Revolution Acupuncture and Herbal Clinic

331 N. Wood Dale Rd, Wood Dale, IL 60191
Phone: 630.422.5232
www.revolutionah.com
revolutionah@gmail.com

PATIENT CONFIDENTIAL INFORMATION

Patient Name: _____ Age: _____ Birth Date: ___/___/___ Gender: M/F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (H) _____ (W) _____ (C) _____

Email Address: _____ Occupation: _____

Marital Status: M S W D Height: _____ Weight: _____

Your family Physician/heath care provider: _____ Phone: _____

Who referred you to us? _____

In an emergency notify: Name: _____

Phone: _____ Relationship to you _____

Main conditions you would like us to help you with? _____

_____

How long have you had this problem? _____Caused by _____

Have you been given a diagnosis for this problem? If so, what is it? _____

_____

What kinds of treatment have you tried for the problem? _____

_____ How long? _____

Effectiveness: _____

Please list current medications you are taking _____

Any allergies to medications _____

Signature: _____ Date: _____
Patient/Representative

Permission to treat a minor
As legal guardian of the named child, _____,
I give permission for this person to receive treatment and be examined at the clinic.

Signed,

_____
(Parent or Legal Guardian)

Personal Medical History

1: Significant Illnesses

a. Cancer
b. Hepatitis
c. HIV (AIDS)
d. Allergies
e. Asthma
f. Seizures
g. Heart Disease
h. Weight Problem
i. Tuberculosis
j. Herpes
k. Diabetes
l. Thyroid Disease
m. Venereal Disease
n. Addictive Disorders
o. High Blood Pressure
p. Rheumatic Fever
q. Stroke
r. Mental Illness
s. Other: _____

Please check if you have experienced any of the following in the last 3 months.

2: General

a. Poor Appetite
b. Fevers
c. Fatigue
d. Tremors
e. Cravings
f. Headaches
g. Localized Weakness
h. Insomnia
i. Strong Thirst
j. Poor Balance
k. Chills
l. Sudden Energy Drop
m. Peculiar Tastes or Smells
n. Bleeding
o Weight Loss
p Weight Gain
q. Joint Pain
r. Hearing Loss
s. Sweat Easily
t. Change in Appetite
u. Night Sweats
v. Depression
w. Emotional Changes
x. Bruising Easily

3: Skin & Hair

a. Rashes
b. Eczema
c. Recent Moles
d. Itching
e. Hair Loss
f. Change in Hair Texture
g. Change in Skin Texture
h. Dandruff
i. Hives
j. Ulcers
k. Acne
l. Psoriasis

4: ENT + Head & Eyes (HEENT)

a. Dizziness
b. Ringing in Ears
c. Gum Problems
d. Night Blindness
e. Facial Pain
f. Color Blindness
g. Eye Pain
h. Glasses
i. Sinus Problems
j. Headaches
k. Blurred Vision
l. Jaw Click
m. Earaches
n. Glaucoma
o. Poor Vision
p. Cataracts
q. Concussion
r. Poor Hearing
s. Migraine
t. Eye Strain
u. Teeth Grinding
v. Floaters
w. Spots in front of Eyes
x. Nose Bleeds
y. Recurrent Sore Throat
z. Sores on Lips
zz. Mouth Ulcers
zzz. Toothache

5: Respiratory:

a. Cough
b. Wheezing
c. Coughing Blood
d. Bronchitis
e. Phlegm
f. Asthma
g. Shortness of Breath
h. Easily Winded
i. Painful Breathing

6: Cardiovascular

a. Blood Clots
b. Phlebitis
c. Chest Pain
d. Fainting
e. Dizziness
f. Swelling of Feet
g. Cold Hands or Feet
h. Swelling of Hands
i. Irregular Heartbeat
j. Low Blood Pressure
k. Shortness of Breath
l. Difficult Breathing

7: Gastrointestinal

a. Nausea
b. Belching
c. Diarrhea
d. Indigestion
e. Bloating
f. Constipation
g. Hemorrhoids
h. Parasites
i. Blood in Stools
j. Black Stools
k. Bad Breath
l. Intestinal Gas
m. Abdominal Pain
n. Vomiting
o. Gastric Ulcers

8: Genito/Urinary

a. Painful Urination
b. Blood in Urine
c. Genital Sores
d. Urgent Urination
e. Impotence
f. Kidney Stones
g. Scanty Urination
h. Unable to Hold Urine
i. Discolored Urine
j. Frequent Urination
k. Frequent Night Urination

9: Gynecology & Pregnancy (females only)

a. Irregular period
b. Clots
c. Light Flow
d. Heavy Flow
e. PMS
f. Duration of Flow _____
g. Painful Periods
h. Age of First Menses ____
i. Date of Last Menses _____
j. Last PAP _____
k. # of Pregnancies____
l. # of Births____
m. # of Miscarriages ____
n. # of Abortions____
o. # of Premature Births
p. Difficult Births _____
q. Fertility Problems
r. Breast Lumps
s. Vaginal Discharge
t. Vaginal Sores

10: Neuro-Psychological

a. Seizures	e. Areas of Numbness	i. Concussion	m. Loss of Balance
b. Dizziness	f. Lack of Coordination	j. Depression	n. Mood Swings
c. Stress	g. Poor Memory	k. Anxiety	o. Irritability
d. Disorientation	h. Migraines	l. Easily Angered	p. Headache

Have you ever received psychiatric treatments? _____

Have you ever considered or attempted suicide? _____

Any other problems you would like us to be aware of? _____

_____

Possibility of pregnancy or are you pregnant? _____

Any presence of biomedical devices, such as artificial joints or cardiac pacemaker? _____

Any history of use of tobacco, alcohol, caffeine and recreational drugs _____

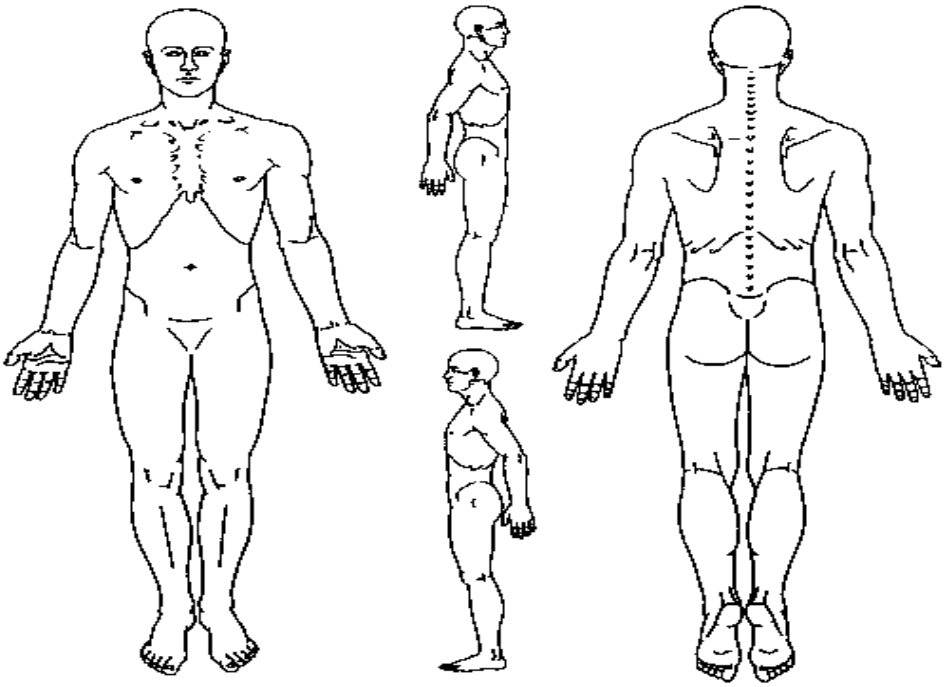
11: Musculo-Skeletal

a. Neck Pain	e. Back Pain	i. Joint Pain	m. Muscle Spasms	q. Hand/Wrist Pain
b. Scoliosis	f. Shoulder Pain	j. Knee Pain	n. Muscle Cramping	
c. Hip Pain	g. Arthritis	k. Muscle Weakness	o. Muscle Soreness	
d. Recent Sprains	h. Weak Joints	l. Injuries	p. Foot/Ankle Pain	

PAIN DIAGRAM

How long have you had pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE	**P**= PINS & NEEDLES	**B** = BURNING
S = STABBING	**N** = NUMBNESS	**O** = OTHER

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(a) Treatments shall be given in surroundings that provide privacy and confidentiality.
(b) Every acupuncture office shall be maintained in a clean and sanitary condition at all times, and shall have a readily accessible bathroom facility.
(c) OSHA Standards for Blood Borne Pathogens shall be met.

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom **I** am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the near future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss, with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture.

I understand and informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks to treatment, including, but not limited to, nausea, a punctured lung, and infection.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complication, and **I** wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the' acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I have read, or have read to me, the above consent **I** have also had an opportunity to ask question about its, content, and by signing below **I** agree to the above-named procedures. **I** intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which **I** seek treatment.

To be completed by patient:

_____

Print Patient Name

_____ _____

Patient's Signature Date

To be completed by patient's representative,

(If the patient is a minor or physically or legally incapacitated)

_____

Print name of patient's representative

_____

Signature of patient's representative Date

_____

Relationship of representative to patient

Revolution Acupuncture and Herbal Clinic of Nann Lang, L.Ac.

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Nann Lang, L.Ac.

Legal Responsibilities of Nann Lang, L.Ac.
As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure

may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.
Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whoever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.81 per page for the first 30 pages and $0.67 for every page after that plus $17.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a 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 at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404) 562-7886

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ACKNOWLEDGMENT OF RECEIPT of the Notice of Privacy Practices

I acknowledge that I have received or been offered the Notice of Privacy Practices

_____

Name of Patient

_____

Signature of Patient or Personal Representative

_____

Name of Personal Representative

_____/_____/_____

Date

If Personal Representative, indicate relationship: _____

Declinations

_____ The Individual declined to accept a copy of the Notice of Privacy Practices.

_____ The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgment of Receipt.

_____ _____

Date Signature of Acupuncturist

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

PATIENT SIGNATURE	**X**	(Date)
(Or Representative)		(Indicate relationship if signing for patient)

OFFICE SIGNATURE	**X**	(Date)