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
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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 ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of acupuncture on me (or the person listed below, for whom I am legally responsible) by one of the licensed acupuncturists at McKay Healing Arts.

I have had the opportunity to discuss with one of the acupuncturists the nature and purpose of acupuncture.

I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some potential risks to treatment, an example being nausea. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications prior to administrating acupuncture. I wish to rely on him or her professional judgment during the course of the procedure, and based upon the facts then known, to proceed with treatment in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

_____

_____
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 Chinese Herbal Medicine & Acupuncture

Name _____ Today's Date _____

Address _____ City _____ State ____ Zip _____

Phone: (Hm)_____ (Other)_____ E-mail_____

Birthdate _____ Male____ Female____ Social Security #_____

Weight ____ Height ____ Pulse Rate ____ Normal Blood Pressure _____

Are you pregnant or think you might be? _____

Current Medications, Herbs, Drugs _____

_____

Major Operations, Surgeries, Illnesses (with dates) _____

_____

Chief complaint; Describe your problem _____

_____

Date it began_____ Was cause an accident? _____ Rate pain 1-10 _____

Does anything make it worse? _____ Make it better? _____

Do you have a medical diagnosis for your problem? _____

Were X-rays, MRI, or lab tests taken? _____

_____

Do you have any other major health problems such as pacemaker, heart condition, or diabetes? ___

_____

Primary Physician _____

How did you hear about us? (Please circle)

Search Engine: Google Yahoo Other_____

Publication: Encore Natural Awakenings Phone Book

Radio Drive By

Referral: (name?)_____

Physician(name?)_____

Other_____

Emergency Contact name _____

Emergency Contact phone _____

NAME: _____ DATE: _____

ENERGY: □ Low □ Medium □ High

Best time of day? _____

Low time of day? _____

FATIGUE: □ Lethargic □ Feels Heavy

What makes it better or worse? _____

_____

STRESS: □ None □ Moderate □ Severe

Cause: _____

THIRST: □ Low □ Medium □ High

Daily water intake? _____

Do you drink ice water? _____

Nauseous after water intake? _____

HOT/ COLD: _____

SWEAT: □ Night □ Day □ Excessive

Hot flashes? _____ How often? _____ With Sweat? _____

HEADACHES: □ Mild □ Severe □ Chronic □ Occasional Date began: _____

What makes them better? _____ Worse? _____

Are they □ Sharp □ Dull □Diffuse □ Bandlike □ Fixed □ Borring

Location: □ ST LI/ Frontal □SJ GB/ Temporal one sided □ UB SI/ Occipital □LIV UB SI/ Parietal

DO YOU EXPERIENCE MEMORY LOSS? _____ □Long term □ Short term

DO YOU SUFFER FROM BALANCE LOSS/ PROBLEMS? _____

EARS: □Hearing Loss □ Ringing □ Infections □ Pain □ Discharge

Other Issues: _____

EYES: □ Loss of sight □ Blurring □ Infections □ Dryness □ Floaters □ Photophobia □ Night Blindness

Other Issues: _____

NOSE/ SINUSES: □Allergies □Sinusitis □Phlegm/ Congestion □Postnasal drip □Sputum □ Nosebleeds

Other Issues: _____

HAIR: □ Loss □ Brittle □ Oily Other Issues: _____

TEETH: □ TMJ □ Gingivitis □ Loss Other Issues:_____

MOUTH/ TONGUE/ GUMS: □ Sores □ Swelling □ Location Other Issues: _____

THROAT/ LYMPH GLANDS: □ Sore □ Swollen □Hoarseness □Difficulty Swallowing

□ Chronic Infections □ Object Sensations in Throat Other Issues: _____

LUNGS: □ Cough □ Wheezing □ Phlegm □ Voice Loss □ Mucus Rattles □ Coughing Blood

Sputum Color? _____ Consistency? _____

Do you experience difficulty breathing? _____

CHEST: □ Pain □ Tightness □ Pressure □ Side Pain

Other Issues: _____

HEART: Do you experience heart palpations? _____

BREAST: □ Pain □ Lumps □ Cysts □Tumors

Other: _____

ABDOMEN/ STOMACH: □ Tightness □ Pressure □ Bloating □ Ulcers □Nausea □Gas

□ Heart burn □ Burning □ Belching □ Bitter Taste □ Bad Breath □ Lumps

ABDOMEN PAIN: □ Dull □ Sharp □ Fixed □ Diffused

Likes pressure Hot/Cold

Dislikes Pressure Hot/Cold

APPETITE: □ Normal □ High □ Low

Favorite Tastes:_____ Unusual Tastes in Mouth? _____

Food Cravings? _____ Tired or weak if missed meal? _____

Do you skip breakfast? _____ Any Snacks? _____

How many meals a day do you eat? _____ Biggest meal? _____

STOOL: □ Normal □ Diarrhea □ Constipation □ Hemorrhoids □ Blood in stool

□ Pain □ Formed □ Unformed □ Undigested food □ Mucus in stool

□ Alternating □ Burning □Odor Other: _____

URINATION: □ Difficulty Urinating □ Burning □ Pain □ Infections □ Blood in urine □ Odor □ Dribbling

Color?:_____ Amount? _____

Water Retention? _____ Location:_____ Urinary Tract Infection? _____

EDEMA: □ Face □ Arms □ Legs □ Upper □ Mid □ Lower □ jiao □ pitting □ hot

SKIN: □ Dry □ Itchy □ Moist/Clammy □ Oily □ Melanoma □ Acne □Moles □ Boils □ Lumps

Other: _____

BONE/JOINT: Do you experience pain in any of the following?

□ Neck □ Shoulder □ Lower Back □ Mid Thoracic □ Elbow □ Wrist □ Knee

□ Leg Weakness □ Ankles □ Feet □ Arthritis □ Other

SLEEP: □ Trouble falling asleep? □ Trouble staying asleep? □ Excessive Dreams □ Restful

On average, how many hours do you sleep a night? _____ Waking time? _____

(Continue on next page →)

NEUROLOGICAL:

□ Seizures □ Irritabilty □ Frequent Crying □Shingles

□ Alzheimer's □ Worry/ Anxiety □ Mood Swings □ Confusion

□ Depression □ Poor Concentration □ Tremors

□ Easily Angered □ Poor Coordination □ Numbness/ Tingling in Limbs

□ Neuralgia □ Suicidal □ Muscle Weakness

MEDICAL HISTORY:

- Please indicate if you have a history of the following:

□ Arthritis □ Heart Trouble

□ Asthma □ Hepatitis

□ Anemia □ Jaundice

□ Cancer: _____ □ Kidney/ Urinary/ Bladder issues

□ Chronic Fatigue □ Lupus

□ Chronic Fevers □ Osteoporosis

□ Chronic Swollen Lymph □ Stroke

□ Diabetes □ Sudden Weight Loss or Gain

□ Epilepsy □ Ulcers

□ Gallstones

FAMILY HISTORY: Any member affected by problems listed above? □Yes □No

Family Member(s): _____

Illness(es): _____

FEMALES

MENSTRUATION & GYNECOLOGY: Last period: _____ Length of Monthly Cycle:_____

Do you have problems w/ regularity? _____ How many days does period last?_____

Color _____ Heavy/ Light flow_____

Clots? _____ Clot Size _____

Cramping: □ Before □ During □ After

PMS: □ Water Retention □ Irritability □ Breast Soreness □ Tearfulness

□ Food Cravings □ Missed Periods

Age Period Started: _____ Age Period Ended: _____

PREGNANCY: # of Miscarriages: _____ # of Deliveries: _____

# of Cesareans: _____ # of Abortions: _____

OPERATIONS: □ Cervix □ Uterus □ Ovaries

Other : _____

SEX DRIVE: □ None □ Low □ Med □ High □ Painful

DISCHARGES: □ Yellow □ White □ Thick □ Thin □ Itching □ Burning □ Chronic

Time in Cycle: _____ Vaginal Dryness: _____

PID: □ Cysts □ Tumors □ Endometriosis

□ Herpes □ Other Infections: _____

LAST PAP: _____ **BIRTH CONTROL:** _____

MALES

OPERATIONS: □ Vasectomy □ Prostate □ Other: _____

SEX DRIVE: □ None □ Low □ Med □ High □ Painful

CONCERNS: □ Lumps □ Tumors □ Impotence □ Infertility □ Prostate Trouble

□ Premature Ejaculation □ Discharges □ Burning Urination □ Herpes

□ Testes □ Ejaculation □ UTI