



**CALDWELL**  
Family Wellness  
Acupuncture & Chinese Medicine

10979 REED HARTMAN HWY, SUITE 129  
CINCINNATI, OH 45242  
PH: (513) 834-8173  
www.CaldwellAcupuncture.com  
info@caldwellacupuncture.com

## Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Caldwell Family Wellness.

**Legal Responsibilities of Caldwell Family Wellness:** As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

**Protected Health Information Use and Disclosure:** Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

**Treatment:** Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

**Payment:** Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**Healthcare Processes:** We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

**Person Involved In Care:** In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare.

**Marketing Health-Related Services:** The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

**Required By Law:** Your protected health information may be used or disclosed if required by law.

**Abuse or Neglect:** As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

**National Security:** Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

**Appointment Reminders:** Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whoever referred you to our practice.

## **Patient Rights**

**Access:** At all times, you have the right to review your protected health information, with limited exceptions.

At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

**Disclosure Accounting:** Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

**Restrictions:** You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**Alternative Communication:** Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

**Amendment:** You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

**Electronic Notice:** If you receive a notice electronically, you are entitled to receive the notice in writing as well.

## **Questions and Complaints**

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

## Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture by licensed acupuncturist, Esly Caldwell III, L.Ac.. I understand that acupuncturists practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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 am aware that certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

## Notice of Privacy Policies and Patient Rights

I have read and understood the HIPAA privacy policies of Caldwell Family Wellness. I acknowledge that I have had an opportunity to ask questions about it and all questions I have asked have been fully answered.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient (if applicable):** \_\_\_\_\_

## Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birth date _____</p> <p>Occupation _____</p> <p>Company name _____</p> <p>Primary physician _____</p> <p>Physician phone number _____</p> <p>How did you hear about us? _____</p> <p>_____</p>	<p>Home phone _____</p> <p>Work phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p>
HEALTH HISTORY	
<p>What are your primary concerns for coming in for treatment?</p> <p>1- _____</p> <p>2 - _____</p> <p>3 - _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries.</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives.</p> <p>c Diabetes c High blood pressure c Stroke</p> <p>c Cancer c Heart disease c Kidney disease</p>	<p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Difficulty in focusing</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Easily startled</li> <li><input type="checkbox"/> Excessive worry</li> <li><input type="checkbox"/> Excessive anger</li> <li><input type="checkbox"/> Excessive fear</li> <li><input type="checkbox"/> Fatigue/tiredness</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Loss of sleep/poor sleep</li> <li><input type="checkbox"/> Loss or gain of weight</li> <li><input type="checkbox"/> Nervousness/irritability</li> <li><input type="checkbox"/> Overwhelmed by life</li> </ul> <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Bleeding disorders</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes</li> </ul> <p>How long has it been since you have had a complete medical exam? _____</p>

## HEALTH HISTORY...CONTINUED

Check symptoms you have or have had in the last year:

### MUSCLE/JOINT/BONES

- Tremors or Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

### EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

### SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

### GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

### CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

### GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

### FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

### FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? \_\_\_\_\_

## SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Pain scale and body chart

1. Please use the scale below to tell us how intense your pain is. Place an "X" through the number that best describes the intensity of your pain **NOW**.
2. Please use the body chart below to help us understand the pain areas
  - a. Please draw on the picture where you feel pain or any other sensations (for example pins and needles)
  - b. Please describe below what the pain feels like (e.g. sharp, aching, burning). Use symbols below if it helps

***Burning***  
 =====

***Tightness or discomfort***  
 0000000  
 0000000

***Ache***  
 XXXXXXX  
 XXXXXXX

***Numbness***  
 +++++++  
 +++++++

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

0= No Pain 10= Most Intense Pain

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

0= No Pain 10= Most Intense Pain

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

0= No Pain 10= Most Intense Pain