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Doctor of Acupuncture and Oriental Medicine
501 Cedar Street, Suite B. Santa Cruz, CA 95060
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# Medical History

Name_____Birth day _____ Age_____

Address_____
*Street* *City* *State* *Zip*

Home Phone (___)_____W. phone (___)_____ Cell phone (___)_____

Which phone is best to leave messages on?_____

Whom can I thank for your referral? _____

Main Concern

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For How Long_____

What has been diagnosed (by M.D., etc.) _____

Other Concerns_____

What have you found helpful for your main concern

_____

Have you ever had acupuncture or herbs? If so why did you discontinue? _____
_____

Dietary Restrictions_____
Dietary Emphasis_____

Food Cravings_____

Allergies_____

Social Drugs, mark past or present (coffee, alcohol, sugar, tobacco, marijuana, etc.)
_____
Are you taking any medications? Please list all medications, herbs, vitamins, and minerals you take with dosages, even if you take them only occasionally (you can bring these with you on your first visit as well):
_____
_____
_____
_____
_____
_____Use the back side of this form to continue…..

Please list the locations of any scars that are numb, sore, painful or inflamed:
_____

**Emergency Contact Information**

Name_____Phone #_____

Relationship_____

## Family History

Use a C for a Current Problem or a problem still present at the death of the individual indicated

Use an H if it is a historical condition that is not present now or was not present when person deceased

I understand that you may not be aware of these condition in many cases; leave these blank

| **Condition or Disease** ☐ | Biological Father | Biological Mother | Spouse or Partner | Brother(s) | | Sister(s) | | Children | |
|---|---|---|---|---|---|---|---|---|---|
| AGE of Individual ☐ | | | | | | | | | |
| Asthma | | | | | | | | | |
| Hay fever/ Seasonal Allergy | | | | | | | | | |
| Food Allergy / Sensitivity | | | | | | | | | |
| Eczema | | | | | | | | | |
| Psoriasis | | | | | | | | | |
| Other Skin Disorder | | | | | | | | | |
| Diabetes I - Juvenile | | | | | | | | | |
| Diabetes II – Adult | | | | | | | | | |
| Hyperthyroid or Graves Disease | | | | | | | | | |
| Hypothyroid or Hashimotos | | | | | | | | | |
| Osteoporosis or Bone Problems | | | | | | | | | |
| Rheumatoid Arthritis | | | | | | | | | |
| Other Arthritis or joint pain | | | | | | | | | |
| Lupus or other Immune Disorder | | | | | | | | | |
| Liver Disease | | | | | | | | | |
| Hepatitis | | | | | | | | | |
| Gallbladder Removed | | | | | | | | | |
| Gallstones | | | | | | | | | |
| Kidney Stones | | | | | | | | | |
| Kidney disease | | | | | | | | | |
| Heart Disease or problem | | | | | | | | | |
| Stroke | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| Cholesterol problems | | | | | | | | | |
| Cancer – Include Type | | | | | | | | | |
| Digestive Disorder | | | | | | | | | |
| Weight Problem | | | | | | | | | |
| Anorexia, Bulemia, Eating Disorder | | | | | | | | | |
| Crohns, Ulcerative Colitis, Colitis | | | | | | | | | |
| Irritable Bowel | | | | | | | | | |
| Chronic Constipation | | | | | | | | | |
| Alcohol Abuse or Excess | | | | | | | | | |
| Insomnia | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Anxiety | | | | | | | | | |
| Depression | | | | | | | | | |
| Other:_____<br>_____<br>_____<br>_____<br>_____<br>___<br>_____ | | | | | | | | | |

## Chronological Life History

Do you have asthma, a congenital heart murmur or an autoimmune condition? Have you been in car accidents? Bike accidents? Had surgery? Lost consciousness? Delivered babies? How was your birth? THIS IS THE PLACE FOR YOU TO TELL ME YOUR UNIQUE MEDICAL HISTORY.

**First list age**, **then event** (milestones or significant events that mark your life) from your birth all the way up to the present day.

# Questions for Women

Gynecologist/Nurse Practitioner_____

Age of onset of menses: _____

Physical symptoms or emotional changes?_____

_____

Are there any problems with you menstrual cycle?

_____

_____

Has it changed? _____

What do you experience? If it is changing, indicate how.

premenstrually_____
at the beginning of period _____
during _____
right after _____
mid-cycle _____

Are your periods regular? _____ Length of cycle (from first day of bleeding or spotting to the first day of next flow)_____

How many days of bleeding? _____generally heavy _____medium_____light_____

Is the blood: pale _____ bright red _____ dark _____ watery _____ clots_____thin _____

Are your periods painful? _____ When? _____

What do you do to relieve the pain? _____Does it work?_____

Breasts: unusual lactation or discharge_____fibroids_____Soreness_____when_____

Do you do a monthly self exam?_____Have you had a mammogram?_____

If so, why?_____

Number of pregnancies_____miscarriages_____abortions_____births_____

Any pregnancy complications or subsequent problems?

_____

Methods of birth control used_____

Complications?_____

Have you ever taken the pill?_____ For how long_____

Ever taken the morning after pill?_____ How many times?_____

Is fertility an issue?_____ How long have you been trying_____

Tests, drugs or other treatments_____

Age period stopped_____Cause_____

If hysterectomy, when, why, and what was removed_____

_____

Physical symptoms or emotional changes

_____

_____

Are you now taking HRT (Natural HRT or Conventional)?_____

Have you ever taken HRT?_____For how long_____ Does it help? _____

Are you taking any vitamins, herbs, or "non prescription" hormones for menopausal symptoms?

_____

Does it help, if yes, in what way?

_____

History of vaginal infections or unusual discharge _____

Other sexually transmitted diseases_____

Pain related to intercourse _____ Changes in sexual energy_____

When?_____
Relationship difficulties around sexuality_____

History of sexual assault or abuse _____

Did your mother take DES _____

Family history of ovarian, uterine, cervical, breast, or prostate cancer

_____

**Endless Possibilities Acupuncture, INC**
**501 Cedar Street # B**
**Santa Cruz, CA 95060**
**(831) 426-1093**

# HIPAA Notice of Privacy and Confidentiality & Patient's Rights

**Patients' rights under HIPAA are described in the "Notice of Privacy Practices" The Notice will be made available to patients. These rights include:**

1. Right to receive the 'Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.

2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copiers. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."

3. Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.

4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.

5. Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.

6. Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

## Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

# Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.

**You have the right to:**

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record
- Ask that your health information not be used for certain purposes, for example, research
- Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
- Specify where and how you should be contacted
- Receive a paper copy of the full Notice of Privacy Practices

### Who is authorized to see confidential Patient Health Information (PHI)?

The "Notice of Privacy Practices" describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.

1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)
3. Health care operations and business operations, including research (when approved by the IRB and with a patient's written permission); health care communications between a patient and their health care practitioner.

### Written Authorizations

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the "Notice of Privacy Practices".

**Exceptions to the Rules**

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the "Notice of Privacy Practices" and "Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
- I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature_____ Date_____

Birth_____

Printed Name_____ Relation (if other than the patient)_____

Patient declined to sign receipt (signature of practitioner)_____

Patent unable to sign (witness signature)_____Reason unable_____

## Informed Consent to Acupuncture Treatment and Care

I hereby request and consent to the performance of procedures, which are within the scope of a California license to practice acupuncture. This includes, but is not limited to, acupuncture treatments on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists or students who now or in the future treating me while working or associated with, or serving as back –up for Maureen H. Rozenn.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion and heat therapy, cupping, electro-acupuncture, Tui-Na (Oriental massage), dietary supplements, herbal therapy, and nutritional counseling. Moxabustion and heat therapy including heat lamps, tiger warmers, cone, pole and Japanese moxabustion may cause discomfort and in rare cases may cause burns. I will alert the acupuncturist, or person watching the progress of my moxa treatment, immediately if any type of heat therapy is uncomfortable. The acupuncturist may choose to perform a form of moxabustion which consists of placing small rice sized pieces of moxa on an ointment barrier and lighting them to stimulate certain acupuncture points. I will decline the procedure if I do not with to receive this or any other treatment.

I understand that acupuncture treatments are generally safe, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a couple of minutes to a few days, dizziness or fainting, and nausea. I will notify the acupuncturist immediately if I feel uncomfortable at any time during or after treatment. There have been instances reported of spontaneous miscarriage and pneumothorax, although these side effects are very rare. Infection is another possible risk, although the acupuncturist only uses sterile, disposable acupuncture needles.

Herbs that have been used in treatment, or are recommended, are traditionally considered safe in the practice of Oriental Medicine, although may be toxic in large doses. Some of the possible side effects of taking herbs are: nausea, gas, hives, rashes, diarrhea, vomiting and tingling of the tongue. If I experience anything

unusual during herbal treatment I will notify the acupuncturist via email immediately. I understand that some herbs and other therapies may be inappropriate during pregnancy. I will notify the acupuncturist if I think I may be pregnant.

Oriental medicine can be used to treat pregnant women for all sorts of disorders ranging from low back pain to the common cold. I understand that receiving treatment during pregnancy may start labor. Treatment (pre-birth treatments) can be administered to prepare women for labor. Also, there are specific points and techniques traditionally used to help the mother promote correct fetal position. When treatment appropriate for my Oriental medical diagnosis is given, during the last few weeks of pregnancy, or when past due, labor may start or a breech baby may turn. I understand this is a possibility and that if I am not willing to take this risk I will refuse treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the acupuncturist to be able to anticipate and explain all of the risk and complications. I wish to rely on the acupuncturist to exercise judgment and perform, during the course of my treatments, and based upon the facts then known, the therapy that is in my best interest.

I understand that results are not guaranteed. 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 conditions for which I may seek treatment.

Patient Signature_____Date_____
(Or Patient Representative)

Acupuncturist Signature_____Date_____

**Hello, and welcome to my practice!**

I am looking forward to our appointment. You should allow 2 hours for this initial visit. During our first meeting we will go over your health history. So, along with the enclosed paperwork, bring with you any herbs/supplements/drugs you are currently taking. Also bring any pertinent lab work and imaging reports.

The cost of the first visit is $190.00. In addition to reviewing your medical history I will also do an Oriental medical examination and acupuncture treatment. We will also discuss my Oriental medial findings and will develop a comprehensive treatment plan detailing recommendations regarding the modalities I feel are appropriate for you such as: acupuncture, herbal therapy, diet and lifestyle changes, supplements etc.

Follow up visits, including an office visit and acupuncture, are $120.00 and last between 60-75 minutes. If you need to be up in less than an hour-please call earlier that day and let us know! If I feel that other modalities will be of benefit, I will discuss them and their cost with you. While I do not bill insurance directly, upon request I will provide you with an attending physician statement (a detailed receipt including all of the diagnosis and procedure codes insurance companies require). You can bill your insurance company directly and collect compensation from them provided they cover my services. Every insurance company and policy has different guidelines regarding acupuncture reimbursement so you should contact them directly to find out the particulars of your policy.

Additionally, as part of my teaching activities I have Chinese medicine students assisting me in my office. They answer phones, do paperwork, book appointments and if a patient is comfortable with it, they come in and observe office visits and acupuncture treatments. If for any reason you do not wish to have a student observing, that is perfectly fine. We will ask you about your preference prior to the start of treatment and simply ask that you vocalize your preference.

If you have to reschedule any future appointments, please give at least 48 hours notice to avoid a late cancellation penalty. Contact by email at dr.rozennscheduling@cedarstreetclinic.com is best. For more information about me and my practice, visit my website www.acupuncturesantacruz.net. Thank you and I look forward to meeting with you!

Sincerely,

Dr. Maureen Rozenn, LAC, DAOM, FABORM

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## Terms of Care - Our Cancellation Policy

***Please Read Carefully***!

Thank you for remembering that cancellation requires 48 hours advance notice.
Under **48hrs** notice = **half** of the appointment price is owed
Under **24hrs** notice = the **full** appointment price is owed

(Example: Cancel by 2:00 Wednesday for 2:00 Friday appointment)

We Prioritize Your Appointment.
We are invested in the achievement of your health goals!
We want to work with people who also prioritize their health. Therefore, we expect our patients to be committed to their treatment plans and appointment times. That means that when something comes up,

honoring the appointment you've made (once you've hit the 48 hour mark) is your first choice. If you're too ill to drive, contact us ASAP.

Late arrival by 15 minutes or more is considered a missed appointment. Email appointment reminders are not guaranteed. Please rely on your personal calendar or appointment card instead. If you owe a missed appointment or late cancellation fee, payment by phone prior to your next appointment is preferred.

By signing below, I agree to the following:

1. I am solely responsible for keeping or canceling any appointments I make.
2. I will do my best to prioritize appointments and arrive on time.
3. I will pay the required amount for all missed appointments and late cancellations.
4. I know that late arrival by 15 minutes or more is considered a missed appointment and the full price is owed.
5. I know that email appointment reminders are in no way guaranteed, and their timing does not correspond in any way to the cancellation policy.

I understand that I should in no way rely on appointment reminder emails. I understand that they are a courtesy only and that I may not receive them for a variety of reasons out of the control of Dr. Rozenn's clinic. I understand that they may not arrive 48 hours before my appointment time, and that I may still owe a late- cancellation fee if I reply to the reminder with a cancellation. I understand that if I do not read my appointment reminder carefully, I may not see the correct time and I am responsible for this should it cause me to miss my appointment.

6. I understand and agree to the Terms of Care of Dr. Rozenn's office.

_____

Printed Name Date

_____

Signature

## Directions

From highway 17 or 1 north, exit into Santa Cruz towards 1 north to Half Moon Bay. Go strait through the first light at River st. and highway 9. Go strait through the second light at the cross between Mission, highway 1 and Chestnut. Going strait through this light will put you on Chestnut Street. Continue down Chestnut and make a left on Lincoln. Then, three blocks down, make a right on Cedar Street. The clinic is at the corner of Cedar and Elm, in a grayish building, on the right.

If coming from north of Santa Cruz, follow 1 south into Santa Cruz. It will become Mission Street. Go right on Chestnut. Go left on Lincoln, then three blocks down make a right on Cedar street. The clinic is at the corner of Cedar and Elm, in a grayish building, on the right.

**Parking**

There is a free (three hour) parking lot right across the street from the clinic. Up and down Cedar Street there are metered parking. Along Elm street is free 2 hour parking. We have only one free parking place in the lot designated for the building, at the far left end corner of the lot. Important: Our suite's designated parking spot is labeled B. Do not use any of the other spots in the back lot (sorry, but our neighbors will tow you)!