bruise Easily
[ ] Peculiar Tastes or Smell
[ ] Strong Thirst (hot or cold drinks)
[ ] Sudden Energy Drop
[ ] Poor Sleep Habits
[ ] Tremors
[ ] Poor Balance
[ ] Cravings
[ ] Weight Gain
[ ] Alcoholism
[ ] Tetanus Shot
[ ] Frequent Cold /Flu

Skin and Hair

[ ] Rashes
[ ] Itching
[ ] Dandruff
[ ] Change in Hair/Skin Texture
[ ] Ulcerations
[ ] Eczema
[ ] Open sore
[ ] Acne
[ ] Corns
[ ] Warts
[ ] Psoriasis
[ ] Recent Moles
[ ] Lose of Hair
[ ] Hives
[ ] Nail Problems
[ ] Dry Skin

Head , Eyes, Ears, Nose and Throat

[ ] Dizziness/Vertigo
[ ] Poor Vision
[ ] Cataracts
[ ] Ringing in ears
[ ] Sinus Problems
[ ] Grinding Teeth
[ ] Nasal Congestion
[ ] Headaches
[ ] Concussions
[ ] Eye Strain
[ ] Night Blindness
[ ] Blurry Vision
[ ] Poor Hearing
[ ] Nose Bleeds
[ ] Hoarseness
[ ] Migraines
[ ] Eye Pain
[ ] Color Blindness
[ ] Earaches
[ ] Spots in front of eyes
[ ] Recurrent Sore Throats
[ ] Facial Pain

Cardiovascular

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Palpitations
[ ] Irregular Heartbeat
[ ] Mitral Stenosis
[ ] Mitral Valve Prolapse
[ ] Myocarditis
[ ] Pneumatic Hear Disease
[ ] Chest Pain
[ ] Varicose Veins
[ ] Swelling of Hands/Feet
[ ] Fainting
[ ] Coronary Heart Disease
[ ] Difficulty in Breathing
[ ] Hardening of Arteries
[ ] Phlebitis
[ ] Blood Clots
[ ] Cold Hands/Feet

Respiratory

[ ] Cough
[ ] Bronchitis
[ ] Difficulty Breathing Laying down
[ ] Emphysema
[ ] Coughing Blood
[ ] Pneumonia
[ ] Asthma
[ ] Pain w/Deep Breath
[ ] Production of Phlegm
[ ] Pleurisy

Gastrointestinal

[ ] Nausea
[ ] Vomiting
[ ] Bad Breath
[ ] Abdominal Pain or Cramps
[ ] Indigestion
[ ] Ulcer
[ ] Constipation
[ ] Gas
[ ] Blood in Stools
[ ] Rectal Pain
[ ] Chronic Laxative Use
[ ] Colitis
[ ] Diarrhea
[ ] Belching
[ ] Black Stools
[ ] Hemorrhoids
[ ] Acid Reflux

Genitourinary

[ ] Bed Wetting
[ ] Kidney Infections/ Stones
[ ] Genital Herpes
[ ] Cystitis
[ ] Blood in Urine
[ ] Painful Urination
[ ] Venereal Disease
[ ] Incontinence
[ ] Frequent Urination
[ ] Bladder Infections
[ ] Prostate Problems

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[ ] Use of Birth Control
[ ] Clots
[ ] Hot Flash/Night Sweats
[ ] Age at 1st Menstruation
_____ Time between Menstruation
_____ Duration of Menstruation
_____First Date of Last Menstruation
[ ] Irregular Periods
[ ] Endometriosis
[ ] Frequent Changes in Emotion
[ ] Unusual Character (heavy/light)
[ ] Vaginal Sores
[ ] Vaginal Discharge
[ ] Breast Lumps
[ ] Painful Periods/Cramps
[ ] Uterine Fibroids
[ ] Osteoporosis

Musculoskeletal

[ ] Neck Pain
[ ] Back Pain
[ ] Hand/Wrist Pain
[ ] Muscle Pain
[ ] Muscle Weakness
[ ] Shoulder Pain
[ ] Knee Pain
[ ] Foot/Ankle Pain
[ ] Hip Pain

Neuropsychological

[ ] Seizures
[ ] Areas of Numbness
[ ] Concussion
[ ] Bad Temper
[ ] Difficulty Concentrating
[ ] Dizziness
[ ] Lack of Coordination
[ ] Depression
[ ] Easily susceptible to stress
[ ] Loss of Balance
[ ] Poor Memory
[ ] Anxiety
[ ] ADD

Infection

[ ] Measles
[ ] Rheumatic Fever
[ ] Malaria
[ ] Small Pox
[ ] Mumps
[ ] Tuberculosis
[ ] Chicken Pox
[ ] Whopping Cough
[ ] Typhoid Fever
[ ] Scarlet Fever

Additional information related above listed (you checked)

_____

_____

_____

_____

_____

List of Hospitalization & Surgeries

_____

_____

_____

_____

Other information

	No	Yes	How many yrs	Daily consumption	Your comments
Coffee	___	___	_____	_____	_____
Tea	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Vitamins	___	___	_____	_____	_____

Family History (please include the relative's age)

[ ] Migraines _____
[ ] Heart Disease _____
[ ] Allergies _____
[ ] Asthma _____
[ ] Arthritis _____
[ ] Diabetes _____
[ ] Glaucoma _____
[ ] Stroke _____
[ ] High Blood Pressure _____
[ ] Mental Illness _____
[ ] Gall Stones _____
[ ] Cancer _____
[ ] Thyroid Disease _____
[ ] Epilepsy _____

The following is for car accident related injury only

Date of accident_____/_____/_____ **Accident occurred at City _____, State_____**

Patient's Car Insurance_____ **Phone_____**

Claim#_____ **Adjuster_____** **Phone_____**

Address _____City _____Zip_____

Fault's Car Insurance_____ **Phone_____**

Claim#_____ **Adjuster_____** **Phone_____**

Address _____City _____Zip_____

Fault Person's name _____

Patient's attorney _____ **Phone_____**

Address _____City _____Zip_____

Contact person _____Fax_____

ACUPUNCTURE INFORMATION AND INFORMED CONSENT (Effective 01/01/13)

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or reflexologist who now or in the future treat me while employed by, working or associated with the acupuncturist named below, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, cupping, electrical stimulation, reflexology and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist indicated below of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed of the risk and benefits of the procedures and products listed below that apply to my treatment: Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points. The use of mechanical, or electrical stimulation of acupuncture points, particularly in instance where such stimulation is applied across the midline of the trunk or in patients with a history of heart trouble, heat therapy, herbs, reflexology, and nutrition and food therapies.

I have been informed and understand the risks and side effect listed below:

Minor bruising; Minor burns or blistering; Pneumothorax ; Spontaneous miscarriage; Some pain at the site of the treatment.

Needle sickness; Broken Needles; Infection and the risks from needling in the vicinity of an infection.

Herbal allergies; Herbal sickness

RECORDS RELEASE AUTHORIZATION

I understand that I am responsible for my bill

I authorize the use of this form and other medical forms for all of my insurance submissions

I have read the NOTICE OF PRIVARY PRACTICES and authorize Lake Bluff Acupuncture, LLC to use or disclose my health information in the manner described in the NOTICE OF PRIVARY PRACTICES.

I direct my previous health care providers to release medical record to this clinic

Acupuncturist (signature) _____ Date_____

Patients' signature_____ Date_____

Consent to treat a minor child or disability:

I authorized _____and whomever she designates as assistants to administer Acupuncture care and Oriental Medicine as deemed necessary to my _____(relationship) Patient name_____.

Adults or Guardian's signature _____Date_____.

This document is for you to read and keep

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices when you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based upon Your Written Consent: You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, Lake Bluff Acupuncture will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by our employees and others that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to seek payment of your health care bills and to support the operation of Lake Bluff Acupuncture. Following are examples of the types of uses and disclosures of your protected health care information that Lake Bluff Acupuncture is permitted to make once you have signed our consent form. These examples are not meant to be exclusive, but to describe the types of uses and disclosures that may be made by Lake Bluff Acupuncture once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed , to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of Lake Bluff Acupuncture . These activities include, but are not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to consultants in our clinic; we may use a sign-in sheet at the registration desk where you will be asked to sign your name; we may also call you by name in the waiting room when we are ready to see you; we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment; we will share your protected health information with third party " business associates" that perform various activities (e.g., billing, transcription services) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization , at any time, in writing, except to the extent that Lake Bluff Acupuncture has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use an disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Lake Bluff Acupuncture may, using

professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Other Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosure to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we have attempted to obtain your consent but are unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if we attempt to obtain consent from you but unable to do so due to substantial communication barriers and we determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. in addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviation, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceeding: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to any order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), In certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime has occurred.

Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

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

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and Lake Bluff Acupuncture created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seg

2. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A" designated record set" contains medical and billing records and any other records that Lake Bluff Acupuncture use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of , or use in , a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact us if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must sate the specific restriction requested and to whom you want the restriction to apply. Lake Bluff Acupuncture is not required to agree to a restriction that you may request. If we believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking you for

information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to us.

You may have the right to have us amend your protected health information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact us to determine if you have questions about amending your medical record.

You have right to receive an accounting of certain disclosures we have made, if any, of your protected health information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family member or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice by reading it where it is posted or by receiving it electronically.

3. Complaints: you may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You may file a complaint with us by notifying us. We will not retaliate against you for filing a complaint.