McKay
Chinese Herbal Medicine & Acupuncture

NORTH CAROLINA NOTICE FORM
Notice of Privacy Practices
to Protect the Privacy
of Your Health Information

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.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment*, and *health care operations* purposes with your consent.

- "**PHI**" refers to information in your health record that can identify you.
- "**treatment**" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician.
- "**payment**" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "**health care operations**" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "**use**" applies only to activities within my (office, clinic, practice, etc.) such as sharing, employing, applying, utilizing, examining, and analyzing in formation that identifies you.
- "**disclosure**" applies to activities outside of my (office, clinic, practice, etc.) such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(as described in section III of this notice). On your request, I will discuss with you the details of the accounting process.

- **Right to a Paper Copy**---You have a right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

My Duty to you

- I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by U.S. mail.

Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complaint to the Secretary of the Department of Health and Human Services.

Effective Date, Restrictions and Changes to Privacy Policy:

This notice will go into effect as of April 14,2003.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice.

McKay
<u>Chinese Herbal Medicine & Acupuncture</u>

Notice Receipt Acknowledgement

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Purpose: This form is used to confirm that an individual has received a copy of the notice of primary practices.

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I, ________________________, acknowledge that I received a paper copy of McKay's Notice of Privacy Practices.

Signature: ________________________ Date: _______________________

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: __________________________________

Relationship to Individual: _______________________________________

Informed Consent to Massage

I hereby request and consent to the performance of massage or other procedures within the scope of the practice of massage therapy on me (or the person listed below, for whom I am legally responsible).

I have had the opportunity to discuss with the Massage Therapist the nature and purpose of massage therapy.

If I am part of an integrated plan with massage and acupuncture, I wish to rely on the licensed practitioners to exercise their professional judgment during my course of treatment and based upon the facts then known, to proceed with treatment in my best interest. This being so, will include and not be limited to the Massage Therapist and any involved practitioners discussing my treatment and reviewing my medical records alike.

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Print Patient's name

______________________________ _______________
Patient's signature Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name____________________________________

Relationship to patient____

Welcome to Massage & Bodywork Therapy

Name: ___________________________ Date: ________________
Address: ____
City: ______________________ State: ________ Zip: _________
E-mail Address: ____
Phone Number: _____________________________
Occupation: _______________________________
Date of Birth: _______________________________
Name of Physician: ___________________________
Date of Your Last Physical Examination: ______________________

Have You Ever Experienced Any of the Following Treatments?

______ Massage
______ Reiki
______ Cranio Sacral Therapy
______ Manual Lymph Drainage

Date of your Last Treatment: _______________________________
How did you hear about us? (Please circle) Radio Drive By
Search Engine: Google Publication: Encore Referral: Friend/Family___________
Yahoo Natural Awakenings Physician_______________
Other______ Phone Book Other_________________

Emergency Contact: ______________________________________
Emergency Contact Phone Number: __________________________

McKAY

Medical History

Please check whether you have (had) any of the following conditions.

_________ HIV Virus
_________ Herpes Simplex
_________ Heart Disease
_________ Heart Attack
_________ High Blood Pressure
_________ Fractures & other serious injuries
_________ Stroke
_________ Epilepsy / Convulsions
_________ Diabetes
_________ Tumor or Cancer
_________ Skin Disease

Major Surgeries____

Allergies: ____

Current Medications ____

Are you pregnant? __________ If so, # of weeks pregnant _____________

Please indicate the appropriate location of pain/discomfort that you are presently experiencing.

Please rate your pain on a scale of 1 to 10 __________________