Blue Lotus Acupuncture Center, LLC

New Patient Questionnaire

Name _____ Date _____

Male _____ Female ____ Height _____ Weight _____ Marital Status _____

Occupation _____ Referred by _____

Emergency Contact – Name _____

and Phone Number _____

Reason for Your Visit _____

Who is Your Physician? _____ Phone _____

Current Medications, Vitamins, Herbs _____

Medical History

Check all of the following conditions you currently have or have had in the past:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart PX
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ MS
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Surgeries _____
  _____
  _____
  _____
- ☐ Thyroid Disorder
- ☐ Major Trauma (car, fall, etc.)
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (specify)
  _____
  _____

Blue Lotus Acupuncture Center, LLC

Anna Pantuso-Plenzick, D.O.M., L.Om.
Kimberly Niezgoda, M.Ac., L.Ac.
954 Town Center
Doylestown, PA 18901
Phone 215-348-7393
Fax 215-348-7394

Consent for Acupuncture and/or Chinese Herbs

Name _____ Birth Date _____ Age _____

Street Address _____

City _____ State _____ Zip _____

Telephone - Home _____ Work _____

Cell Phone Number _____ E-Mail _____

Would you like to receive the Blue Lotus e-newsletter? Yes ___ No ___

Have you ever received Acupuncture or Chinese Herbs before? Yes ___ No ___

Consent for Acupuncture/Herbs Treatment

I, the undersigned, understand that Traditional Chinese Medicine (TCM) to involve the use of needles, herbs, acupressure, massage therapy, nutritional, and diet counseling. The risks, although limited, include the following: Puncturing organs in the abdomen or chest cavities. Some herbs should not be used by pregnant women. TCM may affect people on many levels: physical, emotional, mental, and/or spiritual because it works with the whole body to create harmony and balance. The duration of treatment varies person to person depending on the specific illness and the individual's constitution. I fully understand there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments.

_____

Signature (Parent or Guardian, if under 18)

_____

Date

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Complementary Therapy Form **Date:**_____

Patient Section:

I, _____, give authorization for release of my medical information, if requested by the acupuncture office of Blue Lotus Acupuncture Center.

Name:_____DOB:_____

Signature:_____

Acupuncturist Section:

Signature_____

Physician's Section:

Signature:_____

Any recent
diagnosis:_____

_____ Patient does not have a recent diagnosis (Please check if this is the case). In this instance, the person will be receiving acupuncture for overall well being and prevention.

Any comments:

Fax to: Blue Lotus Acupuncture Center, LLC at 215-348-7394

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We take your Acupuncture Care very seriously, as we know you do. It should be understood that appointments are valuable and missing your scheduled appointment without twenty-four hour (24 hour) notice, or at least a phone call will not be accepted.

This policy stems from an increase in patient non-compliance with scheduled appointments coupled with the overall rising costs and liability associated with providing Quality Acupuncture Care.

Therefore, we have implemented a twenty-five dollar ($25.00) "NO CALL/NO SHOW" Policy. If you are a "No Call/No Show" for a scheduled appointment, you will be charged $25.00. The charge must be paid prior to being treated again at Blue Lotus Acupuncture Center.

Thank you for your understanding regarding this policy.

I, _____, have read and understand the above mentioned policy.

_____ _____
Signature or Signature of Parent if a minor Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____
Patient Name (Please Print)

_____
Patient or Authorized Representative (If applicable)

_____ _____

Signature Date

Blue Lotus Acupuncture Center
954 Town Center, Doylestown, PA 18901
Notice of Privacy Practices

HIPAA, The Health Insurance Portability and Accountability Act of 1996, established rights and protections for healthcare consumers and created responsibilities for healthcare providers.

The HIPPA Privacy Rule of April 14, 2001 requires healthcare providers to implement administrative, technical, and physical safeguards to ensure the security of your individually identifiable health information that we collect to conduct our business.

The following is informing you of the implementation of these Privacy Policies in our Faculty. You will be asked to sign a **Patient Acknowledgement of Privacy Policies** for our records when you have finished reading this notice. You are entitled to a copy of this notice.

Information We Collect to Conduct our Business.
On your initial visit, we ask you to sign an **Acupuncture Consent Form,** and complete a written **Confidential Patient Information Sheet** concerning your health history and other relevant personal data.

Each time you visit the center for your acupuncture treatment a written record of your session is made in our **Acupuncture Progress Notes**. This contains results of your Verbal and Physical Assessment, Acupuncture Diagnosis, Acupuncture Treatment (including acupuncture points or adjunct tools used), and any Recommendations or Referrals.

The Commonwealth of Pennsylvania regulations governing acupuncture include:

1) *A person may be treated by a licensed acupuncturist for a specific condition up to 60 days without a medical diagnosis or physician referral.*
2) *After 60 days, the patient must obtain a medical diagnosis from a physician to continue treatment.*
3) *A patient may be treated for a new condition for up to 60 days without a medical diagnosis or physician referral.*

Therefore, any data we collect from your physician in compliance with this regulation will be placed in your chart. The request for this information may be faxed to your physician's office in our **Complimentary Therapy Agreement Form.** These facsimile transmissions are safeguarded to protect your privacy. The above forms are placed in your own individual and complete confidential file contained in a locked cabinet in a secure room with access by Blue Lotus staff only.

Other data that may be requested throughout your course of treatment, such as **Laboratory or Medical Test Results,** may also be kept in this file.
Any correspondence we receive from medical or acupuncture consultations and/or attorneys will also be placed in your own individual confidential file.

We collect your full payment for each acupuncture treatment upon each visit. Your name and check number are written on a form each day by the receptionist in the secure receptionist area accessible only by Blue Lotus Staff. This is placed in a locked box, and opened by the Financial Officer in a secure area. We do not share any information via electronic mail with any insurance company or bill-collecting agency.

You have the right to decide whom and for how long anyone else may have a copy of our records. You must sign an **Authorization for Release of Health Information** with specific indication of the information that we have collected that you want released. You must also sign the accompanying **Individual Rights Relating to This Authorization Form** indicating how long your authorization is valid.

We do request the right to call you at phone numbers you have given us for the sole purpose of making appointments, notifying you of hour changes or cancellations due to inclement weather; or to inquire about your health status between treatments. We request the right to leave messages on these numbers. If you do not want us to provide this service, please indicate such on the **Patient Acknowledgement of Privacy Policies Form**.

We request the right to mail you information concerning marketing materials, notice of Blue Lotus events, or other materials to the address that you have provided us with. If you do not want us to provide this service, please indicate such in writing on the **Patient Acknowledgement of Privacy Policies Form.**

We do not share your health information with any family member without your written consent. We do request the right to call a family member, at the number you have provided us with, for emergencies, should one occur while you are in our care.

Currently use both a paper and a computerized appointment schedule. They can only be viewed only by Blue Lotus staff, and accessed only for the purpose of maintaining an accurate schedule.

Exceptions to your written authorization

HIPPA explicitly allows disclosure of patient health information without consent for the following situations: emergency circumstances, identification of the body of a deceased person or the cause of death, public health needs, research, oversight of the healthcare system, judicial and administrative proceedings, limited law enforcement activities, and activities related to national defense and security.

Complaints about your privacy rights or how your privacy is handled at this office can be directed to:

DHHS (Office of Civil Rights)
200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC 20201