Malibu Acupuncture & Herbs

Dear New Patient,

Welcome to Malibu Acupuncture & Herbs!

In order to better serve you, below are some reminders to prepare you for your first visit:

- Read, fill out and sign all pages included in this packet.
- If this packet was faxed, an original arbitration agreement form and informed consent will be given to you to sign at the time of arrival.
- Payment is expected at the time of service. New patient consultations are $85, acupuncture treatments are $110, and herbal formulas are approximately $25 per week.
- Payment in the form of cash, check, Visa, MasterCard and Discover are accepted.
- This office provides the option of billing insurance for a fee of 8% of the insurance reimbursement amount received. Alternatively, if you would rather submit a Superbill to your insurance, we will gladly provide it for you free of charge.
- There is parking in the brick lot behind our building. However, on busy days this lot may be full. There are several other lots in the area, and street parking on Cross Creek Road.
- Please allow approximately an hour and a half for your first visit and one hour for subsequent visits.
- Please write down all medications, vitamins, supplements and herbal formulas you have taken in the last 3 months in the space provided. Alternately, you can bring them with you for us to look at.
- Wear something comfortable and loose fitting, do not come too hungry or overly full and please refrain from wearing fragrances or brushing the coat off your tongue. A true picture of the body, including tongue diagnosis, is an integral part of diagnosis and can greatly influence your treatment.

We are looking forward to seeing you!

Sincerely,

Malibu Acupuncture & Herbs

Patient Information

Name: _____Birthdate: _____/_____/____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Employer/ School: _____ ☐Full Time ☐Part Time ☐Retired

Address: _____

Phone: _____Occupation: _____

Who may we thank for referring you? _____

Emergency contact: _____

Phone: _____ Relationship: _____

Office Policies

Late Cancellation/ Missed Appointments

We respect the fact that you may, on occasion, need to cancel an appointment. However, we do request 24 hours notice. Should you cancel an appointment without 24 hours notice, or not show up for a scheduled appointment, a charge equal to your last visit will be applied to your account.

Voluntary Termination of Care

If you suspend or terminate care at any time, your portion of all charges for professional services are immediately due and payable to this office. All outstanding charges are the responsibility of the patient.

Explanation of Insurance Coverage

Many insurance policies cover acupuncture care, but this office makes no representation that your insurance company does. Because of the variance in policies, we require that you, the patient, be personally responsible for the payment of your deductibles, and any unpaid balance to this office.

Payment Arrangements

Payment is due at the time of service, unless otherwise arranged. Balances will be billed monthly. Past due balances are subject to 2.5% interest charges each month.

Assignment of Benefits

I hereby authorize payment of medical benefits by insurance carrier, directly to Malibu Acupuncture & Herbs and/or Lauren Freiman, L.Ac. A photocopy of this signature is as valid as the original.

Release of Information

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

I have read and agree to the above.

_____ _____

Patient's Signature Date

MALIBU ACUPUNCTURE AND HERBS
23410 Civic Center Way, Suite E1 Malibu, CA 90265
Phone (310) 456-8811 Fax (310) 456-5881

Effective May 1, 2003

Malibu Acupuncture & Herbs

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

This notice will remain in effect until it is replaced or amended by changes in law.

B. We may use and disclose your PHI in the following ways:

1. Treatment. Our practice may use your PHI to treat you. We might use your PHI in order to write an herbal prescription, or we might disclose your PHI to another herbal pharmacy to order a prescription for you. People who work in this office, including but not limited to, acupuncturists, massage therapists and office assistants – may use or disclose your PHI to assist others in your treatment. Also, we may disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI to bill and collect payment for the services and items you receive from us.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI
   a. To contact you regarding appointment reminders,
   b. To send birthday cards, holiday cards or coupons (this office will not release your PHI to any other facility for marketing purposes without your written authorization),
   c. When required by law,
   d. In special circumstances (to report abuse or public health risks)

C. You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you in a particular manner or at a certain location.
2. Restrictions. You have the right to request a restriction in our use and disclosure of your PHI for treatment, payment or health care operations.
3. Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical and billing records.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete. For this, you must provide a reason that supports your request.
5. Accounting of Disclosures. You have the right to request a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. For example, the billing department using your information to file your insurance claim.
6. Privacy Notice. You have the right to a copy of this notice.
7. Complaints. You have the right to file a complaint if you believe your privacy rights have been violated. You may file your complaint with this office or the Secretary of the Department of Health and Human Services.
8. Authorization. Our office will obtain your written authorization for uses and disclosures not identified in this notice.

All requests must be made in writing to Lauren Freiman, L.Ac. at Malibu Acupuncture & Herbs, 23410 Civic Center Way Suite E1, Malibu, CA 90265 (310) 456-8811. Requests may be denied.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read, reviewed, understand and agree to the statement of the above Privacy Policy for healthcare services in this office.

_____ _____

Patient Signature Date

Patient Questionnaire

Present complaints:_____
_____
_____
_____

Your condition is due to: ☐ Accident ☐ Job injury ☐ Other
Please explain briefly: _____
_____
_____

Do you have a tendency to faint? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No
Do you bleed for a long time? ☐ Yes ☐ No
Have you ever had hepatitis? ☐ Yes ☐ No
Are you HIV positive? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
# of pregnancies:_____ # of children:_____ Ages:_____
Do you have occupational stress (chemical, physical, psychological, etc.)? ☐ Yes ☐ No
Please explain: _____
Do you have a regular exercise program? ☐ Yes ☐ No
Please describe: _____
How much of the following do you do per week?
Smoke cigarettes:_____ Drink coffee/ tea/ cola:_____ Drink alcohol:_____
Please describe your use of drugs for non-medical purposes: _____
Please list all vitamins, medications, and herbs you have taken in the last 3 months.
_____
_____
_____
Please list any injuries, surgeries, hospitalizations, major illnesses and date.
_____
_____
_____

Family Medical History

Please check any diseases that have been in your family,
And which family member was affected.

☐ Diabetes _____
☐ Cancer _____
☐ High blood pressure _____
☐ Heart disease _____
☐ Seizures _____
☐ Other: _____

☐ Asthma _____
☐ Allergies _____
☐ Orthopedic disease _____
☐ Rheumatology disorders _____
☐ Hereditary disease _____

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Patient Medical History

Please check symptoms you have experienced in the last 3 months.

General

- ☐ Chills
- ☐ Depression/ Anxiety
- ☐ Dizziness/ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Sweats

Musculo-Skeletal

(Pain, weakness, numbness)

- ☐ Arms
- ☐ Upper back
- ☐ Middle back
- ☐ Lower back
- ☐ Shoulders
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Feet
- ☐ Other_____

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Lack of bladder control
- ☐ Venereal disease
- ☐ Pain in genial area
- ☐ Decreased sex drive

Gastrointestinal

- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive appetite
- ☐ Decreased appetite
- ☐ Excessive thirst
- ☐ Nausea/ Vomiting
- ☐ Colitis/ Diverticulitis
- ☐ Belching
- ☐ Heartburn
- ☐ Bloating
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Rectal bleeding

Cardiovascular

- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Heart palpitations
- ☐ Dizziness
- ☐ Chest pain
- ☐ Chest oppression
- ☐ Leg cramps

Respiratory

- ☐ Cough
- ☐ Cough up blood
- ☐ Sore throats
- ☐ Nasal problems
- ☐ Nose bleed
- ☐ Asthma or wheezing
- ☐ Pneumonia
- ☐ Hayfever
- ☐ Bronchitis

Skin

- ☐ Boils
- ☐ Rash
- ☐ Edema
- ☐ Itchiness
- ☐ Acne

Males Only

- ☐ Prostate problems
- ☐ Pain in testicle
- ☐ Cold in genital area
- ☐ Impotence

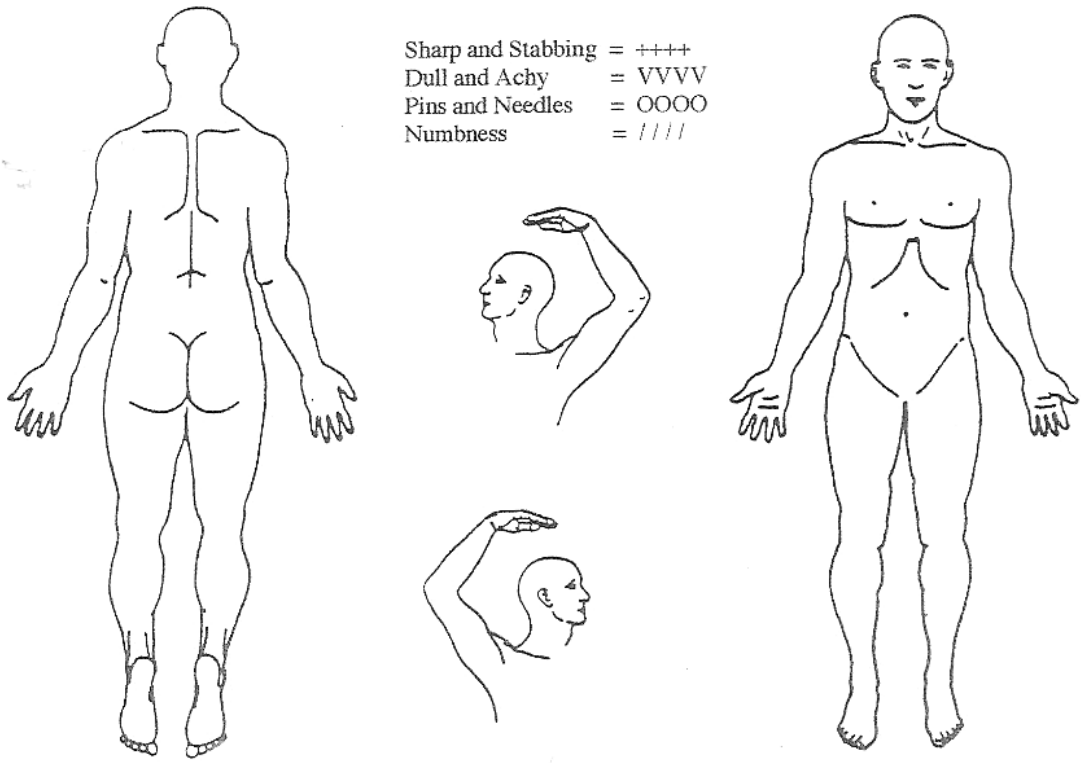
Females Only

- ☐ Pre-menstrual pain
- ☐ Menstrual pain
- ☐ Irregular cycle
- ☐ Breast swelling/pain
- ☐ Mood swings

Miscellaneous

- ☐ Jaundice
- ☐ Hepatitis
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Sensitivity to weather changes
- ☐ Kidney stones

Please indicate the appropriate location of pain and mark with the symbol that best describes the discomfort you are presently experiencing.



Please circle the appropriate number to describe your present pain level.
Check "C" for constant pain and "I" for intermittent pain.

Area of pain	Normal	Mild pain	Moderate pain	Severe pain	C	I
Neck	0 1	2 3 4	5 6 7	8 9 10		
Middle back	0 1	2 3 4	5 6 7	8 9 10		
Lower back	0 1	2 3 4	5 6 7	8 9 10		
Hip(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10		
Shoulder(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10		
Arm(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10		
Leg(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10		
Headaches	0 1	2 3 4	5 6 7	8 9 10		
Other:	0 1	2 3 4	5 6 7	8 9 10		
Other:	0 1	2 3 4	5 6 7	8 9 10		
Other:	0 1	2 3 4	5 6 7	8 9 10		

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