SYNERGY
acupuncture & wellness
working together toward better health

7 Central Street, Suite 225
Arlington, MA 02476
617-826-3422
www.synergyacupunctureandwellness.com

Welcome to our clinic!

The following registration card, office policies forms and health questionnaire will take several minutes to complete. Please complete the questionnaire as completely as possible and let us know if there is anything else we can do to help you reach your health goals.

Name:____________________________________ Date of Birth:________________

Street Address:____

City: ___________________________ State:__________ Zip Code:_____________

Phone (Home): ______________(Cell): ________________(Work): ________________

EmailAddress:____

Occupation: ____

Preferred pronouns: She/Hers He/His They/Theirs

Primary Care Physician: ____

Emergency Contact Name: __________________________ Relationship:_____________

Emergency Contact Phone: ____

Would you like an appointment reminder phone call or email? YES NO

What is the best way to contact you?____

Would you like us to add you to our email/mailing list?
Email: YES NO Mail: YES NO

How did you hear about Synergy Acupuncture & Wellness? (please circle all that apply)

Website Internet search Physician referral Friend Other:_______________

Please let us know if someone referred you. We would like to thank them!

Referred by:____

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Acknowledgement of Notice of Privacy Practices

I have received, read and understood the Notice of Privacy Policies of our clinic. I understand how Synergy Acupuncture may use or disclose my health information. I understand when Synergy Acupuncture may not use or disclose my health information. I understand my health information rights and understand that Synergy Acupuncture reserves the right to change this Notice of Privacy Practices. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of Synergy Acupuncture.

____
Initial

Late Cancellation/No Show & Payment Policies

We at Synergy Acupuncture & Wellness value your health and your time. It is important that our patients keep to their prescribed treatment plan and come regularly to their appointments. In the event that you need to cancel or reschedule an appointment, kindly provide us with a minimum of 24 hours notice by phone or email so that we may offer your appointment time to other patients.

Unless otherwise agreed upon in advance or in the case of inclement weather, patients who cancel last minute or miss an appointment with no notice will be subject to the full charges for their appointment. Appointments that are rescheduled to a different time on the same day will not be subject to this charge. Synergy Acupuncture gladly accepts cash, check and credit as forms of payment. A $30 processing fee will be charged for any returned checks.

I have read and understand the Synergy Acupuncture & Wellness Late Cancellation/No Show & Payment Policies.

____
Initial

Assignment of Benefits/Release of Information

I am receiving or about to receive acupuncture services in this office. I understand that I am responsible for all non-insurance related fees when services are rendered. If I choose to use my insurance I understand I will be responsible for all “non covered” services/coinsurance/copays associated with my visit. In addition, I authorize insurance payment of medical benefits to Synergy Acupuncture and Wellness.

____
Initial

Your insurance company may require medical reports to document your treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

____
Initial

By signing below, I agree to comply with the office policies and authorize the use of this signature for all insurance submissions.

____	______________________
Signature of Patient or Authorized Representative	Date

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Acupuncture Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient names below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now of in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist names below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage) and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes major risks of treatment, other side effects and risks may occur. The nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some supplements may be inappropriate during pregnancy. Some possible side effects are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that 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 condition(s) for which I seek treatment.

____ ______________________
Signature of Patient or Authorized Representative Date

____ ______________________
Office Signature Date

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Health History Form:

Name: ____Date: _______________

MAIN COMPLAINTS

Please list up to 3 main health concerns that you would like help with in order of importance to you.

#1____

How does this affect you?_________________________
____
When did this start?_____________________________
What makes it better? ___________________________
What makes it worse?____________________________
Have you seen a doctor for this?__________________

#2____

How does this affect you?_________________________
____
When did this start?_____________________________
What makes it better? ___________________________
What makes it worse?____________________________
Have you seen a doctor for this?__________________

#3____

How does this affect you?_________________________
____
When did this start?_____________________________
What makes it better? ___________________________
What makes it worse?____________________________
Have you seen a doctor for this?__________________

PAST PERSONAL MEDICAL HISTORY

Please check off any that apply to you

- ☐ Anemia
- ☐ Asthma
- ☐ Auto-immune Disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Herpes
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Allergies: please list
  ____
  ____
  ____
- ☐ Other: please list
  ____
  ____

CURRENT MEDICATIONS

Please list anything taken within the past 2 months including prescriptions, vitamins, supplements, etc.

____
____
____
____

HOSPITALIZATIONS, SURGERIES, INJURIES

(please include dates)

____
____
____
____

LIFESTYLE

Do you follow any special diet (vegetarian, vegan, raw, macrobiotic, medically prescribed, etc.)?
____
How often do you eat every day?_________________
Do you have a regular exercise program?
Yes___ No___ If yes, please describe:
____

How much of the following do you drink per day:
Alcoholic beverages _______________
Caffeinated beverages_______________
Water (8 oz cups) _______________

Do you smoke? Yes___ No___
If so, how many cigarettes per day? _________

SLEEP

of hours of sleep per night _____
- ☐ Restless or light sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Waking _____ x/night at __________ pm/am
- ☐ Wake to urinate_____ x/night
- ☐ Disturbing dreams
- ☐ Unrested upon waking

EMOTIONS

Have you been treated for emotional issues?YES NO
Have you ever considered suicide? YES NO

Which emotion(s) dominate your experience?

☐ anger	☐ irritability	☐ depression
☐ anxiety	☐ worry	☐ sadness/grief
☐ joy	☐ indecision	☐ mood swings
☐ fear	☐ happiness	☐ obsessive thoughts

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING, PARTICUARLY IN THE PAST 3 MONTHS

HEAD, EYES, EARS, NOSE & THROAT:

Eye strain/pain | Poor/blurry vision | Glaucoma/cataracts | Tearing/Dryness | Spots in vision
Red/itchy eyes | Ringing in ears | Ear aches | Poor hearing | Headaches
Migraines | Sinus problems | Nose bleeds | TMJ/jaw problems | Grinding teeth
Frequent sore throats | Facial pain | Lip or mouth sores | Tooth/Gum problems | Dizziness
Concussion | Other______________________________

SKIN:

Dry skin/hair | Rashes | Eczema | Acne | Hives | Itchy skin | Recent moles
Psoriasis | Dermatitis | Dandruff | Oily skin | Recent changes in skin or hair texture
Hair loss | Dry/brittle nails | Other __________________________________

RESPIRATORY:

Cough | Pneumonia | Coughing blood | Asthma /Bronchitis | Pain with deep breath
Shortness of breath | Chest tightness | Wheezing | Difficulty breathing while laying down
Frequent colds | Phlegm (what color)_____________ | Other __________________________

CARDIOVASCULAR:

Chest pain | Irregular heartbeat | High/Low blood pressure | Cold hands/feet
Swelling/Edema | Blood clots | Fainting | Varicose veins | Blocked arteries
Heart disease | Palpitations | Stroke | Heart murmur | Other________________

GASTROINTESTINAL:

How frequently do you have a bowel movement? ______x/day?
Ulcers | Nausea /Vomiting | Acid reflux | Heartburn | Excessive gas | Abdominal pain
Belching | Bloating | Colitis | Hernia | Indigestion | Bleeding gums
Diarrhea | Constipation | Rectal pain | Hemorrhoids | Blood in stool | IBS/Crohn's disease
Bad breath | Chronic laxative use | Slow digestion | Other_______________________________

URINARY:

Frequent urination | Urgent urination | Pain with urination | Blood in urine | Unable to hold urine
Kidney stones | Burning sensation | Cloudy urine | Decreased/interrupted flow
Waking to urinate | Urination frequency _____x/day? | Urinary/Kidney infections
Scanty urination | Excessive amount of urine | Other_________________

GENERAL:

Weight gain/loss | Poor or excessive appetite | Cravings for ___________ | Peculiar tastes/smells
Fevers/Chills | Night sweats | Bleeding or bruising easily | Fatigue
Sudden energy drop at __________time of day | Unusual sweating | Hot flashes
Strong thirst for: hot or cold drinks | Thirst but no desire to drink | Cold hands/feet

FEMALE REPRODUCTIVE:

Are you currently sexually active? YES NO

Are you or could you be pregnant right now? YES NO

Are you using birth control? YES NO

Age of first period_____	Date of last period ____	Period duration ____ days	Days between periods____
Heavy/scanty periods	Painful periods	Irregular periods	Menstrual clots PMS
Mid-cycle bleeding	Endometriosis	Ovarian cysts	Uterine fibroids
Difficulty getting pregnant	Western infertility treatment	Genital sores	Yeast infections
# of pregnancies _____	# of live births ____	# of miscarriages _____	# of abortions _____
Breast lumps	Vaginal dryness	Vaginal discharge	Polycystic ovarian disease
Hysterectomy	Menopause	Low libido	Other_______________

MALE REPRODUCTIVE:

Are you sexually active? YES NO

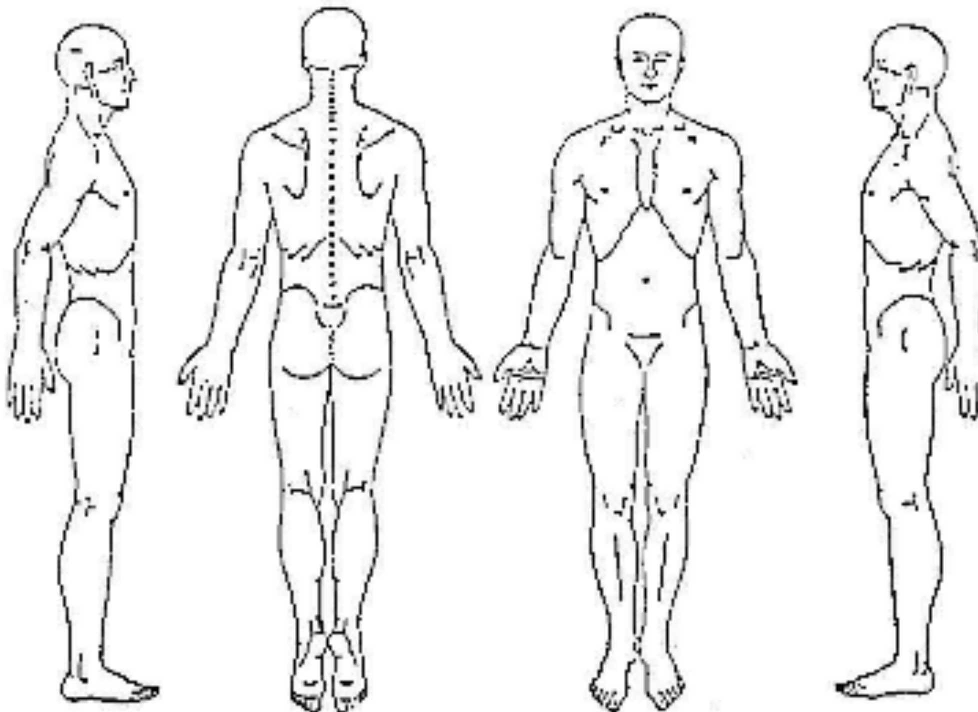
Do you practice birth control? YES NO

Prostate problems	Testicular problems	Erectile difficulties	Penile discharge	Premature ejaculation
Low libido	Vasectomy	Low sperm count/motility	Other__________________________	

MUSCULOSKELETAL:

Neck pain	Shoulder pain	Hand/wrist pain	Hip pain	Knee pain	Foot/ankle pain
Muscle pain	Bursitis	Muscle weakness	Sciatica	Muscle spasm	Tendonitis
Sprains	Strains	Carpal tunnel	Arthritis	Osteoporosis	Fibromyalgia
Back Pain: Low___	Middle___	Upper___	Numbness	Other_____________________	

Please indicate any painful or distressed areas by circling the affected areas on the picture below.



HIPPA Notice of Privacy Policies

This notice describes how your medical information may be used and disclosed and how your privacy is being protected at our clinic. The privacy of your medical information is important to us and we are committed to protecting your medical records. We create a record of the care and services you receive at our organization to provide you with quality care and to comply with certain legal requirements. In order to maintain the level of service that you expect from our clinic, we may need to share limited personal medical and financial information. This notice will also describe your rights and certain duties we have regarding the use and disclosure of medical information.

How Our Clinic May Use or Disclose Your Health Information

Our clinic collects health information about you and stores it in a chart and on a computer. Your medical records are the property of Our Clinic, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians, health care providers or other health care facilities that will provide services that we do not provide. We may disclose medical information to family or others who can help you when you are sick or injured.

Health Care Operations & Payment: We use and disclose medical information about you to obtain payment for the services we provide and perform daily operations at Our Clinic. For example, we may use and disclose this information to review and improve quality of care, or the competence and qualifications of our professional staff.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification & Communication with Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Required by Law: We will limit our use and disclosure of your health information to relevant requirements of the law. When the law requires us to report abuse, neglect, domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
Public Safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

When Our Clinic May Not Use or Disclose Your Health Information

Our clinic will not use or disclose health information that identifies you without your written authorization except as described in this Notice of Privacy Polices. If you do authorize our clinic to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
Right to Inspect and Copy: You have the right to inspect and copy your health information with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect or copy the record. We will charge a reasonable fee, as allowed by Massachusetts law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

Questions and Complaints

Questions and complaints about this Notice of Privacy Practices or how our clinic handles your health information should be directed to our Privacy Officer during regular business hours. If you are not satisfied with the manner in which our clinic handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.