Cassandra Dugan L.Ac.
(518) 512-0822

HIPPA Notice of Privacy Practices Compliance Policy

Please review the information below carefully.
This notice describes the office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA):
HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This act provides the patient rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

Our Responsibility:
We respect the legal obligation to keep health information that identifies you privacy. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use it and disclose your health care information. We do not use your health information inside our office or outside without your written permission. In some limited cases, the law requires us to disclose your health care information without either a written or verbal consent.

Safeguards in place at the office include:
Limited access to facilities where information is stored.
Policies and procedures for handling information.
Requirements for third parties to contractually comply with privacy laws.
All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Use and Disclose With Consent:
We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. Treatment can be stopped with refusal to sign the form. We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

Use and Disclosure Without Consent:
In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:
When state or federal law mandates certain health information be reported for a specific purpose.
For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
Disclosures in response to subpoenas of orders of the court.
Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
Disclosure related to worker's compensation programs.

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Your Rights Regarding Your Health Information:
You have the following rights with respect to your protected health information, which you can exercise in writing to our office:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to the request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
The right to ask to communicate with you in a confidential way, such as contacting you at work rather than at home. Please provide a written request.
The right to see or get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a health care provider. Please complete our written records request for billing or medical records release.
The right to receive an accounting disclosure of protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice at your request.

You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated. I request the following restrictions to the use of disclosure of my health information:

_____
_____
_____
_____

_____ _____
Patient Signature (Parent or Guardian if under 18) Date

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CONSENT FOR TREATMENT FORM

I herby request and voluntarily consent to receiving acupuncture treatments, which consist of inserting fine, sterile needles through the skin into the underlying tissues. I understand that the treatments may also include, but are not limited to, the use of cupping, gua sha, moxa, heat therapy, tui na (Chinese massage), electrical stimulations, diet and nutritional counseling. Purpose of Treatment: I understand that the purpose of the treatment is to resolve my symptoms, the reason that I am requesting treatment. The procedures used will attempt to remedy bodily dysfunction and to make normal the bodies' physiological functions.

I fully understand that the risks of acupuncture treatments, although limited and rare, could include the following: minor bruising and burns, minor pain at the needle site, dizziness or faintness. If I use a pacemaker, am taking any drugs or herbs, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning the treatment. I understand and accept these risks involved in treatment.

I understand that because acupuncture works within the entire body to restore balance, acupuncture may affect people on all levels: physical, emotional, mental, and spiritual. I understand that the duration of treatment varies from person-to-person depending on the specific illness and body constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. I state that I have completed the patient information form completely and accurately. I have been informed that I have a right to refuse any form of treatment. I understand that Cassandra Dugan has received her training in Acupuncture and Chinese Medicine and is licensed by the State of New York as a Licensed Acupuncturist. She is not, nor claims to be, a medical doctor. I understand that the evaluation, diagnosis, and treatment I receive are not a replacement for Western Medical Care. Patient advisory to consult a physician: To comply with Article 160, section 8211.1 (b) of NYS Education law, I must advise that you consult a physician regarding your condition.

Use of Disposable Needles: I understand that to prevent any possibility of infection from acupuncture, all needles used are pre-sterilized, one time use, surgical stainless steel needles that are disposed of after usage as medical waste. Needles are never reused.

Your signature indicates that you have read, understand and agree with the above information. 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. I give my permission and consent to treatment.

_____ _____

Patient Signature (Parent or Guardian if under 18) Date

HIPPA Notice of Privacy Practices Compliance Policy

Please read the Notice of Privacy Practices and sign below to confirm your consent and understanding of the policy.

_____ _____

Patient Signature (Parent or Guardian if under 18) Date

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect for 1 year or until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____
Witness: _____ Date: _____

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

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.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

HEALTH HISTORY

Date: ____ / ____ / _____

Name, first and last (as you would like to be called):		Gender (identity):	Age:
Address:	City:	Zip Code:	
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:	Emergency contact:	Contact #:	Relationship:
Best form of contact:	Want to join our mailing list?	If your legal name is different from your prefered name and you want us to have it, put here:	
What pronouns would you like to be addressed by? (her, him, hir, they, etc.)	Occupation:		
Physician:	Physician's Phone #:		
How did you hear of our clinic? Who can we thank for the referral?	Have you been treated by acupuncture before? ☐ No ☐ Yes ____/____/____		

MAIN CONCERNS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the ↑ if you have / had the condition and note the year it started.
Circle the ↑↑↑ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?*	↑	_____	↑↑↑
_____	↑	_____	↑↑↑
Diabetes	↑	_____	↑↑↑
Hepatitis ____	↑	_____	↑↑↑
High Blood Pressure	↑	_____	↑↑↑
Heart Disease	↑	_____	↑↑↑
Stroke	↑	_____	↑↑↑
Seizure Disorder	↑	_____	↑↑↑
Thyroid Disease	↑	_____	↑↑↑
Asthma	↑	_____	↑↑↑
Pacemaker	↑	_____	↑↑↑

	YOU	Year	FAMILY
Osteoporosis	↑	_____	↑↑↑
Kidney Disease	↑	_____	↑↑↑
Autoimmune Disease	↑	_____	↑↑↑
Anemia	↑	_____	↑↑↑
Rheumatic Fever	↑	_____	↑↑↑
Alcoholism	↑	_____	↑↑↑
Allergies *type(s)?*	↑	_____	↑↑↑
_____			
Other _____			

Would you like support cutting back on any addictive habits? _____
Are you in recovery? _____
Any recent major life change? _____

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:
_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly (prescribed or otherwise)

_____
_____
_____

SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

On the following page, please check the appropriate boxes and indicate where you fall on the continuums.

TEMPERATURE

How warm/cold do you feel (not in degrees) relative to other people? (do you wear more or less layers, etc.)

COLD			HOT
☐ Cold hands or feet	☐ Thirst with no desire to drink	☐ Night sweats	☐ Hot hands , feet, chest
☐ Chills	☐ Absence of thirst	☐ Unusual sweats	☐ Hot flashes
☐ Cold "in the bones"	☐ Excessive thirst	When _____am/pm	☐ Hot in the afternoon
☐ Areas of numbness	☐ Thirst for cold / hot drinks	Where on body_____	☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY			OILY
☐ Dry skin/hair/nails	☐ Dry lips	☐ Edema/Swelling _____where on body?	☐ Oily skin/hair
☐ Dry eyes	☐ Dry throat	☐ Rashes _____	☐ Pimples
☐ Dry nose / nosebleeds	☐ Dry mouth	☐ Itching _____	☐ Weight gain / loss

DIGESTION

DIARRHEA			CONSTIPATION
BM: How often? ___ x / every____ days	☐ Gas/ Bloating	☐ Nausea / Vomiting	☐ Dry stools
Stools keep shape? ☐ Y ☐ N	☐ Belching	☐ Bad breath	☐ Difficult to pass
☐ Alternating diarrhea/constipation	☐ Poor appetite	☐ Heartburn	☐ Tired after BM
☐ Indigestion	☐ IBS	☐ Excessive hunger	☐ Foul smelling stools

ENERGY

LOW			HIGH
☐ Sudden energy drop	☐ Dependence on caffeine	☐ Shortness of Breath	☐ Hard to concentrate
Time of day: _____	☐ Wired / ungrounded feeling	☐ Heart palpitations	☐ Poor memory
☐ Energy drop after eating	☐ Body / Limbs feel heavy	☐ Blood pressure high/low	☐ Dizziness / lightheaded
☐ Fatigue	☐ Body / Limbs feel weak	☐ Bleed / Bruise easily	☐ Headaches _____/wk

SLEEP

Hours per night _____
- ☐ Difficulty falling asleep
- ☐ Wake ____x night @ ____am/pm
- ☐ Wake to urinate *How often?*___
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested on waking

EMOTIONS

☐ Anger	☐ Grief
☐ Irritability	☐ Depression
☐ Anxiety	☐ Joy
☐ Worry	☐ Fear
☐ Obsessive thinking	☐ Timid/Shy
☐ Sadness	☐ Indecision

EYES, EARS, NOSE THROAT

☐ Poor vision	☐ Poor hearing
☐ Night blindness	☐ Ringing in ears
☐ Red eyes	☐ Excess earwax
☐ Itchy eyes	☐ Sore throat
☐ Spots in front of eyes	☐ Dental problems
☐ Sinus congestion	☐ Mouth sores
☐ Phlegm (color_____)	☐ Cough

HORMONAL BALANCE / HORMONAL CHANGES

Age at last menses:_____ Year changes began:_____

☐ Hot flashes _____x/day ☐ Night sweats _____x/wk ☐ Vaginal dryness ☐ Loss of sex drive ☐ Other

Age at first menses: _____	☐ Heavy periods	☐ Cramps	☐ Mood changes
Length of full cycle _____ days	☐ Light periods	☐ Before bleeding	☐ Fatigue with menses
Length of menses: _____ days	☐ Painful periods	☐ First day	☐ Digestive changes w/menses
Last menses start date ____/____	☐ Irregular periods	☐ During period	☐ Midcycle spotting
# of pregnancies _____	☐ Changes in	☐ Clots	☐ Yeast infections
# of births ____ premature ____	body/psyche prior to	☐ Breast tenderness	
# of abortions/miscarriages ____	menstruation (pms)		

URINARY

Fluid in = fluid out ☐ Y ☐ N

☐ Decrease in flow/dribbling	☐ Urgent urination
☐ Difficulty starting/stopping	☐ Frequent urination
☐ Incontinence	☐ Pain/burning sensation
☐ Kidney stones	☐ Cloudy urine
	☐ Blood in urine

OTHER

☐ Change in sex drive: ⇑ ⇓	☐ Prostate disease
☐ Erectile dysfunction	☐ Genital pain
☐ Premature ejaculation	☐ Fibroids/cysts
☐ Infertility	☐ Hernia
☐ Discharge	☐ Hemorrhoids

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW? PLEASE DESCRIBE ON THE BACK OF THIS FORM OR A SEPARATE SHEET OF PAPER. THANKS!

Cassandra Dugan L.Ac.
(518) 512-0822

BEFORE & AFTER YOUR ACUPUNCTURE TREATMENT

To assist you in deriving the greatest benefit possible from your acupuncture treatments, please observe the following:

1. Do not wear make-up, perfume or heavily scented lotions, shampoos or soaps to treatment. This is particularly important your first couple of treatments.

2. Avoid alcohol for 24 hours before and after treatment.

3. It is important to have something in your stomach prior to treatment. However it is best not to eat an unusually large meal either before or immediately after your treatment.

4. Avoid very hot or cold baths or showers the day of treatment.

5. Do not rush to your appointment! It is better to be a few minutes late than to arrive with an elevated pulse or blood pressure.

6. Continue all prescription medications and treatments exactly as directed by your physician or other health care providers.

7. Plan your activities so that after treatment (especially at first) you can get some rest and allow your body to gain the maximum benefit from treatment.

8. Note and report any changes in physical or emotional patterns that occur between your acupuncture treatments. This detail is valuable in planning the course of your treatment.

Please keep this sheet for your future reference.