HOLISTIC HEALTH
ASSOCIATES
603-B W. Patrick Street, Frederick, MD 21701
301-620-1414

ACUPUNCTURE

Medical History

CONFIDENTIAL

Legal Name _____ Preferred Name_____
DOB _____ Today's date _____
Address _____ City _____ State _____Zip _____
Telephone (home) _____ (cell) _____ (work) _____
Ok to leave voicemail? Yes or No Indicate which phone number: _____
Email _____Married: Yes or No
Preferred means of contact: **(please indicate one):** O text message O email
Occupation _____ Employed by _____
Primary Care Doctor _____ Experienced Acupuncture/Herbs in the past? Y or N
Height _____ Weight _____ Average Blood Pressure Reading _____
How did you hear about us? (please indicate): Radio Sign Yellow Pages Health Fair BNI
Referral-Who? _____ Internet-Which Search? _____

CHIEF COMPLAINT

Main problems you would like help with: _____
When did your issue(s) begin? _____ Did anything initiate symptoms? _____
Does anything make it worse or better? (such as heat, cold, massage, rest, fatigue etc.)
Explain:_____
Have you been given a diagnosis for this problem? If so, what? _____

Past Medical History / Family History

	Family	Yes	No		Family	Yes	No		Family	Yes	No
Diabetes	□	□	□	Osteoporosis	□	□	□	Blood clots	□	□	□
Chest Pain/Angina	□	□	□	Asthma	□	□	□	Peripheral Vascular Disease	□	□	□
High Blood Pressure	□	□	□	Stroke	□	□	□	Tuberculosis	□	□	□
Heart Disease	□	□	□	Seizure	□	□	□	Depression	□	□	□
Heart Attack	□	□	□	HIV / AIDS	□	□	□	Congestive Heart Failure	□	□	□
High Cholesterol	□	□	□	Hepatitis	□	□	□	Thyroid Disease	□	□	□
Pacemaker	□	□	□	Stomach Ulcer	□	□	□	Other (please list below)			
Headaches	□	□	□	Liver Disease	□	□	□				
Kidney Stones	□	□	□	Heart Palpitations	□	□	□				
Kidney Disease	□	□	□	Arthritis	□	□	□				
Cancer	□	□	□	Heart Surgery	□	□	□				

ROS	**Circle all that apply** - currently experiencing
Constitutional/ General	Weight loss – Fevers – Chills - Poor Appetite – Fatigue - Weight gain – Insomnia - Night Sweats Sweat easily - Localized weakness – Peculiar - Tastes or smells - Poor Sleeping – Chills - Cravings
Eyes	Blurry vision - Eye pain - Eye discharge - Eye redness - Decrease in vision - Dry eyes Double vision – Floaters – Glasses – Cataracts - Eye strain - Night blindness
ENMT	Sore throat – Hoarseness - Ear pain - Hearing loss - Ear discharge - Nose bleeds - Tinnitus Sinus problems – Dizziness - Ringing in ears - Teeth problems - Concussions - Poor hearing Facial pain - Jaw clicks – Migraine - Color blindness – Earaches - Grinding teeth Lip or tongue sores - Headaches
Cardiovascular	Chest pain – Palpitations - Rapid heart rate - Heart murmur - Poor circulation - Swelling in extremities High blood pressure - Low blood pressure - Irregular heart beat - Cold hands or feet Blood clots – Dizziness – Phlebitis – Fainting - Difficulty breathing
Respiratory	Shortness of breath - Chronic cough - Coughing up blood - History of Tuberculosis Phlegm – Bronchitis - Pain with deep breath – Pneumonia - Asthma

Gastrointestinal	Nausea – Vomiting – Diarrhea – Constipation - Blood in stool - Frequent heartburn Trouble swallowing - Black stools - Bad breath - Abdominal pain or cramps Chronic laxative use – Gas - Rectal Pain – Belching – Indigestion - Hemorrhoids
Uro-genital	Frequent urination - Blood in urine – Incontinence - Painful urination - Urinary retention - Frequent UTIs Urgency to urinate - Decrease in flow - Unable to hold urine – Impotency - Sores on genitals Do you wake up to urinate: ____ If yes, how often: _____ Any particular color to urine: _____
Gyno (women)	Number of pregnancies:____ Number of births: ____ Age at first menses: ____ Birth Control: _____ Premature births - Miscarriages/Abortions:_____ # of days between menses: ____Duration of menses: ____ Date of last menses: ____ Heavy period - Light period - Painful periods - Clots with flow - Irregular periods - Vaginal discharge Vaginal Sores - Breast lumps - PMS
Skin	Rash – Hives - Hair loss - Skin sores or ulcers – Itching - Skin thickening - Nail changes Mole changes – Dandruff – Ulcerations – Eczema - Pimples
Musculoskeletal	Joint pain - Muscle aches - Frequent leg cramps - Muscle weakness - Bone pain - Joint swelling Back pain - Neck pain - Hand/ wrist pain - Shoulder pain - Knee pain - Foot /ankle pain - Hip pain
Neuropsycho	Anxiety – Depression - Alcohol or drug dependence - Suicidal thoughts - Panic attacks Use of anti-depressants – Seizures - Areas of numbness – Concussion - Bad temper - Dizziness Lack of coordination - Easily susceptible to stress - Loss of balance - Poor memory
Endocrine	Goiter - Heat intolerance - Cold intolerance - Strong thirst - Change in skin pigment - Excess sweating
Neurological	Seizures – Tremors – Migraines – Numbness - Dizziness/ vertigo - Loss of balance - Slurred speech Stroke
Hem/Lymphatic	Low blood count - Easy bruising - Swollen lymph nodes – Transfusions - Prolonged bleeding - Blood clots
Allergic/Immun	Allergic reactions - Hay fever - Frequent infections – Hepatitis - HIV positive – Positive tuberculin skin test (PPD)

Early Development: Were there any in-utero complications before you were born? Please describe any labor and delivery, natural or C-section, and how long breast fed: _____

_____

Significant traumas (auto accident, falls etc.): _____

Allergies: _____

LIFESTYLE

Prescription Medications: _____

_____

Medicines, Vitamins, Herbs: _____

_____

Do you have a regular Exercise Program? _____ Describe: _____

_____

Describe your average daily diet:

Breakfast Lunch Dinner

_____

_____

_____

Smoke cigarettes? _____ How many per day? _____

How much coffee, tea or caffeine per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

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Pain Disability Questionnaire

Date: _____

Instructions: These questions ask your views about how your pain NOW affects how you function in everyday activities. Please answer every question and make ONE number on EACH scale that best describes you feel as it relates to the **CHIEF COMPLAINT** you indicated on the first page.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally — Unable to work at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all personal care

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel when absolutely necessary

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

4. Does your pain affect your ability to sit or stand?

No problems — Cannot sit/stand at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

7. Does your pain affect your ability to walk, run, or exercise?

No problems — Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

8. Has your income declined since your pain began?

No decline — Lost all income

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

9. Do you have to take pain medication to manage your pain?

No medication needed — Medication throughout the day

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

10. Does your pain interfere with your ability to see the people who are important to you?

No problem — Never see them

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

11. Do you need help with everyday tasks because of your pain?

Don't need help — Need help all the time

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

12. Do you feel more depressed, tense, or anxious than before your pain began?

No depression / tension — Often depressed / tense

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

13. Does your pain cause emotional problems that interfere with your family, social, and or work activities?

No problems — Severe problems

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

Office use only: **Total: _____**

I certify that pgs 1-3 of the Medical History – Acupuncture and Pain Disability Questionnaire forms were reviewed.

_____ _____

Signature of reviewing practitioner — Date

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ASSOCIATES

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INFORMED CONSENT FOR CARE

By signing below, I hereby request and consent to the performance of acupuncture, massage therapy, and/or nutrition/health counseling treatments and other procedures within the scope of the practice of these respective forms of care on me (or on the patient named below, for whom I am legally responsible) by a licensed practitioner in the practice listed above. I understand that acupuncturists and massage therapists are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

I understand that acupuncture is performed by the insertion of single use, sterile needles through the skin, at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that methods of treatment related to acupuncture 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 be 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.

Acupuncture typically involves safe methods of treatment, however, certain adverse side effects may result. These unusual side effects could include, but are not limited to, minor bruising or bleeding, soreness, numbness or tingling near the needling sites that may last a few days, dizziness, fainting, infection, spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). 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. 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.** I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment. I understand that results are not guaranteed and that I am free to stop the treatment at any time. I understand that while this document describes the major risks of treatment, albeit rare, there are other side effects that may occur.

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 carefully read, or have had read to me, all of the above information and have been told about the risks and benefits of acupuncture, massage therapy, and other procedures. I have had an opportunity to ask questions and am fully aware of what I am signing. 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.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

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FINANCIAL POLICY

We are dedicated to providing you with the highest quality of healthcare. Beyond the practice of medicine, all healthcare providers are faced with the task of working with many different insurance companies who help coordinate your healthcare and also help you meet your medical financial responsibilities. It is therefore important to us that you understand our financial policy. By signing this form, you acknowledge your financial responsibility. Please you're your insurance. **Your responsibility** begins when you call to make an appointment. Be aware of what your insurance pays for and does not pay for, as well as any co-pay and deductible. If you have health coverage with more than one plan, know the information for all. It is very important that all demographic information you provide at the time of scheduling is accurate. This includes any secondary insurance and in the event you are a dependent on a policy, the subscriber information.

Private Insurance

We currently accept and process for Aetna, Blue Cross Blue Shield, United, and Cigna. We will also process when Medicare is primary and one of the afore-named insurance providers is secondary. We are a group practice; the services that you will receive may be billed under numerous providers.

Your health insurance coverage is a contract between you and your health insurance company. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. We provide billing as a courtesy to you and we will do our best to verify your insurance coverage. The information we receive is a QUOTE from the insurance and not a guarantee of benefits or payment for services. It is your responsibility to know your plan. You need to know what your plan will and will not pay as well as your co-pay and deductible. You may be required to present your current insurance card at each visit. We will submit your services to your insurance company as long as you have provided us with the proper information. Waiting for the insurance company to reimburse our practice is a courtesy and it may be withdrawn under certain circumstances. Patient is still responsible for payment in instances when the insurance company does not reimburse our practice. If you change insurance companies or employers, or your policy is updated or changed, you agree to provide this office with the current information immediately.

By signing this form, you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. You may also choose to opt out of insurance assignment by signing an insurance waiver provided by this office.

If we are a participating provider with your plan, all co-pays and deductibles are due in full at time of service and we will accept the usual and customary rate allowed by your insurance company. However, there are some modalities we use that may not be covered by different insurance plans or may require an additional co-pay, even if we are a participating provider. If so, the patient is responsible for the unpaid balance or the additional co-pay.

Copays and Co-Insurance

If you have a policy that identifies a flat copay, we require that you pay the copay amount at the time of each visit. If your policy identifies a % liability, we require that you pay an approximate amount at the time of service. Amounts are as follows: 10% - $10, 20% - $20, 25% - $25, and so forth. Once the insurance carrier has processed the claim and designated the exact amount due, you will be credited for any over payment or billed for any remaining balance. In addition, if we are able to identify a consistent trend amount with your percent responsibility, we will update our records and collect the most common percent identified by your insurance, and any amounts more or less than the average amount, will be "balance billed".

If we are not a participating provider with your plan, you will be responsible for full payment of services, regardless of your insurance company's determination of usual and customary rates. If your plan has out-of-network benefits you can file the claim yourself and a form to do so can be provided our office upon request and payment should be sent directly to you by your insurance. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to address those directly with your insurance adjuster or agent.

Self-Pay

Patients who are not covered by a current insurance plan or do not present a current insurance card at the time of service, are required to pay, in full, for all charges on the day of service. We accept cash, check and credit card payments. There will be a $30 fee for a returned check. If a second check is returned, cash will be required for all future payments.

Worker's Compensation and Motor Vehicle Accidents/Personal Injury

In a case where a third party may be liable for payment of your bills, **you are responsible for your charges and we require full payment at the time of service.** Upon request, we will provide you with a superbill containing the details from your visit so that you may submit your own claims. We will not sign a Doctor's Lien with your attorney, and we are not permitted to bill your regular insurance for these services. The only exception is an insurance company in which our contract with them specifically states that we must file these claims with the subrogation department. Ultimately, you are responsible for the full balance of these charges. Regular insurance will not be filed for any visits associated with a possible worker's compensation claim, unless a notification is received from the insurer that the claim has been disallowed by Workers Compensation.

Unpaid Balances

Any account that goes beyond 90 days (3 months) with an unpaid balance and for which no contact or arrangements have been made, is automatically put into our in-house collection system. If an additional 2 months goes by with no response to our collection letters, the account will be evaluated for potential collection by our outside collection agency and you will be notified by mail that you have been dismissed from our practice.

At times temporary financial problems may affect the timely payment of your account. You are encouraged to contact and keep in touch with our billing staff to do everything possible to keep our relationship in good standing.

Missed Appointments

Please see and sign our separate form for our patient missed appointment policy.

Please be prepared when you schedule an appointment. Know your insurance and your responsibilities. We are happy to provide a further explanation for any of the above criteria. Our number one goal is to make our patient's time with us as worry-free and smooth as possible so that we can focus on assisting in your healing.

By signing this form, I have read, understand and agree to the financial policies of Holistic Health Associates.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Patient Name or Personal Representative **Relationship to Patient**

HOLISTIC HEALTH
ASSOCIATES
603-B W Patrick Street, Frederick, MD 21701 Phone: 301-620-1414

PATIENT MISSED APPOINTMENT POLICY

It is our goal that every patient cared for by Holistic Health Associates receives the very best care and service possible. Your program consists of a specific series of treatments given over a pre-planned time span, to maximize results. We care deeply about your results and the results of our other patients who are trying to maintain their programs in our busy center. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange your activities so that this can occur.
2. If you become ill, please check with us by phone. We may still want you to arrive, because treatments may be able to help you.
3. If you are unable to make an appointment due to an emergency, please contact us by phone so we can reschedule your appointment.
4. With the exception of an unexpected emergency, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled/missed appointments should be rescheduled & made up within 1 week.
6. There is a $40 service charge for cancellations made with less than 24-hour notice or no call/no show appointments.

I have read, understand, and agree to follow the above policy.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Patient Name or Personal Representative **Relationship to Patient**

HOLISTIC HEALTH
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603-B W Patrick Street, Frederick, MD 21701 Phone: 301-620-1414
Privacy Officer Contact: Lauren Embrey

INSURANCE INTAKE FORM

Providers: Ryan Diener ·: Priscilla Sullivan ·: Caitlin Toft ·: Ludwig Kragler ·:Frank Neely ·: KJ Sauer

Legal Name: _____ Preferred Name: _____

Address: _____ City_____ State _____ Zip_____

Client Phone: (day)_____

DOB: _____ Sex: M or F Marital Status: S M D W Full Time Student? Y or N

Employer: _____Full Time:___ Part Time:___ Position:_____

Primary Insurance: _____

Primary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number (on card): _____

Member ID# _____Group # _____

Secondary Insurance: _____

Secondary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number: _____

Member ID# _____Group # _____

****Please provide us with your insurance card(s) to photocopy for claims filing**.**

My signature below authorizes:

1) **Provider to render treatment and apply for benefits.**
2) **Payment of medical benefits directly to the Provider.**
3) **The release of any medical or other information necessary to process this claim.**
4) **MEDICAL INSURANCE: We have contracts with BC/BS Carefirst, Cigna, Aetna and United Healthcare companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.**

_____ _____

Signature of Patient or Patient Representative **Date**

_____ _____

Printed Name of Patient or Patient Representative **Relationship to Patient**

HOLISTIC HEALTH
ASSOCIATES
603-B W Patrick Street, Frederick, MD 21701 Phone: 301-620-1414

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.

WHO WILL FOLLOW THIS NOTICE

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. Current federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information and we respect our legal obligation to keep health information that identifies you private. This practice (all medical professionals, all employees, staff and other personnel, subsidiaries and business associates (e.g. software program company)) are required to abide by the terms of the Notice Of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. We reserve the right to change this notice at any time as allowed by law. If we change the Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post information about the change in our office, have copies available in our office, and post it on our Website. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are (if applicable): allergies you may have to certain materials, herbs or supplements, setting up an appointment for you, calling to remind you of an appointment, prescribing herbal supplements, developing treatment plans, or referring you to another doctor, practitioner or clinic for services. Examples of how we use or disclose your health information for payment purposes are: so that the treatment and services you receive from us may be billed and payment may be collected from you; an insurance company or a third party or inquiring about your health care plan(s). "Health care operations" mean those administrative and managerial functions that we must do to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES AND HEALTH RELATED BENEFITS AND SERVICES. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also leave voicemail messages, emails or text messages unless indicated otherwise.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family member or close friend. Proper authorization for release of information to persons other than the patient or getting copies of your health information from another professional that you may have seen before us will be given by written consent from the patient.

RESEARCH. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. In this situation, your name will not be used without permission, only the results of the treatment.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid if applicable; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to business associates (Ex: software company) who perform health care operations for us and who commit to respect the privacy of your health information

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You are welcome to request, in writing; a restriction; amendment or adjustment to the use or disclosure of your information. All written requests should be sent to the Privacy Officer and address listed at the beginning of this Notice. You have the right to:

- ask us to restrict our uses and disclosures for purposes of treatment, payment or health care operations.
- ask us to communicate with you in a confidential way, such as phoning at work rather than home, by mailing health information to a different address, or via email to your personal email address.
- ask to see or obtain photocopies of your health information. You will be able to review your information within 5 business days of your written request, once received and/or receive a copy of your health information within 15 business days of your written request, once received.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from the date the written request was received.
- get a list of all disclosures that we have made within the last six years (or any shorter period).
- get additional paper copies of this Notice of Privacy Practices upon request.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, please send a written complaint to the Privacy Officer at the address shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I, _____, have been presented with the Notice of Privacy Practices explaining my rights
(First and Last Name)

regarding my individually identifiable protected health information (PHI). I consent to the use and disclosure of my PHI for purposes of treatment, payment or other health care operations. Other uses of my PHI will require an authorization from me for the specific intention of disclosure.

Thank you for your continued confidence in our practice and for supporting our requirements.

_____ _____/_____/_____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

HOLISTIC HEALTH
ASSOCIATES

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

□ There are no other affiliated parties that I require to have access to my health information

****CHECK BOX ABOVE OR COMPLETE THE FOLLOWING BELOW****

1. **AUTHORIZATION**
   I, _____, authorize Holistic Health Associates to use and disclose the protected health information described below to the following person(s) or health care professional(s):
   (First and Last Name)

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. **DATES OF SERVICE (check one)**
   This authorization for the release of information covers the period of healthcare from:

   □ _____/_____/_____ to _____/_____/_____

   ****OR****

   □ All past, present and future periods.

3. **EXTENT OF AUTHORIZATION (check one)**
   □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse).

   ****OR****

   □ I authorize the release of my complete health record with the exception of the following information:
   - Mental Health Records
   - Communicable diseases (including HIV and AIDS)
   - Alcohol/drug abuse treatment
   - Other (please specify): _____

4. **EXPIRATION**
   Unless sooner revoked, this authorization expires **one year** from the date this authorization is signed, or as otherwise indicated here: _____.

5. **REVOCATION**
   I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to **Holistic Health Associates at 603-B West Patrick Street, Frederick, MD 21701**. I understand that a revocation is not effective to the extent of any person or entity that has already acted in reliance on my authorization or if my authorization was acquired as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. This medical information may be used by the person(s) or health care professional(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization form.

8. I understand that protected health information (PHI) used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law privacy regulations.

_____ _____/_____/_____
Signature of Patient or Personal Representative **Date**

_____ _____
Printed Name of Patient or Personal Representative **Relationship to Patient**