Meriam Chaheen, L.AC.

Patient's Information

Last Name:	First Name:	M.I:
Home Address:		
City:	State:	Zip Code:
Home Phone :( )	Cell Phone( )	
Date Of Birth:	Gender:	
Email Address:		
Driving Lic Number:	Occupation:	
Employer's Name:	Employer's Phone No:	
Employer's Address:		
In Case of Emergency Contact: Relationship:		
Emergency contact Phone Number:		
Relative /Friend not living with you:	Phone No:	
Referred By:		

I hereby authorize Meriam Chaheen , L.Ac to administer any treatment she consider for my health and well-being, and release her from all medical responsibilities if I consider to discontinue such treatment before such treatment is all completed. Meriam Chaheen, L.Ac is authorized to furnish from the patient's record necessary information to the referring physician, if any, insurance company or designated attorney all information which said referring physician ,insurance company and/or designated attorney may request.

Acupuncture is a technique utilizing very fine sterile stainless steel needles inserted at specific points in the body to cause a positive response in order to correct various ailments and the depth of their insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by some painful sensations and that there is slight possibility that a minor swelling, bleeding, discoloration, hematoma or bruise may occur at the site of the insertion. There are some risks to treatment, including but not limited to nausea, punctured lung or infection. I understand that results to treatment are not guaranteed.

I hereby authorized my insurance company to pay Meriam Chaheen, L.Ac the benefits allowable as payments towards the total charges for services rendered. I understand that I am fully responsible for the charges resulting from my treatment that is not covered by this assignment and pay them promptly as received.

Signature of Responsible Party:	Date:

Health History

Name: ____**Date:**________________

Conditions (Check conditions you have or have had in the past)

AIDS	Diabetes	Kidney disease	Skin Diseases
Alcoholism	Emphysema	Liver Disease	Stroke
Anemia	Epilepsy	Measles	Suicide Attempt
Anorexia	Fracture	Migraine	Thyroid Problems
Appendicitis	Glaucoma	Miscarriage	Tonsillitis
Arthritis	Goiter	Mononucleosis	Tuberculosis
Artificial Heart Valves/Joints	Gonorrhea	Multiple Sclerosis	Tumor/Growth
Asthma	Gout	Mumps	Typhoid Fever
Bleeding Disorders	Heart Disease	Osteoporosis	Ulcers
Breast Lump	Hepatitis	Pacemaker	Vaginal Infections
Bronchitis	Hernia	Pneumonia	Other
Bulimia	Herpes	Polio	
Cancer	High Blood Pressure	Prostate Problem	
Cataracts	High Cholesterol	Psychiatric problem	
Chemical Dependency	HIV Positive	Rheumatic fever	
Chicken Pox	Joint Dislocation	Scarlet Fever	

HOSPITALIZATION/ SURGERIES ***MAJOR ILLNESS/INJURIES***

Year	Reason for Hospitalization	Year	Illness/Injuries

Medications & Supplements **(List meds you are currently taking)**	***Allergies*** **(To medications or substances or foods)**

For Women Only:

Are you Pregnant? Yes________ No __________

Date of Last Pap smear: ____

Date of last menstrual Period: ____

Date of last Mammogram: ______________________________________

Indicate number of Occurrence:

Live Births _________Pregnancies _____ Miscarriage _______Abortions_________

Health Habits: (Check which substances you use and describe how much you use.)

Caffeine____

Tobacco____

Alcohol____

Chief Complains (Please identify the health concerns that have brought you here today). How does these conditions affect you?

1.____

2.____

3.____

4.____

5.____

<u>Financial agreement:</u>

I, ________________________________ (print your name), am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including Herbs. If I choose to use my health insurance I understand that this is a quotation of benefits and not a guarantee of payment***. I will be responsible for all "non-covered "services and /or co-insurance associated with my office visits.***

<u>Insurance Coverage:</u>

Many insurances cover acupuncture but we do not claim that your does. Policies can differ greatly in term of deductible, percentage of coverage and number of visits for acupuncture. We can verify coverage and submit your claim form for reimbursement.

<u>If you do not have acupuncture coverage:</u>

Payment is due in full at the service are rendered unless other arrangements have been made.

<u>Payments:</u>

We accept ***<u>cash, Credit cards and personal checks</u>***. Please bote there is a $25 charge for checks return due to insufficient funds.

<u>Cancellations:</u>

As a Courtesy to our office and other patients, we ask that you please notify to office at ***least 24*** hours in advance if you need to cancel or reschedule your appointment. If you miss or cancel an appointment without giving at least ***24 hours'*** notice you will be charged the full cost of the scheduled appointnemet. The fee will be collected on the same day at the missed appointment and charged to the credit card we have on file.

I authorize the release of medical information necessary to process my claim. In addition I authorize insurance payment of medical benefits to **Meriam Chaheen L.Ac.**

By signing below I agree to comply with the office policies, stated above which I have read and understand. I also authorized the use of this signature on all insurance submissions.

Patient's Name: ___________________________________ ***Date:*** ________________

Patient's signature: ____

<u>Consent Form for Acupuncture</u>
<u>Meriam Chaheen L.Ac</u>

I hereby request and consent to the performance of acupuncture treatments and other procedure within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and /or other licensed acupuncturist who now or in the future while employed by, working or associated with or serving as backup for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic. You are always welcome to ask for more details if you wish. Contraindications (Symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs may include a history of bleeding disorder or current anticoagulation therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and /or pregnancy. It is important that you notify your practitioner if any of these apply to you.

________I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM) and in no way purports to replace allopathic medical evaluation, diagnosis or treatment.

________ I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

________I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

________ I understand that methods of treatment may include but are not limited to acupuncture, Moxibustion, cupping, electrical stimulation, Tui Na, herbal formulas or nutritional counseling.

________I understand that while this document describes major risks of treatment, other side effects and risks may occur.

________**Acupuncture:** I Understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, numbness or tingling near the needling sites or a bruise that may last a few days or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include, spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapse lung) and infection.
________**Cupping:** I understand that this application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.

______**Tui Na massage**: I understand that may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that side effects that may result from this treatment include, but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

_______ **Herbal & Nutritional Supplements**: I understand that oriental medicinal substances may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate body's own restorative process. The herbs are usually taken in Tea form, mixing powdered granules, Capsules or pills. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

________ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplants, may have side effects of their own or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers or children. Potential risks include are not limited to: allergic reactions, nausea, gas, stomachache, headache, vomiting, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment

_______I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

________ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

_________ I hereby state that I have read and understand this form, that I have given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name: ________________________________ **Date: _______________**

Signature of Patient or person authorized to consent on behalf of the patient:

____

Practitioner Signature:

____

Meriam Chaheen L.Ac

MERIAM CHAHEEN, L.Ac.
NOTICE OF PRIVACY PRACTICES

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.

Meriam Chaheen, L.Ac. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide my patients with notice of my legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
I may disclose your health care information to other healthcare professionals within my practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Meriam Chaheen, L.Ac."*

Payment
I may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy of my patients, I will submit an itemized billing statement to your insurance carrier for the purpose of payment to Meriam Chaheen, L.Ac. for health care services rendered. If you pay for your health care services personally, I will, as courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Worker's Compensation
I may disclose your health information as necessary to comply with state Worker's Compensation Laws.

Emergencies
I may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, I may disclose your health information to public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
I may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
I may disclose your health information to a law enforcement official for purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
I may disclose your health information to coroners or medical examiners.

Organ Donation
I may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
I may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
I may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
I may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to may patients, it is my policy to call your home on the evening prior to your scheduled appointment to remained you of your appointment time. If you are not at home, we leave a reminder massage on your answering machine or with the person*

answering the phone. No personal health information will be disclosed during this recording or message other than date and time of your scheduled appointment along with request to call my office if you need to cancel or reschedule your appointment.

Change of Ownership

In the event that Meriam Chaheen, L.Ac. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Meriam Chaheen, L.Ac. is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect or copy your health information.

- You have the right to request that Meriam Chaheen, L.Ac amend your protected health information. Please be advised, however, that Meriam Chaheen, L.Ac. is not required to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Meriam Chaheen, L.Ac.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Meriam Chaheen, L.Ac. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Meriam Chaheen, L.Ac. is required by law to comply with this Notice

Meriam Chaheen, L.Ac. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Meriam Chaheen L.Ac. by calling this office at (818) 625-2019. if Meriam Chaheen L.Ac. is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints

Complaints about your privacy rights or how your health information has been handled should be directed to Meriam Chaheen, L.Ac. by calling this office at (818) 625-2019. if Meriam Chaheen, L.Ac. is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

This notice is effective as of May 15, 2006

Please read the Privacy Notice and understand your rights contained in the notice

By way of signing this notice, you provide Meriam Chaheen, L.Ac. with your authorization and consent to use and disclosed your protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

__________________________________ ____________________
Patient's Signature Date

__________________________________ ____________________
Authorized Facility Signature Date