Hollenbach Family Chiropractic
250 Main Street
Madison, NJ 07949

ACUPUNCTURE OFFICE POLICIES

Patient Name: ___________________________ **Patient Date of Birth: ___________________**

Appointments and Scheduling

- Treatments are by appointment only. Emergency appointments are available if there is time in the schedule. Please call.
- Please be on time for appointments. Unfortunately, because the schedule is often tight, your treatment time may be shortened if you arrive late.
- We value the time we have set aside to see and treat you and/or your child. If you are not available to keep an appointment, we require 24-hour notice. There is a charge of $50.00 for same day cancellations unless specifically waived by our office.
- Credit card information will be collected at the time of first appointment.

Financial Responsibility

- The fee for acupuncture is $150 for an initial evaluation and treatment, which typically lasts 1 to 1.5 hours, and $100 for each subsequent treatment, which typically lasts 45 minutes to 1 hour. Rates are subject to change with notification.
- If your treatment is not covered by insurance, payment in full is expected from you at the time of your visit, unless other arrangements have been made in advance.
- If previous arrangements have *not* been made with our office, any account balance outstanding longer than 90 days will be forwarded to a collection agency.
- For scheduled appointments, prior balances must be paid prior to the visit.
- A $50.00 fee will be charged for any checks returned for insufficient funds.
- We accept all types of credit cards.

Acknowledgement of Receipt of Notice of Privacy Practices

- I acknowledge receipt of a Notice of Privacy Practices from the practitioner
- I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

Authorization to Leave Messages in my Absence

- I give the practitioner or its proxy permission to leave a message on my answering machine or addressed to my email regarding appointments or other administrative concerns, in my absence. We will not leave a message with protected health information.

I have read and understand the above policies, and I agree in full to these terms.

Responsible Party's Name/Relationship: _____________________________

Responsible Party's Signature: _____________________________________ **Date: _______________**

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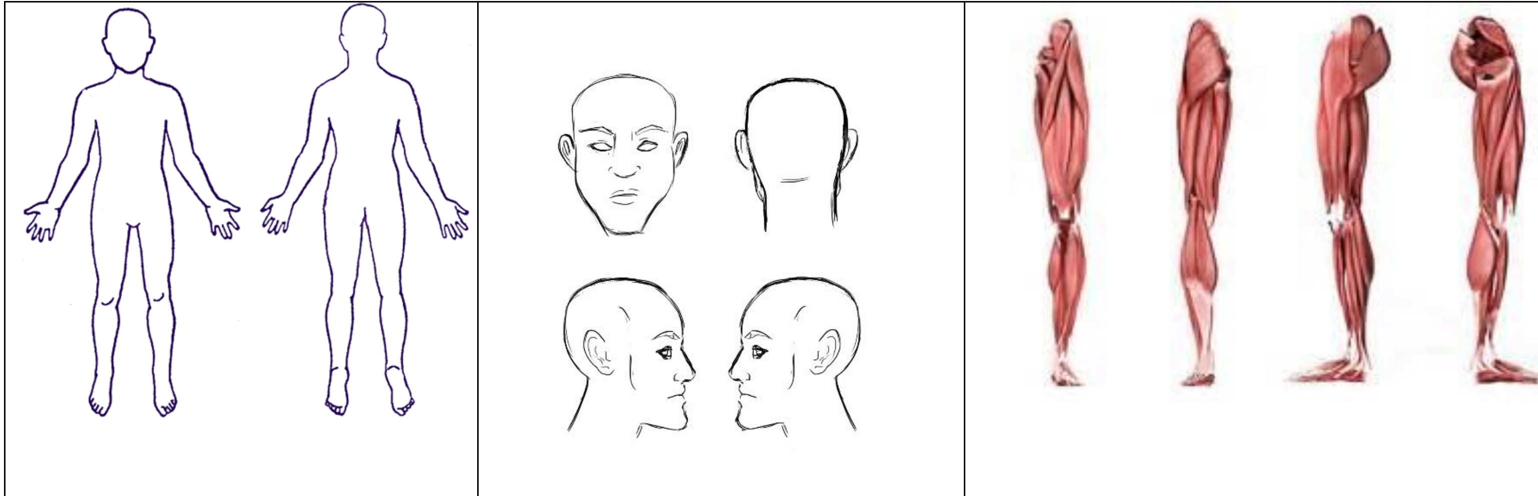
Initial Acupuncture Health History Form

Name		
Address	City	
State	Zip Code	
Age	Height	Weight
Home Phone	Cell Phone	
Date of Birth		
Occupation	Marital Status	
Email		
Emergency Contact Name		
Emergency Contact Telephone #		
Family Physician		
Insurance Carrier	Policy Number	

CHIEF COMPLAINTS:
Does this problem affect your daily activities? (work, sleep and eating, etc.)
How long have you had this condition?
Have you been diagnosed for the problem by a physician? If yes, what is the diagnosis?
If yes, please provide physician's name and telephone.
Is the condition relieved by medication/treatment/rest/other?
What makes the condition worse? Exacerbated by moving/standing/walking/lying down/other?

Please Mark Painful or Distressed Areas Below



Medical History

What medications are you taking and for what conditions?

Medication/Year	Condition

Major Surgeries and Hospitalizations, please list most recent first.

Year	Operations/Hospitalizations

Please list diagnostic tests done. (MRI, CT Scan, XRAYS. Etc.)

Do you have any of the following? Please circle.

Pace Maker   Surgical Implants   Bleeding Disorders

Are you allergic to any of the following? Please circle.

Medicine   Food   Herbs   Latex   Others

Please check off if you have the following conditions:

Cancer	**Birth Trauma**
Seizures	**Hepatitis**
High Blood Pressure	**Heart Disease**
Low Blood Pressure	**Diabetes**
Rheumatic Fever	**Venereal Disease**
Thyroid Disease	**Asthma**
Stroke	**Other**

Lifestyle

Do you smoke? If yes, how many packs a day?	
Do you drink coffee or tea? If yes, how many cups a day?	
Do you drink alcohol? If yes, how many drinks do you have per day?	Per week?
Do you use recreational drugs? If yes, what?	
Do you have dietary restrictions? If yes, what?	
Do you have food cravings? If yes, what?	
Do you take vitamins or herbs? If yes, what?	
Do you have problems with sleeping?	
What are your sleeping patterns?	
What is your exercise routine?	
What leisure activities do you enjoy doing?	

Family History: please write down: self, mother, father, sibling, spouse, child

Allergies	Asthma
Cancer	Migraine
Diabetes	Arthritis
Blood/Bleeding Disorder	Anemia
High Blood Pressure	Heart Disease
Strokes	Seizure/Epilepsy
Depression	Mental Illness
Glaucoma	Hepatitis
Gall Stones	Kidney Disorders
Parkinson's Disease	Thyroid Disorders
Other	

PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN **THE LAST THREE MONTHS.**

GENERAL		
☐ Poor Appetite	☐ Weight Gain	☐ Night Sweats
☐ Insomnia	☐ Weight Loss	☐ Fever
☐ Disturbed Sleep	☐ Changes in Appetite	☐ Chills
☐ Localized Weakness	☐ Sweating Easily	☐ Sudden Energy Drop
☐ Cravings	☐ Tremors	☐ Strong Thirst
☐ Bleeding	☐ Bruising Easily	☐ Poor Balance

SKIN AND HAIR		
☐ Rashes	☐ Eczema	☐ Recent Moles
☐ Ulcerations	☐ Pimples	☐ Changes in Texture of Hair
☐ Hives	☐ Dandruff	☐ Changes in Texture of Skin
☐ Hair Loss	☐ Acne	☐ Itching

HEAD, EYES, EARS, NOSE, THROAT		
☐ Dizziness	☐ Color Blindness	☐ Recurrent Sore Throats
☐ Concussions	☐ Cataracts	☐ Nose Bleeds
☐ Migraines	☐ Blurry Vision	☐ Grinding Teeth

Glasses	Earaches	Sores On Lips Or Tongue
Spots In Front Of Eyes	Ringing In Ears	Facial Pain
Eye Pain	Poor Hearing	Teeth Problems
Poor Vision	Eye Strain	Headaches
Night Blindness	Sinus Problems	Jaw Clicks

CARDIOVASCULAR		
Dizziness	High Blood Pressure	Swelling Of Feet
Low Blood Pressure	Fainting	Blood Clots
Chest Pain	Cold Hands Or Feet	Difficulty In Breathing
Irregular Heartbeat	Swelling Of Hands	Phlebitis

RESPIRATORY		
Cough	Bronchitis	Excessive Phlegm
Coughing Up Blood	Pain With Deep Inhalation	Asthma
Pneumonia	Difficulty Breathing When Lying Down	

DIGESTIVE		
Nausea	Belching	Rectal Pain
Vomiting	Black Stools	Hemorrhoids
Diarrhea	Blood In Stools	Abdominal Pain or Cramps
Constipation	Indigestion	Chronic Laxative Use
Gas	Bad Breath	

GENITOURINARY		
Pain On Urination	Urgency To Urinate	Decrease In Flow
Frequent Urination	Unable To Hold Urine	Impotence
Blood In Urine	Kidney Stones	Sores On Genitals
Urge To Void At Night	Elevated PSA	

Any particular color to your urine?____

GYNECOLOGIC		
Premenstrual Changes	Heavy Menstrual Flow	Premature Births
Menstrual Clots	Light Menstrual Flow	Miscarriages
Painful Menses	Irregular Menses	Unusual Menses
Abortions	Ovarian Cysts	Fibroids

Age of first menses: ____ Age at menopause: ____

Time between cycles: ____ Duration of bleeding: ____

First day of last menses: ____ Number of pregnancies: _____ Number of live births:________

Do you practice birth control, if so what and how long? _______________________________________

Other gynecologic problems? ____

ARE YOU PREGNANT: YES ☐ NO ☐

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

NEUROPSYCHOLOGICAL		
Seizures	Poor Memory	Anxiety
Dizziness	Lack Of Coordination	Bad Temper
Loss Of Balance	Concussion	Susceptible To Stress
Areas Of Numbness	Depression	

Have you ever been treated for emotional problems? ____

Have you ever considered or attempted suicide? ____

Any other neurological or psychological problems? ____

Please list any other problems you would like to discuss?

____

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ACUPUNCTURE INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to the performance of acupuncture and other related treatments and procedures on me or my son/daughter (name) ______________________
who is currently under my legal guardianship by the practitioner now and in the future.

I understand that acupuncture and related treatments and procedures may include, but are not limited to, needle acupuncture, acupressure, moxabustion, heat therapy, electric stimulation and the use of lasers, magnets or metal beads to stimulate acupuncture points. I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including but not limited to bruising, numbness at the needle site, dizziness and fainting. Moxabustion and the use of heat therapies may in rare instances cause burning and scarring. I understand that although it is rare, acupuncture during pregnancy can result in induction of premature labor. I will notify a staff member if I become or suspect I or my legal minor am/are pregnant. I will also notify a staff member of any drugs (medicinal or recreational) and supplements I or my legal minor am/are taking and if there has been any change to them. I understand that I may choose to stop the treatment at any time at my discretion. I will immediately notify a staff member of any unanticipated or unpleasant effects of my treatment. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand results cannot be guaranteed.

I understand the practitioner clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand that the practitioner may from time to time send me information via mail or e-mail but that my name and contact information will never be released to any business or organization.

By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my or my legal minor's present condition and for any future condition(s) for which I seek treatment.

____

Patient Signature Date Relation To Patient If Not Self

____

Practitioner Date

NOTICE OF PRIVACY PRACTICES
FOR PROTECED HEALTH INFORMATION

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

I, ____ have read and understand these guidelines above.

Patient Signature: ____

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal policy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Hollenbach.

This notice is effective as of ____________________________________. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____	____	________________________
Name (Please Print)	Signature	Date

If you are a minor or if you are being represented by another party:

____	____	________________________
Personal Representative Name	Personal Representative Signature	Date

____
Description of the authority to act on behalf of the patient.