Clinic Registration

General Information

NAME: _____ DATE: _____

DATE OF BIRTH:_____AGE:_____SEX: Male Female

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ HOME/CELL PHONE:_____

WORK PHONE:_____ EMAIL ADDRESS:_____

HEIGHT:_____ WEIGHT:_____

Emergency Contact Name:_____ Relationship:_____ Phone Number:_____

Do you have insurance coverage that you would like to submit? No Yes Insurance Company Name:

Has the patient had an acupuncture/massage (circle) treatment before? No Yes If so, when and for what condition?

Is the patient presently under a doctor's care? No Yes , Explain:

Are there any other therapies which the patient is receiving services? No Yes, Explain:

Demographics

What is the patient's marital status? (Please check most current status)
☐ ……Married or living with significant other
☐ ……Divorced/Separated
☐ ……Widowed
☐ ……Never been married
☐ ……..Declined to disclose

How much schooling has the patient completed? (Please check one)
☐ ……Completed less than high school
☐ ……Graduated from High School
☐ ……Completed 1-3 years of college
☐ ……Graduated from a 2-year Associate degree program or technical school
☐ ……Graduated from college
☐ ……Completed post-graduate or professional program
☐……..Declined to disclose

Please identify the patient's race, as defined by the federal government. (Please check one)
☐ ……Asian or Pacific Islander
☐ ……Black/African American
☐ ……Hispanic
☐ ……American Indian or Alaskan Native
☐ ……White
☐ ……Other _____
☐…… Declined to disclose

Primary Reason for Visit

Please tell us what the patient's primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

Is it constant or comes and goes?

What makes it better?

What makes it worse?
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Stretching ☐Other:

This problem interferes with the patient's following daily activities?
☐Work ☐Daily routine ☐Emotional ☐Recreation ☐ Social life ☐ Relationship ☐Sleep

What services has the patient received for this condition?

Is the patient interested in?
☐Pain Relief ☐Preventative Care ☐Oriental Nutrition ☐Maintenance Care ☐Stress Relief

What are the patient's health goals?

Family Health History: Do/did any members of the patient's immediate family (mother, father, sister, brother) have any serious health conditions?
No
Yes, Please describe your relation to this individual and their condition(s)

Surgical History: Please list any surgeries the patient has had in the past and dates:

Injury History: Please list any auto, workman's compensation, or other injury or trauma with date and descriptions.

Medications, allergies, over the counter drugs or vitamins, or special diets the patient is currently taking: (Include dose, purpose and if prescribed)

Infectious Diseases and Vaccine History:

Please indicate if the patient has had the following diseases and/or vaccinated for these diseases.

Chicken Pox	Yes	No	Vaccinated	Rotavirus	Yes	No	Vaccinated
Diphtheria	Yes	No	Vaccinated	Rubella	Yes	No	Vaccinated
Haemophilus Inf. Type B	Yes	No	Vaccinated	STD	Yes	No	Vaccinated.
Hepatitis B	Yes	No	Vaccinated	Small Pox	Yes	No	Vaccinated
Measles	Yes	No	Vaccinated	Tetanus	Yes	No	Vaccinated
Mumps	Yes	No	Vaccinated	Whooping Cough	Yes	No	Vaccinated
Polio	Yes	No	Vaccinated	Other:			
Pneumoncoccal	Yes	No	Vaccinated				

Health History

Please list or check any health problems the patient currently has or has had. Answer to the best of your knowledge.

Chronic or Acute Infectious Diseases
- ☐ Hepatitis
- ☐ HIV
- ☐ Chills
- ☐ Fever
- ☐ Sore throat
- ☐ Low energy/fatigue
- ☐ Spontaneous sweating
- ☐ Night sweating
- ☐ No sweating
- ☐ Aversion to heat/cold
- ☐ Frequent colds
- ☐ Growth disorder

Heart, Lung and Circulation
- ☐ Asthma
- ☐ High blood pressure
- ☐ Previous heart attack
- ☐ Chest pain
- ☐ Palpitation
- ☐ Irregular heartbeat
- ☐ Stuffiness in the chest
- ☐ Low blood pressure
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Varicose veins

Digestion
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Acid reflux
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Excess thirst
- ☐ Tired after eating
- ☐ Mouth or tongue sore
- ☐ Stomachaches
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Gas
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Recent change in number or consistency of bowel movements

Psychosocial
- ☐ Depression
- ☐ Anxiety
- ☐ Violence toward self/others
- ☐ Forgetfulness
- ☐ Poor memory
- ☐ Trouble concentrating
- ☐ Stress
- ☐ Irritability
- ☐ Easy to anger
- ☐ Sadness
- ☐ Crying
- ☐ Much fear

Skeleton and Joint Problems

S=Sharp Pain/stabbing
D=Dull Pain
N=Numbness
T=Tingling
R=Refers pain
A=Aching pain
B=Burning pain
- ☐ Head
- ☐ Neck
- ☐ Shoulder
- ☐ Upper back
- ☐ Arm
- ☐ Hand/finger
- ☐ Lower back
- ☐ Hips
- ☐ Leg
- ☐ Knee
- ☐ Feet/toe
- ☐ Stiffness
- ☐ Numbness
- ☐
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ General weakness
- ☐ Swelling of joints

Genitourinary
- ☐ Difficult or painful urination
- ☐ Kidney stones
- ☐ Cloudy urine
- ☐ Dark or scanty urine
- ☐ Dilute urine
- ☐ Scant urine
- ☐ Burning urination
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Nervous system
- ☐ Headaches
- ☐ Migraine
- ☐ Dizziness
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Fainting
- ☐ Seizures
- ☐ Convulsions
- ☐ Paralysis
- ☐ Tics
- ☐ Tremors
- ☐ Balance issues
- ☐ Recent clumsiness
- ☐ Vertigo

Eyes, ears, nose and throat
- ☐ Loss of vision or hearing
- ☐ Ringing in ear
- ☐ Severe dental problems
- ☐ Vision problems
- ☐ Ear problems
- ☐ Ear infections
- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Allergies
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ TMJ
- ☐ Teeth grinding
- ☐ Teeth problems
- ☐ Cough
- ☐ Itchy or scratch throat
- ☐ Sore or painful throat
- ☐ Strep throat
- ☐ Vision see halos

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Moles that have changed
- ☐ Dry skin
- ☐ Itchiness
- ☐ Rashes/hives
- ☐ Eczema
- ☐ Bruises easily
- ☐ Acne
- ☐ Brittle nails
- ☐ Dry or brittle hair

Chronic immune system deficiencies
- ☐ Cold
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes

Sleep
- ☐ Insomnia
- ☐ Difficult falling asleep
- ☐ Waking at night
- ☐ Waking early
- ☐ Excessive or vivid dreams
- ☐ Night terrors
- ☐ Sweating at night

Exercise and Body weight
- ☐ Exercise regularly
- ☐ Exercise excessively
- ☐ Underweight
- ☐ Normal weight
- ☐ Over weight

Eating and Health habits
- ☐ Vegetarian
- ☐ Health diet
- ☐ Craves fried foods
- ☐ Craves sour foods
- ☐ Craves sweet food
- ☐ Craves salty food
- ☐ Prefer warm/cold
- ☐ Food allergies
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Drink pop/soda
- ☐ High Stress level
- ☐ Exercises regularly

Female health
- ☐ Heavy period
- ☐ Light period
- ☐ Long period
- ☐ Short period
- ☐ No period
- ☐ Irregular periods
- ☐ Bleed between period
- ☐ Painful periods
- ☐ Vaginal pain
- ☐ Painful sexual intercourse
- ☐ Pain during ovulation
- ☐ Premenstrual symptoms
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal sores
- ☐ Urinary tract infection
- ☐ Candida/yeast infection
- ☐ Use of contraceptive
- ☐ Prolapse uterus/bladder
- ☐ Low sexual energy
- ☐ High sexual energy
- ☐ C-section delivery of children
- ☐ Difficult labors
- ☐ Premenopausal
- ☐ Menopause
- ☐ Pregnant/Trying to get pregnant

Age of first menstrual period:
Date of last menstrual period:
Days of cycle:
Length of period:
Number of pregnancies:
Number of miscarriages:
Number of abortions:
Number of children:

Male Health
- ☐ Impotence
- ☐ Hernia
- ☐ Genital pain
- ☐ Genital itching
- ☐ Genital sores
- ☐ Low sexual energy
- ☐ High sexual energy
- ☐ Gout/foot fungus

Bonnie M. Abel Bolash, M.Ac., L.Ac.

4060 Hampshire Ave. N. 221 1ST Ave. NE.
Crystal, MN 55427 Osseo, MN 55369
763-537-4955

Informed Consent for Treatment

I understand that Acupuncture practice is a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Its treatment techniques include the insertion of acupuncture needles through the skin and the use of other methods of acupuncture point stimulation, including the use of heat, Oriental massage, and electrical stimulation. Additionally, herbal supplemental therapies, dietary guidelines, breathing techniques and exercise based on Oriental Medical principles may also be used. Oriental Medicine is a healing art that perceives the circulation and balance of energy in the body as being fundamental to the wellbeing of the individual. It implements the theory through specialized methods of analyzing the energy status of the body and treating the body with acupuncture and other related modalities for the purpose of strengthening the body, improving physiological function and reducing pain.

I understand that acupuncturist do not make Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

I understand that there may be some conditions that require a referral to a licensed healthcare provider for the safety of my health, and I will cooperate if such referral is needed. The following conditions will require a referral to a licensed healthcare provider: uncontrolled hypertension; acute, severe abdominal pain; acute, undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% of the body weight in less than a three-month period; suspected fracture or dislocation; suspected systemic infection; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without a previous history.

I hereby authorize Bonnie Bolash, Master of Acupuncture, Licensed Acupuncturist by the Board of Medical Practice license number 1176, to perform, diagnosis and treat according to the professional standards of Oriental medicine and professional judgment. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. I understand that there are possible unforeseen risks to the performance of the procedures of Oriental medicine. I have been informed that possible side effects of acupuncture treatment are rare and may include, but are not limited to, bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness; brief generalized fatigue or nausea; temporary worsening of some symptoms; risk of infection; needle sickness; or broken needles. Herbal remedies may have side effects including, but not limited to gastrointestinal disturbances. Moxibustion can cause burns. Massage can cause increased muscle soreness, spasms, bruising, and generalized fatigue or nausea and temporary worsening of some symptoms. Electro acupuncture may cause electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. Cupping therapy may cause circular bruising.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I may make an educated decision regarding the duration and appropriateness of continuing care and that I may refuse any therapy at any time. All of my questions have been answered to my satisfaction.

Current Illness or Injury:_____

I **HAVE/HAVE NOT** (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have provided Bonnie Bolash, LAc. with an accurate diagnosis of my condition.

I **DO/DO NOT** (circle one) have a pace maker or bleeding disorder.

I AM/AM NOT (circle one) currently pregnant. Please let practitioner know if you do become pregnant.

_____ _____ _____

Patient Name or Minor Child Name Date of Birth Date

Patient Signature or Parent Signature for treatment of Minor_____

Cost for Treatment: **Evaluation** $30.00 **Acupuncture Treatment** $60.00 **Acupressure Massage 30 minute appointment** $40.00

updated 1/24/2015

Bonnie M. Abel Bolash, M.Ac., L.Ac.

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CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: We are concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us. Ways that we may use or disclose your health care information include, but are not limited to:

Another health care provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.

Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered

The use of that information within our practice for quality control or other operational purposes.

Business associates that we contract with to perform a service for your benefit.

The use of that information to contact you by telephone, mail or e-mail with appointment reminders, lab or imaging results, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.

The use of communication including birthday cards, newsletters, emails, postcards, letters, text messages or telephone calls,

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any or your authorizations at any time; however, you revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, OUR OFFICE WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT.

I acknowledge receipt of the Notice of Privacy Practices and I hereby give consent to Bonnie Bolash, LAc. or staff to disclose my personal health information as noted above.

_____ _____ _____

Print Patient Name or Minor Child Name Date of Birth Date

Patient Signature or Parent Signature for treatment of Minor_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR PRIVACY PLEDGE: We are concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us.

OUR DUTIES: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices and to abide by the terms of this notice while it is effect. However, we reserve the right to change the terms of our privacy notices in accordance with federal or state law; any such change will apply to all of your information in our files. Patients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow Bonnie Bolash, LAc. or support staff members to:

Use your health information within the clinic, or disclose your information to another health care provider or facility for the purpose of diagnosis, assessment or treatment of your condition.

Use your health information within the clinic or disclosure your examination, treatment and billing records to another party, such as an insurance carrier, an HMO or your employer for the purpose of receiving payment for services rendered to you.

Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.

Disclosure your health information to business associates that perform services for the clinic or your benefit and bill for it. All clinic business associates are contractually require by us to similarly safeguard the privacy and confidentiality of any personal health information disclosed to them.

Use your personal health information to contact you by telephone, mail or e-mail with appointment reminders, newsletters, information about treatment alternatives or other health related information that may be of interest to you. If not at home to receive an appointment reminder, a message may be left on your answering machine.

REQUIRED OR PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to: 1) The extent that we are required or permitted to do so by applicable federal or state laws; 2) A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal or state law; 3) An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence; 4) Federal or state health care system and government benefit program oversight activities; 5) A response to a court order, or in response to a subpoena, discovery requires or other lawful purpose; 6) Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests; 7 An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or public; 8) A correctional institution if we provide health care services to you as an inmate; 9) Emergent care situations; and 10 Providing care to you that is relate to a work-place injury to the extent necessary to comply with Minnesota's worker's compensation laws.

THE HEALTH CARE INFORMATION RIGHTS OR OUR PATIENTS INCLUDE:

Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation requires: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give you authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as the information remains in our files; such request must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the records was created or as long as the information remains in our files. Amendment request must be in writing and give us a reason to support the change you are asking us to make; however the clinic is not obligated to comply with your request if it judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purposes; 7) Were made to correctional or law enforcement officers; or 9) Were made prior to April 2003. **We will provide the first accounting within any 12-month period without charge.** Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Right to Receive Notice of a Privacy Breach. You have the right to receive written notification if Bonnie Bolash discovers a breach of unsecured protected health information involving your health information. Breach means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the information.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. US. Department of Health and Human Services: DHHS (Office of Civil Rights) 200 Independent Avenue S.W. Room 509F HHHA building Washington, DC 20201. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the clinic at:

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Updated 7/26/2014