Becca Seitz, MAcOM, LAc
6123 SE 83rd Ave, Portland, OR 97266
(971) 285-4825
Becca@ThriveAcupuncture.org www.ThriveAcupuncture.org

The Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF THRIVE ACUPUNCTURE, LLC PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may gain access to this information.

Becca Seitz, MAcOM, LAc will ask you to sign an Acknowledgement that you have received the Notice of Thrive Acupuncture, LLC Patient Privacy Practices. In accordance with the HIPAA Privacy Regulation, this Notice describes how Thrive Acupuncture, LLC may use and disclose your protected health information and carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The Notice also describes your rights and Thrive Acupuncture, LLC's requirements to protect your health information.

Treatment, Payment and Health Care Operations

For purposes of treatment: We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. Your treatment may include acupuncture, massage and herbs. We may also, for the purpose of treatment, disclose your protected health information to another health care provider when needed by the provider to render treatment to you.

For Payment Services: We will use your health care information to receive payment for services and products. We will bill you and/or a third party payer for the cost of treatment and herbs provided to you. The information on or accompanying the bill may include your identification as well as the herbs you are taking.

For Health Care Operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal Privacy Regulations. For example, we may use information in your health record to train acupuncture personnel.

Other Uses and Disclosure of Protected Health Information Permitted or Required by Regulation.

The following is a description of other possible ways we may use and/or disclose your protected health care information.

Friends and Family: We may disclose your protected health care information to friends and family in case of an emergency to the extent necessary to help with your health care or with payment for health care. Using their judgment as health care professionals, our acupuncture staff may disclose protected information with a family member, other relative, close personal friend, or any person you identify as being involved in your health care.

Phone Calls, Email, Newsletters and Appointment Reminders: We may contact you by phone or by electronic means to provide reminders of herbal refills, appointments, health-related information, or clinic news that may be of interest to you.

Disclosure to the US Department of Health and Human Services: When the US Department of Health and Human Services is investigating or determining our compliance with the Federal Privacy Regulations, we are required to disclose your protected health information to the DHHS.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we believe that you may be a possible victim of abuse, domestic violence, neglect or other crimes.

Serious Threat to Health or Safety: We may disclose your protected health care information if we believe that the disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health and Safety: We may release your protected health information to the public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we may release information in your health record to the Food and Drug Administration relative to adverse events regarding drugs, foods, supplements and other health products or to post marketing surveillance to enable product recalls or replacements.

Law Enforcement: We may disclose to law enforcement agencies in response to a court order, subpoena, discovery request, administrative order, or other lawful process by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health care information.

Other Required or Permitted Disclosures: We may disclose your health care information to the following entities under given circumstances:
Whenever required to do so by law;

- To a correctional institution or its agents, if a patient is or becomes an inmate of such an institution when necessary for the patient's health or the health and safety of others;
- To notify, or assist in notifying a family member, personal representative, or another person responsible for the patient's care or the patient's location, or general condition.
- To the military authorities under certain circumstances when the patient is a member of the Armed Forces.
- To authorized federal officials for intelligence, counterintelligence and other national security activities.

Authorized Use and Disclosure
We will obtain your written Authorization before using or disclosing your protected health care information for purposes other than those listed above or otherwise permitted or required by law. You may revoke an Authorization in writing at any time. Upon receipt of this revocation, we will stop using or disclosing your protected health care information except to the extent that we have already taken action in reliance on the Authorization.

Patient Rights
Requests for Restrictions: You have the right to request that we restrict how your protected health information is used or disclosed in carrying out treatment, payment or health care operations. Such requests must be made in writing to Thrive Acupuncture, LLC at the address listed below. In your request, tell us: 1) the information of which you want to limit our use and disclosure and 2) how you want to limit our use and/or disclosure of the information.

We are not required to agree to the requested restrictions, but if we do, we will abide by our agreement except in an emergency.

Access to Protected Health Information: You have the right to look at or obtain a copy of your protected health information. You must make a request in writing to Thrive Acupuncture, LLC (see address below) to obtain access to your protected health information. If you request copies, we may charge you a reasonable fee for copies and postage, if you want them mailed.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed.

Accounting of Disclosures: You have the right to receive an accounting of the disclosures we have made of your protected health information. We will provide the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information.

Amendments to Health Care Information: You may request that we amend your protected health information if you feel that it is incomplete or incorrect. Your request must be in writing and it must explain why the information should be amended. If we did not create the information you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide you with a written explanation. If denied, you have the right to file a statement of disagreement with the decision.

For more information or to report a problem
If you would like additional information or have questions about our privacy practices, you may contact Thrive Acupuncture, LLC at the address or phone number listed below. You may also file a written complaint at this address. If you believe your privacy rights have been violated, you may file a complaint with Thrive Acupuncture, LLC or with the Department of Health and Humane Services.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or the Department of Health and Human Services.

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Acknowledgement of Receipt of the Notice of
Thrive Acupuncture, LLC Privacy Practices

I have received the Notice of Thrive Acupuncture, LLC Patient Privacy Practices from Becca Seitz, MAcOM, LAc, which describes how she may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This Notice also describes my patient rights and Thrive Acupuncture, LLC's requirements to protect my health information.

Thrive Acupuncture, LLC reserves the right to change the privacy practices that are described in the Notice of Thrive Acupuncture, LLC Patient Privacy Practices. All changes will be posted in the Clinic. I understand that I may request a copy of this notice at any time and discuss its contents with Becca Seitz, MAcOM, LAc.

The most current copy of this notice will be posted in the clinic.

Signature of Patient or Personal Representative Date

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

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This is the medical consent form for Thrive Acupuncture, LLC.

Primary Care and Medical Records: Acupuncturists (LAcs) practicing in the state of Oregon are not primary care providers. Thrive Acupuncture recommends that all patients have a regular primary care physician. All patients must provide medical records from a primary care physician upon request.

Pregnancy: If at any time you think you may be pregnant or are trying to become pregnant, please inform us immediately. Acupuncture and herbal treatments must be modified during this time.

Acupuncture: Acupuncture is performed by the insertion of needles through the skin to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. There may occasionally be adverse side effects such as: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment and, very rarely, lung puncture (pneumothorax).

Electro-Acupuncture: Electro-Acupuncture may be administered with the acupuncture. There may be certain adverse side effects such as electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs: Chinese herbs and substances may be recommended to treat bodily dysfunction or diseases or to modify or prevent pain perception and to normalize the body's physiological functions. Patients must follow directions for administration and dosage. There may occasionally be adverse side effects such as: changes in bowel movements, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. With any problems associated with these substances, patients should suspend taking them and call Thrive Acupuncture as soon as possible.

Miscellaneous Techniques: Acupressure, Massage, cupping, guasha, plum blossom and Reflexology are used to modify or prevent pain perception and to normalize the body's physiological functions. There may be certain adverse side effects such as: muscle soreness or achiness, bruising and the possible aggravation of symptoms existing prior to treatment.

- All of the above information has been explained to me by Becca Seitz, MAcOM, LAc and I have had my questions answered.
- I consent to treatment with acupuncture and Oriental medicine at Thrive Acupuncture.
- I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician.
- I understand that I am free to refuse or stop treatment at any time.

Patient Signature:_____ Date: _____

Printed Name: _____ Date of Birth: _____

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Name: _____Date:_____
(First) (Middle) (Last)

Address: _____

City, State, Zip: _____Phone: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ Preferred Name & Pronouns:_____

Email Address: _____

Emergency Contact: _____ Phone: _____

How did you hear about me? _____

Are you interested in receiving our E-newsletter? Y N

Who is your Primary Care Provider? _____

What health concerns have brought you here today (in order of importance to you)?

	Condition	Past Treatment
1.	_____	
2.	_____	

Do you have any reason to believe you're pregnant? Y N

Do you have any chronic infectious diseases? Y N If yes, please explain: _____

Do you currently suffer from any chronic illnesses? Y N If yes, please explain: _____

Please list any allergies or hypersensitivities (environmental, foods, medications): _____

_____

Please list all prescribed medications, over-the-counter medications, vitamin supplements, mineral supplements or herbal supplements that you are currently taking: _____

_____

Height: _____ Weight (current): _____ Weight (past maximum): _____ When? _____

What was your most recent blood pressure reading? _____ When was this reading taken? _____

Hospitalizations and Surgeries:

Reason: _____ Date: _____

Reason: _____ Date: _____

X-Rays/CT Scans/MRIs/Special Studies:

Reason: _____ Date: _____

Reason: _____ Date: _____

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Name: _____ Sex: _____ DOB: _____ Date: _____

Family History:	Mother	Father	Brothers	Sisters	Spouse	Children
Age: (if living, or at death)						
Health: (G=Good, P=Poor)						
Cause of death: (if deceased)						
Check any conditions below that the above family members have had:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Please check the box for symptoms below that you have experienced in the past year:

Head, Eyes, Ears, Nose and Throat:
- ☐ Headaches/Migraines
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Tearing/Dryness
- ☐ Hay Fever
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throat
- ☐ Teeth Grinding
- ☐ TMJ/Jaw Problems
- ☐ Other? _____

Gastrointestinal:
- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Passing Gas
- ☐ Heartburn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis B or C
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Other?_____

Cardiovascular:
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Palpitations/Fluttering
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Other?_____

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Persistent Cough
- ☐ Difficulty Breathing
- ☐ Frequent Common Colds
- ☐ Shortness of Breath
- ☐ Other?_____

Stools:
- ☐ Blood in Stool
- ☐ Undigested Food
- ☐ Diarrhea
- ☐ Constipation
- ☐ Mucous
- ☐ Other?_____

Urinary:
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Impaired Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Frequent Urinary Tract Infections
- ☐ Cloudy Urine
- ☐ Other?_____

Musculoskeletal:
- ☐ Muscle Spasms/Cramps
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Other?_____

Neurological:
- ☐ Dizziness/Vertigo
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy
- ☐ Other?_____

Endocrine:
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Night Sweats
- ☐ Feeling Hot or Cold
- ☐ Other?_____

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Name: _____ Sex: _____ DOB: _____ Date: _____

Miscellaneous:	**Male Reproductive:**	**Female Reproductive:**
☐ Fatigue	☐ Sexual Difficulties	☐ Irregular Cycles
☐ Slow Wound Healing	☐ Prostate Problems	☐ Breast Lumps
☐ Chronic Infections	☐ Testicular Pain/Swelling	☐ Breast Tenderness/Swelling
☐ Mood Swings	☐ Penile Discharge	☐ Nipple Discharge
☐ Nervousness	☐ Sexually Transmitted Infections	☐ Vaginal Discharge
☐ Mental Tension	☐ Other?_____	☐ Heavy Flow
☐ Anemia		☐ Clotting
☐ Cancer		☐ Premenstrual Symptoms
☐ Rashes/Eczema/Hives		☐ Menopausal Symptoms
☐ Cold Hands/Feet		☐ Difficulty Conceiving
☐ POTS		☐ Sexual Difficulties
☐ Hypermobility		☐ Sexually Transmitted Infections
☐ Other?_____		Other?_____

Female Reproductive/Menstrual History:

Age of first menses:	# of Pregnancies:	# of Miscarriages:
# of days of flow:	# of Live Births:	# of Abortions:
Length of cycle:	Birth Control:	

Lifestyle:

Diet: Are you (circle one): Vegetarian Vegan Omnivorous Other?_____

Fluid Intake (amount and type): _____

Exercise: _____

Education: _____

Occupation: _____ Do you enjoy your work? Y N Why/Why Not? _____

Nicotine/Alcohol/Caffeine Use: _____

FINANCIAL POLICIES

- Payment must be made at the time of service. Payment may be made in the form of cash, check, debit or credit card.
- A $25 fee will be assessed for all returned checks.
- If you should need to reschedule or cancel an appointment, please do so at least 24 hours prior to your appointment time. If an appointment is cancelled within 24 hours or missed, please note that a $30 missed appointment fee will be charged to your account.
- We may be able to bill your insurance company for your treatment. If we are unable to directly bill your insurance company, we will provide you with a receipt that contains all of the information needed by an insurance company to reimburse you.
- You are financially responsible for your account, regardless of insurance coverage. Accounts more than 30 days past due (after receipt of insurance payments, if applicable) will be assessed a 2% monthly fee.

I have read and understand the above financial policies.

Signature: _____ Date: _____