Laurel Brody – Patient Information

LAST NAME_____FIRST NAME_____M.I._____

PO BOX/STREET ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____

BIRTH DATE_____SEX_____ARE YOU A SENIOR CITIZEN? Yes ◯ No ◯

(If yes, you may be eligible for our senior discount)

EMAIL ADDRESS_____

EMPLOYER_____WORK PHONE_____

EMPLOYER ADDRESS_____

CITY_____STATE_____ZIP_____

Charges are due and payable at the time service is rendered.

EMERGENCY CONTACT PERSON_____PH#_____

*REFERRED BY*_____

DO WE HAVE YOUR PERMISSION TO THANK YOUR REFERRER? Yes ◯ *No* ◯

PATIENT/CLIENT'S SIGNATURE_____

(DO NOT WRITE BELOW THIS LINE)

****

FOR OFFICE USE ONLY

EMP-REL_____ACC-REL_____AUTO? _____(YES OR NO) NEITHER_____(CHECK ONE)

INJ (A)_____ILNS (I)_____(CHECK ONE) FINANCIAL AGREEMENT SIGNED_____

D/O/ONSET_____(DATE OR GRADUAL)

D/O/1ST CONSULTATION_____

DIAG. CODE #S (LIMIT TO 4)_____

CASH PAYING? (YES OR NO)

CHART #_____

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PATIENT INFORMATION

What, if anything, would you like us to know about your family, who you live with, primary relationships, children? _____

_____

Please list any major physical or emotional traumas you've had to deal with in your life.

_____

_____

HEALTH MATTERS

What is your chief concern? _____
When did you first have symptoms? _____
What aggravates your condition? _____
What relieves it? _____
Are there other health issues you would like to discuss or work on? _____

_____

Who else is currently involved in your health care? (Doctors, therapists, bodyworkers, etc.)

_____

_____

MEDICAL HISTORY

List any known or suspected food allergies: _____
List any other allergies (medical, environmental): _____

_____

PAST INJURIES

Auto Accidents: _____
Broken Bones: _____
Sprains/Strains: _____
Dislocations: _____
Head Injuries & Concussions: _____

PAST SURGERIES

List type and year of surgeries: _____
Have you ever been advised to have surgery which was not done? _____
Have you ever been hospitalized for anything other than surgery? _____

_____

PAST MEDICATIONS

_____

_____

_____

_____

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Indicate any past conditions with a "**P**" and any current conditions with a "**C**".

WATER ELEMENT
____ Hearing loss
____ Ringing in the ears
____ Sinus congestion
____ Dizziness
____ Asthmatic coughing
____ Poor memory
____ Darkness under the eye
____ Loose teeth
____ Tired spirit
____ Hair thinning or loss
____ Pre-mature aging
____ Low back pain
____ Frequent urination
____ Kidney stones
____ Weak knees/legs
____ Reduced sexual energy
____ Night sweats
____ Perspire very easily
____ Rapid weight change
____ Thyroid problems
____ Diabetes
____ Edema/esp. lower body
____ Burning dark urine

WOOD ELEMENT
____ Headaches
____ Migraines
____ Ringing in the ears
____ Poor eyesight
____ Eye infections
____ Dry eyes
____ Red eyes
____ Eczema
____ Ulcer
____ Dry throat
____ Shingles
____ Tight feeling in chest
____ Herpes simplex
____ Warts
____ Nervousness
____ Convulsions/Spasms
____ Irritability
____ Anger easily
____ Constipation
____ Hemorrhoids
____ Hepatitis
____ Gallstones
____ Problems making decisions
____ Shoulder/neck tension
____ Insomnia 11pm-3am
____ Bitter taste in mouth

FIRE ELEMENT
____ General insomnia
____ Dry scalp
____ Dream disturbed sleep
____ Mental restlessness
____ Flushed cheeks
____ Low grade fever
____ Forgetfulness
____ Skin eruptions/rashes
____ Cysts/tumors
____ Ear infections
____ Sore throat
____ Lymphatic swelling
____ Hot palms and soles
____ Heart palpitations
____ Gum problems
____ Nose bleeds
____ Facial redness
____ Itching/burning skin
____ Thirsty
____ Dark urine
____ Night sweats

EARTH ELEMENT
____ Indigestion
____ Flatulence
____ Food allergies
____ Stomach aches
____ Limbs feel heavy
____ Diarrhea
____ Undigested food in stool
____ Abdominal bloating
____ Nausea
____ Anemia
____ Bad breath
____ Sores in the mouth
____ Heartburn
____ Strong appetite
____ Weak appetite
____ Vomiting

METAL ELEMENT
____ Bronchitis
____ Asthma
____ Shallow breathing
____ Cough
____ Sinus infections
____ Nasal infections
____ Fatigue
____ Painful joints
____ Sciatica
____ Tendonitis
____ Bursitis
____ Craving hot drinks
____ Craving cold drinks

WOMEN ONLY
____ Vaginal infection
____ Yeast infection
____ Urinary tract infection
____ Ovarian cyst
____ Genital herpes
____ Pelvic inflame.disease
____ Breast lumps
____ Irregular periods
____ Menstrual cramping
____ Bright red menst. blood
____ Dark red menst. blood
____ Excessive bleeding
____ Scanty bleeding
____ PMS
____ Infertility
____ Genital burning
____ Positive PAP
____ Anal fissures
____ HPV (genital warts)
____ # of Pregnancies
____ Deliveries
____ Abortions
____ Cesareans
____ Miscarraige

MEN ONLY
____ Prostatitis
____ Nocturnal emission
____ Burning urination
____ Premature ejaculation
____ Urinary incontinence
____ Impotence
____ Low sperm count
____ Venereal disease
____ Genital herpes
____ Anal fissures
____ HPV (genital warts)

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LIFESTYLE FACTORS

Note the degree to which these figure into your life.

0 – Rarely/Never **1 – Occasionally** **2 – Frequently** **3 – Daily**

_____ Meditation
_____ Exercise
_____ Sleep Disturbances
_____ Stress – Financial
_____ Stress – Home
_____ Stress – Health
_____ Stress – Relationships
_____ Stress – Job/School
_____ Drugs – Pain Killers
_____ Tobacco
_____ Coffee
_____ Tea
_____ Chocolate
_____ Soda Pop
_____ Alcohol

_____ Compulsive Eating
_____ Red Meat
_____ Pork
_____ Fowl
_____ Fish
_____ Vegetables
_____ Fruit
_____ Whole Grain
_____ Soy/Tofu
_____ Dairy
_____ Hydrogenated Oil
_____ Butter
_____ Sugar
_____ Water

_____ Drugs/Painkillers
_____ Aspirin
_____ Diuretic
_____ Tranquilizers
_____ Sedatives
_____ Anti-depressants
_____ Cortisone/steroids
_____ Antibiotics
_____ Sulfa Drugs
_____ Other

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FAMILY/PERSONAL HISTORY

Circle if your mother or father have had any of these:

Cancer Heart Disease Stroke TB Epilepsy Diabetes Ulcers Glaucoma

Alcoholism Drug Addiction Mental Disorder Arthritis High Blood Pressure

Circle if you have had any of the following:

Cancer Heart Disease Stroke TB Epilepsy Diabetes Ulcers Glaucoma

Alcoholism Drug Addiction Mental Disorder Arthritis High Blood Pressure

Pneumonia Anemia Bladder Infection Venereal Disease Gallbladder Disease

Candida Yeast Infection AIDS HIV Positive Environmental Illness Hay Fever

Asthma PMS Migraine Headaches Eczema Fibrocystic Breasts Insomnia

Hepatitis A B or C Allergies Fibroids Endometriosis

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our clinic and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of this office, we would like to explain how your health care bills will be handled.

It is our policy to maintain your account on a current basis. Charges for treatment and supplies are due at the time they are provided.

If you have health insurance coverage, we will provide you with "Super Bills" (receipts) to submit to your insurance company. Based on the terms of your policy, you will be reimbursed directly by your insurance carrier for your treatments at the clinic.

We ask that you give us at least 24 hours notice when you wish to cancel or reschedule an appointment, as this allows us to schedule someone else for that time. Due to the fact that we set aside a significant amount of time and effort for your appointment, our policy is as follows:

1) **To provide a warning if an appointment is canceled with less than 24 hours notice or is missed entirely; and**
2) **If it should happen a second time, you will be charged 100% of your last appointment fee.**

We adhere to this policy because we wish to be able to see everyone who needs our care. We recognize that on rare occasions emergencies may occur in which it is impossible to give the required notice. In these cases, please notify the office as soon as possible and we will be as fair as possible in applying our policy.

Once again, we'd like to welcome you to our office. If you have any questions at any time, please feel free to ask us.

Your signature below confirms that you have read and agreed to the above terms.

_____ _____

Signature **Date**

NOTICE OF PRIVACY PRACTICES

Harmony Healing Center
Laurel A. Brody, L.Ac.
9051 #D Mill Station Road Sebastopol, CA 95472 707-829-3658

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.

This notice takes effect on: **April 15, 2003** and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people.who are taking care of you. We also may share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose your medical information for the following purposes

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose medical information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning crimes at the request of law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have A Right to:

1. Look at or get copies of your medical information. You may request in that we provide copies in a format other than photocopies. We will use the form you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies we will charge you $2.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed on the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times or our business associates shrared your medical information for purposes other than treatment, payment, or health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in cases of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate with you about your medical information by different means or to different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complain with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court of administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

PRIVACY PRACTICES ACKNOWLEDGEMENT

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Laurel A. Brody, L.Ac.
9051 #D Mill Station Road Sebastopol, CA 95472 707-829-3658

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____