M25.521PATIENT INFORMATION (Please print) *Patient File #:* _____

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ (_____) Gender: M F Marital Status: M S D W other
MM-DD-YY Age

Mailing Address: _____
Street City State zip

Phone #: H ( ) _____ O ( ) _____ C ( ) _____

Email Address: _____ How you heard about us? _____
(Please specify the name of referral, internet or yellow book if possible)

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Patient SSN #: _____ DL#: _____ State: _____

Occupation: _____ Employer: _____

Employer address: _____
Street City State zip

PLEASE READ AND SIGN

I take full responsibility for any and all charges for services performed by Chung-Hwei Chernly, Hsiao-Lan Chung or Shirley Wang, all L.Ac., Dipl. Ac., OMD, regardless if I have insurance coverage or not. I realize full payment (or co-pay) for all services is due at the time the services are rendered. I have read and understand the office policy of the Acupuncture Center, Inc.

If I am or become an insurance patient, I authorize the release of any medical records necessary to process any insurance claims to process any auto accident claims or to give a progress report to any referring physician on my behalf. I authorize payment of medical benefits to Chung-Hwei Chernly/Acupuncture Center, Inc. or Hsiao-Lan Chung/C & C Wellness Center, Inc. for the services described on any processed insurance claims for recorded dates of service. I am personally aware of and responsible for the status of my insurance eligibility and benefits regardless of the source of those insurance benefits. If for any reason the insurance company does not pay for services performed, I assume full responsibility for all outstanding bills and will pay any balance due to Chung-Hwei Chernly/Acupuncture Center, Inc. or Hsiao-Lan Chung/C & C Wellness Center, Inc.

_____
Patient/Guardian name print Patient/Guardian signature Date

INSURANCE INFORMATION

Insurance Company: _____ Group/Plan # _____ Effective Date: _____

Insured's Name: _____ Your relation to Insured: self spouse child other

Insured's Address if different from above: _____

Insured's ID/SS# _____ Insured's Birth Date: _____ Insured's Phone: _____

Insured's Gender: M F Insured's Employer: _____

Is this insurance: ( ) group plan ( ) TWCC ( ) auto ( ) other (explain) _____

If auto accident/ injury: Claim # _____ Date of injury _____

Secondary Insurance Company _____ ID/SS# _____

Secondary Insured's Name: _____ Date of Birth (MM-DD-YY) : _____

MEDICAL HISTORY

Patient Name: _____

Height: _____ ft _____ in Weight: _____ lb

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: (Check only if it applies)

_____abdominal pain
_____acid reflux
_____alcoholism
_____allergies (air born)
_____anemia
_____arm pain
_____arthritis
_____asthma
_____back pain
_____back pain, lower
_____bronchitis
_____bursitis
_____candidiosis
_____carcinoma/cancer
_____carpal tunnel syndrome
_____chest pain
_____cholesterol, high
_____circulation problems
_____colitis / diarrhea
_____common cold
_____constipation
_____depression
_____diabetes
_____disc disorder, cervical
_____disc disorder, thoracic
_____disc disorder, lumbar
_____earache/ear infection
_____edema
_____elbow pain
_____emphysema
_____endometriosis
_____fatigue, chronic
_____fibromyalgia
_____flu
_____foot pain
_____hand pain
_____headaches
_____hepatitis,
_____hernia
_____high blood pressure
_____hip pain
_____hyperthyroidism
_____hypoglycemia
_____hypothyroidism
_____incontinence
_____infertility
_____joint pain
_____knee pain
_____leg pain
_____menstrual irregularity
_____menstrual pain
_____migraines
_____neck pain
_____neuroma
_____osteoarthritis
_____osteoporosis
_____pneumonia
_____prostate enlargement
_____rheumatoid arthritis
_____sciatica
_____sclerosis, _____
_____seizures /convulsions
_____shoulder pain
_____sleeplessness
_____skin infection
_____spondylosis
_____stenosis
_____tendonitis
_____tinnitus
_____TMJ
_____tingling, numbness, _____
_____trigeminal neuralgia
_____twitch, tremors
_____vertigo
_____others _____

Currently Medication &/or Herbs: _____

Previous surgeries (& dates): _____

Have you ever been tested positive for AIDS? Yes No HIV? Yes No Hepatitis C? Yes No

WOMEN ONLY: Last menstrual period: _____

Currently pregnant: Yes No If yes, how long? _____ Ever pregnant: Yes No Number of live births: _____

NOTICE TO THE PATIENT

I am seeking treatment at the Acupuncture Center for the following condition: _____

_____

Pursuant to the requirements of title 3, sec. 205.301(a)(1) of TX. OCC code governing the practice of acupuncture.

I, _____ ,am notifying the acupuncturist(s), C. H. Chernly, H. L. Chung and/or X. H. Wang, of the following:

Last Visit Date to PCP: _____ Name of PCP: _____ Referred by PCP? Y N

Currently under another physician's care? Yes No If yes, for: _____

I have been evaluated by a physician (MD/DO) or dentist for the condition being treated within 6 months before receiving acupuncture treatment. Initial of Patient _____ Date: _____

(If no initial above, patient must sign below attesting that the Acupuncturist has referred him/her to a physician as pursuant to the requirement of sec. 205.301(b), title 3, TX OCC code governing the practice of acupuncture.) I recognize that I should be evaluated by a physician (MD/DO) or dentist for the condition being treated by the acupuncturist. This serves as a referral by the acupuncturist for me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

_____

Pursuant to the requirements of title 3, sec. 205.301(a)(2)(c) of TX OCC code governing the practice of acupuncture:

I have received a referral from my CHIROPRACTOR within the last 30 days for acupuncture? Yes No

After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician, and consider this written notice a referral in advance. It is my responsibility and choice whether to follow this advice.

Patient's signature _____ **Date** _____

Acupuncture Center
470 W. Harwood, Hurst, TX 76054

Patient Privacy

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information

We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

- For treatment
- For payment
- For healthcare operations
- When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls or mail.

Patient Rights

1. Upon written request, you have the right to access, review, or receive copies of your health care records. There is a copy fee of $15 and will be processed in 14 days.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request that we amend your protected health information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact us.
Contact: Grace Chernly
Telephone: 817-498-8449
Address: 470 W. Harwood, Hurst, TX 76054
Send written complaints to: U.S. Department of Health and Human Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand and agree to the statement of Patient Privacy for healthcare services in the Acupuncture Center.

Patient Signature _____ Date_____

Acupuncture Center
470 W. Harwood, Hurst, TX 76054

Informed Consent to Treatment

I, _____, consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by a licensed acupuncturist of Acupuncture Center named below and other members of the Clinic Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Medical Staff named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na(Chinese massage), Chinese herbal medicine, therapeutic exercise, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects: bruising (a common side effect of cupping), numbness or tingling (near the needling sites that may last for a few days), and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including chest cavity puncture (pneumothorax). Acupuncture Center uses sterile needles and maintains a clean and safe environment, though as with any medical office, infection is another possible risk. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

Herbal formulas and acupuncture points may have effects on pregnancy. I understand that I must inform the practitioner if there is any possibility of pregnancy.

I understand that herbs and supplements need to be prepared, consumed, and used according to the instructions provided orally and in writing. I will immediately notify a member of the Clinic Medical Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal supplements.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment which the Clinic Medical Staff thinks at the time, based upon the facts then known, is in my best interests.

I understand the Clinical Medical and Administrative Staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for 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 (or by patient's representative if the patient is a minor or is physically or legally incapacitated)

_____
Print Name of Patient

_____
Signature of Patient (or Representative)

_____
Print Name of Patient or Representative

_____
Date Consent Completed

To be completed by the member of the Clinic Medical Staff providing information and obtaining consent.

_____
Print Name of Clinic Medical Staff

_____
Signature of Clinic Medical Staff

_____
Print Name of Witness/Translator

_____
Signature of Witness/Translator