Chicken Soup Chinese Medicine

New Patient Intake Packet

Read through the information carefully and complete all necessary questions.
Our staff is available Monday through Friday
to answer questions, address concerns,
and support you in the process of developing a healthier, happier you.

How to get here on time

Chicken Soup Chinese Medicine is located at

2325 3rd Street, Suite 48
San Francisco, California, 94107

We are on the 3rd floor of the American Industrial Center Building,
at the corner of 3rd Street and 20th Street
in the historic Dogpatch neighborhood.

Street parking is available in the neighborhood and
there is a parking lot located behind the AIC building on Illinois St. .

Easy access to Muni lines, including the 22 Fillmore, 48 Quintara, and T lines run right by our door.

We look forward to scheduling you as soon as we receive all your information.

Questions? Call 415-861-1101

New Patient Checklist

Welcome to Chicken Soup Chinese Medicine! We look forward to meeting you soon. In order to schedule your initial consultation and to provide you with the best possible care, we need you to mail, e-mail or fax your completed new patient forms back to us.
In order to ensure that we receive all the necessary paper work, we have created the following checklist for your reference.

New Patient Forms:

✔	**Document Type**	# of pages
	Consulting Procedures (signature required)	2
	Client Identification Forms	4
	Payment & Billing Policy (5 signature required)	1
	Informed Consent to Treatment (5 signatures required)	2
	Missed Appointment Policy (signature required)	1
	Medical Insurance Intake (2 signatures required)	1
	Notice of HIPAA Privacy Practice (signature required)	1
	HIPAA Confidentiality (signature required)	1
	Credit Card Authorization (signature required)	1
	Authorization for Communication, Appointment Reminders & Scheduling (signature required)	1
	Authorization for Release of Medical Records (signature required)	1

Narrative:

Along with your intake forms, please also provide a **narrative** about your chief health concern. If you have additional concerns, please let us know in your narrative.
List all **current medications, herbs, supplements**, includ the **exact dosage, time of day** you normally take them. Write down any **specific questions** you would like to address in your consultation.

Labs & Pertinent Medical Records:

Please be sure to have your pertinent medical records sent to us as soon as possible or **at least a week prior** to your appointment.

✔	Lab Facility	Phone #	Fax #	Lab Type

Chicken Soup Chinese Medicine
2325 3rd Street, Suite 48, San Francisco, CA 94107
Telephone 415-861-1101 Fax 415-644-0614
email: chickensoupchinesemedicine@docmisha.com www.chickensoupchinesemedicine.com

Consulting Procedures

At Chicken Soup Chinese Medicine, we specialize in working with patients with complex health issues that require a high degree of sophistication and integrated knowledge on the part of your practitioner. We also see many patients with less complicated or less severe health concerns such as pain from sitting at a desk, or tennis elbow. The initial visit, or consultation, provides time to diagnose and prescribe a treatment plan for ongoing care. A deposit secures your time in our schedule.

Comprehensive/Complex Consultation:

Chronic disease, Cancer support, Complex health conditions

Your consultation time varies and includes both in-person and office time dependent on complexity

- Preview of your relevant western medical records
- Preview of an additional health narrative, written by you, describing your situation
- Consultation to discuss your health condition, answer your questions, and arrive at a Chinese medical diagnosis for you

• Optional development of a treatment plan to include recommendations for acupuncture, herbs, diet, exercise, and any other appropriate recommendations or referrals - this would be an additional fee.

Standard Consultation:

General health issues, Herbal support, Fertility, Menstrual support

Your consultation will include both in-person and office time:

- Preview of your relevant western medical records
- Preview of an additional health narrative written by you describing your situation
- Consultation to discuss your health condition, answer your questions, and arrive at a Chinese medical diagnosis for you
- Optional development of a treatment plan to include recommendations for acupuncture, herbs, diet, exercise, and any other appropriate recommendations or referrals - this would be an additional fee.

Focused Consultation:

Pain management, Acute symptoms

Your consultation will include acupuncture:

- An initial evaluation of your current health status, focused specifically on your chief complaint
- Initial acupuncture
- Herbal and supplement recommendations when necessary

* ***Note that all the services are approximated based on information collected during initial contact. Levels of care may change based on practitioner review of lab work and health history. Any changes in care are dependent on patient approval and participation.***

* Deposits are required to finalize an appointment time. For Comprehensive and Standard Consultations, $295 is required. A Focused Consultation requires a deposit of $175.

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Basic Consultation Process

Complete the New Patient Forms online or by request via email

- If you have any medical reports or lab results that relate to your health concerns, please send them to us, or have them sent to us from your medical provider(s).
- Upon receipt of your materials, we will contact you to schedule a consultation. We will schedule you for an appropriate amount of time based on the complexity of your health concerns.
- We will ask you for a deposit in order to reserve space in the schedule for your consultation. We require seven days (7) notice if you need to cancel or reschedule for this initial visit.
- We will meet with you and conduct a consultation. (See above for more information.)
- Once the visit is completed, your card will be charged the full amount. Your deposit can be applied to the total cost. Let us know in advance if you prefer another form of payment, like an HSA or FSA card. We are happy to accommodate.

Fees and Payment

Consultation fees are dependent on complexity. Many insurance contracts and third-party payers do not cover consultation procedure codes or diagnosis codes; however we are happy to bill these codes to your insurance company or managed care as a courtesy.

For follow-up acupuncture visits, we are happy to bill your insurance if your diagnosis is covered by your insurer. If you do not have health insurance that will cover your acupuncture, we offer a same day fee schedule as a courtesy to our patients who pay in full at the time of the visit.

Case Management/Follow-Up Consultation

The following situations may call for ongoing case management or periodic follow-up consultations:

- Patients who live at a distance from Chicken Soup and do not come in for regular visits
- Patients who are going through a period of particularly close monitoring by their western and Chinese medicine physicians for some reason, where strategic decisions must be made more quickly and/or frequently than can be accomplished in regular acupuncture visits
- Patients who have been on a stable regimen, but for whom a significant life or health status change requires a new strategic direction

We are happy to schedule additional time via phone or in-person to consult over lab work, suggest changes to herbal regimens, or provide other consultative guidance that requires more than what can be accomplished in a quick e-mail or during an acupuncture session.

The process for scheduling such a service is much the same as our usual consultation procedure. Please ask for more information from our office manager.

Signature:	Date

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Patient Identification Form

Today's date:_____

Name:_____ Birthdate:_____Age: _____

Preferred name:_____Gender M F MTF FTM NB Place of birth:_____

Marital status:_____Number of children:_____

Occupation:_____Employer:_____

Address: _____ Phone: _____

_____

Emergency contact:

Name:_____Phone:_____Relationship:_____

How did you hear about our clinic (referred by) :_____

May we send a thank you card: ☐ Yes ☐ No

Primary treating physician:_____Phone:_____

OB/Gyn:_____Phone:_____

Oncologist:_____Phone:_____

Reproductive endocrinologist:_____Phone:_____

Hepatologist_____Phone:_____

HIV Specialist:_____Phone:_____

Other specialist:_____Phone:_____

Have you ever been treated with acupuncture? ☐ Yes ☐ No

Have you ever had Chinese herbal treatment? ☐ Yes ☐ No

If yes, condition(s) treated:_____

Please state your present complaint, injury, or illness and give a brief history of its development (include dates if possible). Please attach a separate narrative.

_____

_____

_____

_____

Describe the history of any previous illnesses, accidents, or trauma, etc., including any of treatment received and results:

_____

_____

_____

_____

Please check any current or past conditions:

- ☐ HIV
- ☐ AIDS
- ☐ HPV
- ☐ Cancer: _____
- ☐ Diabetes: Type I Type II Type III
- ☐ Asthma
- ☐ Allergies
- ☐ COPD/emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Bronchitis: acute chronic
- ☐ Arthritis: osteo rheumatoid
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Aneurysm
- ☐ Acute hepatitis: HAV other
- ☐ Chronic hepatitis: HCV HBV
- ☐ Other liver disease
- ☐ Gall bladder disease
- ☐ Ulcers
- ☐ Irritable bowel syndrome
- ☐ Colitis: _____
- ☐ Other gastro-intestinal disease

  _____

- ☐ Depression
- ☐ Nervous breakdown
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Other psychological diagnosis:

  _____

- ☐ PTSD
- ☐ Trauma:

  _____

- ☐ Menstrual cramps
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Other gynecological disorders
- ☐ Hysterectomy: partial total
- ☐ Infertility: female male
- ☐ Prostate problems
- ☐ Kidney disease
- ☐ Polio
- ☐ Meningitis: viral bacterial
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Hashimoto's Thyroiditis
- ☐ Thyroid disease:_____
- ☐ Seizures
- ☐ Vertigo/dizziness
- ☐ Eye disease: _____

Childhood disease: _____

Opportunistic infections: _____

Other: _____

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Major hospitalizations, surgeries, illnesses, injuries, accidents:

Year	Description	Outcome / Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current medications/vitamins/herbs/drugs/etc:

_____

_____

_____

_____

Do you use? (Describe usage)

Cigarettes:_____ Marijuana:_____

Coffee:_____ Heroin:_____

Tea:_____ Methamphetamine:_____

Cola/soda:_____ Alcohol:_____

Other: _____

Family History

Has anyone in your immediate family ever had:

- ☐ Cancer
- ☐ High blood pressure
- ☐ Allergies
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Heart disease
- ☐ Stroke
- ☐ Diabetes: ☐ Type I ☐ Type II ☐ Type III
- ☐ Obesity

☐ Psychological disorders: _____

☐ Other: _____

Nutrition, diet and eating habits: “Check all that apply”

- ☐ Omnivore (animal & vegetable source)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Processed foods
- ☐ Whole foods

Specific food restrictions:

- ☐ Dairy
- ☐ Wheat
- ☐ Eggs
- ☐ Soy
- ☐ All Gluten

- ☐ Skip breakfast
- ☐ Eat three meals/day
- ☐ Eat two meals/day
- ☐ Eat one meal/day
- ☐ Graze (small frequent meals)
- ☐ Eat constantly, hungry or not
- ☐ Generally eat on the run
- ☐ How many meals do you eat out per week?
- ☐ Eat during the night

Food frequency: “Record numbers of servings per day for each of food type listed”

Fruits:	_____	Nuts and Seeds:	_____	Legumes:	_____
Vegetables:	_____	Dairy:	_____	Fish:	_____
Grains:	_____	Eggs:	_____	Meat Poultry:	_____

Payment and Billing Policies

Third Party Coverage

For those with third party coverage, Chicken Soup Chinese Medicine is happy to work with you to bill your insurance carrier. We will work with you on Worker's Compensation or Personal Injury as well. Please speak with the Office Manager if you have specific questions about your third party or health insurance coverage. We bill your insurance carrier directly. We do not provide Super Bills. We can provide an itemized receipt of services for reimbursements and medical letters of necessity. These can be batched according to your specifications and will be emailed to you. Simply ask the Front Desk.

Signature:	Date:

Non-Direct Assignment of Payment

For patients with insurance carriers that only pay the insured person (patient), we collect co-insurance payment at the time of service. We offer you the courtesy of billing your insurance carrier directly from this office. All patients personally receiving insurance checks must endorse the check and send it to CSCM within 30 days of check date. CSCM receives notice when the insurance company issues these checks. Failure to provide the endorsed check within 30 days will result in a charge of the total amount sent on the credit/debit card on file.

Signature:	Date:

Worker's Compensation and Personal Injury

All Worker's Compensation and Personal Injury cases must be pre-approved and/or pre-authorized by your insurance carrier in advance of the first session. For all Worker's Compensation cases a pre-authorization detailing the diagnosis to be treated and the number of approved visits is required. Once your pre-authorized visits end, you must either receive a new pre-authorization or pay for your treatment at the time of service. For Personal Injury cases, when you have met your maximum coverage, we ask that you pay for your visits at the time of the visit. Discuss any alternate arrangements directly with our Office Manager.

Signature:	Date:

Managed Care Plans

For managed care plans with which we have a contract, you must be pre-approved for treatment and we will collect only the required co-payment at the time of each visit. Usually, managed care organizations must approve a treatment plan after the initial visit before you can receive additional treatments.

Signature:	Date:

PPO and EPO Plans

For PPO and EPO plans: once you have met your yearly deductible and CSCM has begun to receive payments from your third party payer, you become responsible for the co-payment and/or co-insurance only up until your benefits are exhausted for the year. CSCM will bill directly for services involving CPT (procedure) and/or ICD-10 (diagnosis) codes that are not covered or paid for by your insurance company or third party payer. If you would like to see our detailed fee schedule, please ask our office manager.

Signature:	Date:

Informed Consent to Treat

Understanding Treatment Risk

I do give consent to acupuncture treatments and other procedures associated with Chinese Medicine by the staff acupuncturist and/or any guest acupuncturist, tutorial student, or clinic assistant working under their supervision. I understand that methods may include, but are not limited to, acupuncture, moxibustion, cupping, electric stimulation, Tui-Na Chinese massage, herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including, but not limited to, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and heat lamps. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

Signature:	Date:

Understanding Herbal Side Effects

The herbs and 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 some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify a member of the clinic staff of any unpleasant effects associated with the consumption of the herbal teas or products. I will notify my practitioner if I am or become pregnant.

Signature:	Date:

Confidentiality and Adherence

I understand the clinic staff may review my medical records and lab reports, but all my records will be kept strictly confidential and will not be released without my consent. Data may be gathered anonymously from files with no identifiers for analytic purposes. It is agreed: With regard to medical care and services, the attending acupuncturist will provide services to the patient and, to the best of their skill and knowledge, medical care appropriate to the situation. The patient will cooperate fully with the acupuncturist by following her instructions and adhering to such treatment plan or course of action as may be set forth and agreed.

Signature:	Date:

Authorization to Release Information

I hereby authorize any health care practitioner, medical service organization, insurance company, or other institution or organization to release to you, and you to them, any medical or other information acquired concerning any condition or other disability. A photocopy of this authorization shall be as valid as the original. I authorize Chicken Soup Chinese Medicine and members of its clinic medical staff and students to review my records for the purposes of collecting statistical data or consent to the publication of statistical and/or clinical data obtained from my records. I understand that if any particulars of my case are used for the purpose of publication, all possible clues to my identity will be disguised or altered. I understand there is a remote possibility of being accidentally identified as the source of the clinical data, but the way information is handled makes the risk extremely small.

Signature:	Date:

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Insurance Billing and Payment Agreement

This practice recognizes the responsibility of filling out the practitioner's insurance statement and bill for your insurance and for your accounting purposes. By signing below I hereby irrevocably assign the insurance benefit payments directly to Chicken Soup Chinese Medicine. A photocopy of this authorization is accepted with the same authority as the original. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this acupuncturist's office will prepare any necessary reports and forms needed to make collection from the insurance company and that any amount over the co-payment paid directly to acupuncturist's office will be reimbursed after receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature:	Date:

In Summary

By voluntarily signing below, I show that I have read, or have had read to me, this 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 seek treatment at this clinic.

Signature: | Date:

Staff name printed: _____

Staff signature: _____ *Date:* _____

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Missed Acupuncture Treatment Appointments

Running Late

Arrive a few minutes before your scheduled visit. Your appointment time is when the doctor will see you, not when you walk through the door. Plan for time to check-in at our front desk. Let us know if you are running late so we can reschedule for a later time/date if available. In light of the current health crisis, we are unable to extend your appointment visit past the allotted time if you are running late. Please be on time.

Late Cancellations

If you cancel your appointment with less than 24 hours notice a fee of $85 will be added to your account and charged to your credit/debit card on file. If you cancel your appointment with less than 48 hours notice, a fee of $50 will be added to your account and charged to your credit/debit card on file. If you miss any appointment without giving any notice, a fee of $125 will be added to your account and charged to your credit/debit card on file (exceptions are made for true emergencies). We will also be concerned, so expect a phone call to make sure you are OK! If you frequently cancel less than 24 hours in advance, we will have the option to put you on a same-day schedule.

Rescheduling

If we can rebook you for a new appointment within the same calendar week, we will waive the late cancellation fee. We appreciate that it doesn't feel good to charge fees for missed appointments so please call and let us help you reschedule you later in the week.

Missed New Patient Intakes & Consultations

- Less than 48 hours notice of cancellation: we reserve to right to hold the full deposit.
- Less than 7 days notice of cancellation: we reserve the right to hold $150 of deposit.
- Rescheduling 7 days in advance: we transfer your deposit to the rescheduled consultation time.

So, if you want to cancel AND receive a full refund of your deposit, we ask that you tell us at least 1 week in advance

We would like to see you, so help us by managing your schedule and committing to the consultation times. We don't like keeping deposits. Emergencies happen, so inform us as soon as they happen and we will work with you to find a solution.

Signature:	Date:

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Medical Insurance Intake Form

Name _____ Date of Birth _____

Address _____

_____

City State Zip

_____

Phone

Employer _____

Is this an employee insurance policy? ☑ ☐ Is this an HMO? ☑ ☐

Insurance Company _____ Phone _____

Address _____

Policy Number _____ Member Number _____

Group Number _____ Other Health Coverage _____

If yes, what is it? _____

Does your policy cover: acupuncture? ☐ ☒ Massage? ☐ ☒

Name of policy holder (if other than yourself) _____

Relationship to you _____

Their policy number _____ Group number _____

Is your problem related to a work injury or accident? _____

I authorize the release of any medical information necessary to process insurance claims.

Signature _____ **Date** _____

I authorize payment of benefits to Chicken Soup Chinese Medicine for services rendered.

Signature _____ **Date** _____

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Chicken Soup Chinese Medicine
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 this summary and the full Notice carefully.

CSCM Pledge: Staff and Employees of Chicken Soup Chinese Medicine (CSCM), its affiliates, and contract providers understand that information about you and your health is personal. We are committed to protecting your health information.

Who will follow the rules in this notice: All CSCM staff contract provider, employees and CSCM affiliates, as well as students, clinical assistants, and volunteers' must follow these rules.
You have the right to:

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

Who is authorized to see confidential Patient Health Information (PHI) at CSCM?
The Acupuncturists and other licensed providers in the health care team may access the entire medical record, based on their "need to know". All other members of our workforce have access only to the information needed to do their jobs. The "Notice of Privacy Practices" describes the ways in which we may use PHI 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, including appointment reminders.
2. **Payment** of health care bills (insurance claim submission, authorizations and payment posting).
3. Health care **operations** and business operations, including, teaching and medical staff quality activities, research (when approved by the IRB and with a patient's written permission), health care communication between a patient and their health care practitioner.

Minimum Necessary Standard

CSCM will apply the "minimum necessary" standard regarding PHI. For example, although Clinical Administration, Acupuncturists, Massage Therapists, Students and Clinical Assistants and other care providers may need to view the entire record, a billing/insurance clerk or data entry staff member might only need to see specific report to determine the billing codes. An admissions staff member may not need to see the medical record at all, only an order form with the admitting diagnosis and identification of the admitting physician.

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 Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. (Available as of April 14, 2003 at http:www.uscf.edu/hipaa.) If you do not know or understand 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 the CSCM Privacy Coordinator or call 415-861-1101. 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 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 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 it is the practice of CSCM to place a reminder phone call to me the night before treatment, and I agree to receive these calls.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Relation (if other than patient): _____

Reason unable: _____ Interpreter: _____

Patient/Client declined to sign receipt (staff signature): _____

Chicken Soup Chinese Medicine
HIPAA Notice of Privacy and Confidentiality
Patients' Rights

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

1. Right to receive the "Notice of Privacy Practices," which informs patients of their rights and how to exercise them. CSCM is required to make this notice available to patients. We are required to make a good faith effort to obtain the patient's acknowledgement of receipt.
2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copies. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."
3. Right to Request an Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.
4. Right to an Accounting of Disclosures. We can be asked to account for all unauthorized disclosures of Patient Health information (PHI). Patients have the right to receive an accounting of disclosures of their PHI. The Notice describes how to request an accounting.
5. Right to Request Restrictions. Patients have the right to request restrictions on how we will communicate with the patient or release information. Generally, we will make 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, either within or outside of CSCM. CSCM Privacy Coordinator can be reached at 415-861-1101.

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.

_____ _____

Signature **Date**

Chicken Soup Chinese Medicine
Credit Card Authorization Form
Statement of Understanding

I, (print name)_____, hereby authorize Chicken Soup Chinese Medicine to charge my credit card account number listed below for deposit and/or final payment for phone or in-clinic consultation, acupuncture treatments, case management by phone or e-mail, missed appointments, herbs, supplements, and any other related items.

For consultations: To hold the consultation space for a consultation in person or by phone, a deposit of $150 will be charged to my account at the time my appointment is scheduled. If the appointment is cancelled less than 7 days prior to the consultation and more than 48 hours, $100 will be refunded. Less than 48 hours advance cancellation or rescheduling will result in a charge of the full deposit fee.

Credit Card Details

Full Name on Credit Card _____

Check One ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover

Card #:_____ **Exp. Date:** _____

Billing Address

Street Address:_____

City:_____

State:_____ **Zip Code**:_____

Billing Phone: (_____)_____

SIGNED AUTHORIZATION

Signature: _____ Today's Date: _____

This authorization can be revoked upon your written notice to our office.

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Patient Authorization for Communications from Chicken Soup Chinese Medicine

◉ ○ Yes No I give permission to Chicken Soup Chinese Medicine to contact me individually by e-mail regarding appointments, treatment plans, labs and any medical related issues.

◉ ○ Yes No I give permission to Chicken Soup Chinese Medicine to add me to their e-mail mailing list so I can receive newsletters, updates and special offers.

Name _____

Address _____

Street Address **City** **State-Province** **ZIP** **Country**

E-mail _____@_____

Please indicate which number to use for:	Messages	Do Not Call
Home Telephone:_____	☐	☐
Work Telephone:_____	☐	☐
Cellular Telephone:_____	☐	☐
Text: _____	☐	☐

Chicken Soup Chinese Medicine values your privacy. If you choose to subscribe to our newsletter, we will send a confirmation request to the e-mail address you provided.

You must respond to that confirmation e-mail to initiate your subscription.

If you choose to opt in to Chicken Soup Chinese Medicine, we will not sell, rent, or share your e-mail address or any other personal information.

You may revoke this authorization at any time. Please advise us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be complete.

_____ _____

Signature **Date**

Chicken Soup Chinese Medicine
2325 3rd Street, Suite 48, San Francisco, CA 94107
Telephone 415-861-1101 Fax 415-644-0614
email: chickensoupchinesemedicine@docmisha.com www.chickensoupchinesemedicine.com

Chicken Soup Chinese Medicine
Authorization for the Release of Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

Patient: _____ Date of Birth: _____

Please **obtain** information **from** the following:

_____ (_____)_____
Name of Physician/Practitioner Phone

_____ (_____)_____
Street Address Fax

_____ _____
City, State, Zip Code E-mail

Please send my medical information to:
Chicken Soup Chinese Medicine
2325 3rd Street, Suite 342
San Francisco, CA 94107

Fax: 415-644-0614 (HIPAA secure fax)

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information going back one year. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

☐ Medical records for continuity of care ☐ Diagnostic imaging reports ☐ Pathology reports

☐ Laboratory reports Other:_____

_____ _____
Date Patient Signature

_____ _____
Date Parent/Guardian Signature (if applicable)

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Chicken Soup Chinese Medicine. I also authorize the above Physician/clinic/hospital to provide the following information via telephone consultation:

_____
Patient Signature

HIV/AIDS test results and related information, including high risk behavior documentation. **This information may not be further disclosed without the specific written authorization of the tested individual.**

_____
Patient Signature

Drug/Alcohol diagnosis, treatment or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be Disclosed. Please provide a description of this information.

_____
Patient Signature

Mental Health treatment information

Office use only: Date sent: _____ Initials:_____

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