Balanced Living Acupuncture
Blanca O. Lopez, M.D.

Instructions for New Patients

Thank you for choosing Balanced Living Acupuncture, LLC. This page is intended to assist you in completing your intake paperwork and preparing for your first visit. We ask that you carefully read, complete, and submit the required paperwork listed below prior to your first appointment. You are welcome to bring your completed paperwork with you to your appointment or fax it to us at (478) 216-3437. Please arrive at least 15 minutes for your first appointment in order to verify that all of your paperwork is in order.

Your first appointment consists of a new patient exam that will be used to develop an initial plan of care. Your doctor will review your medical history with you as well as the concerns for which you are seeking treatment and conduct a physical exam. This appointment usually lasts 45-60 minutes.

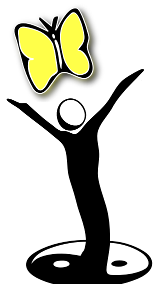
Required Forms

- *New Patient Intake* — May be completed online or on paper. The link to the online intake is delivered in email and expires after 24 hours. If your link has expired, please call our office at (478) 952-1719 and request a new one be sent.
- *Informed Consent for Acupuncture*
- *Payment Agreement* — Must be completed by the individual responsible for payment, e.g. a parent, guardian, or the patient.
- *Your Information. Your Rights. Our Responsibilities*
- *Patient Rights and Responsibilities*
- *Will Insurance Cover My Visit?*
- *Missed/Canceled Appointments Policy*

Optional

We are not able to discuss the details of your treatment with any other person without your permission, including appointments. If you would like for us to be to discuss your treatment in your absence with a family member, friend or other person, or leave detailed phone messages for you concerning appointments, results, etc., you will need to complete one or both of the following forms. This is completely voluntary; your treatment will in no way be impacted, whether or not you complete and/or sign one of the following authorizations. Should you complete one or both, you are free to modify (just request a new form) or revoke them in writing at any time. Please beware that revocation won't affect any disclosures that occurred prior to the revocation. Also, if a party directed to receive disclosures isn't covered by HIPAA, your information won't be protected from disclosure by that person to anyone else.

- *HIPAA Disclosure Authorization*
- *Telephone Message Authorization*



New Patient Questionnaire

Name: ____Date: __________

Age: _________ DOB: ____________________

Street Address: ____

City: _____________________________State:__________ Zip:__________

Home #_________________________Cell #___________________________

Email: _______________________________

Primary Care Physician: ____

Physician's Phone Number: _______________________________________

Emergency Contact: ____________________________________Phone#______________________

1. Please list in order of importance (1 being the most important) the reasons you wish to see the doctor.

1.
2.
3.

2. Have you ever had acupuncture before?
If yes, please indicate the condition(s) treated:

3. Medical History:
Please mark conditions that have been diagnosed by a physician or health care professional.

Condition	Yes	Age or Year of diagnosis
High Blood Pressure		
Heart Attack		
Heart Rhythm disease		
Stroke		
Migraine Headaches		
Glaucoma		
Cataracts		
Thyroid disease		
Diabetes		
Asthma		
Emphysema (COPD)		
Lung cancer		
Cystic fibrosis		
Breast cancer		

Gastritis		
Ulcers		
Gallbladder disease or stones		
Irritable Bowel Syndrome		
Colon cancer		
Kidney disease		
Kidney infections		
Kidney stones		
Bladder infections		
GYN cancer		
Infertility		
Prostatitis or Prostate cancer		
Anemia		
Leukemia (Blood cancer)		
Multiple Sclerosis		
Muscular Dystrophy		
Restless leg syndrome		
Sleep Apnea		
Dementia		
Depression		
Anxiety disorder		
Alcoholism		
Drug dependence (Rx or Recreational)		
Other:		

4. Medications:

Medication	Dosage	Reason	Began

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5. Allergies: Please list medications, food or environmental allergies

Substance	Outcome

6. Surgeries: Please list all surgeries and procedures, including heart catheterizations,

Surgery	Age or Year	Outcome

7. Accidents/Trauma:

	Age or Year	Description

8. Habits

	Active		Past		Description	
	Yes	No	Yes	No	Packs per day	Number of years
Smoking Tobacco						
Chewing Tobacco						
Caffeine					Amount/day	
Marijuana						
Cocaine						
IV Drugs						
Other drugs						
Alcohol					Type	Amount/week

9. Hobbies: ____

____

____

____

____

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10. Current State of Health (ROS)

General	Yes	Description
Fatigue/Low energy		
Weight changes		
Appetite changes		
Fever		
Neuro/Emotional		
Fear		
Grief		
Worried		
Depression		
Anxiety		
Anger		
Panic Attacks		
Suicidal		
Irritable		
Manic		
Difficult to focus		
Dizziness		
Loss of balance		
Tremors		
Memory loss		
Lack of coordination		
HEENT		
Headaches		
Migraines		
Concussion		
Dry eyes		
Red Eyes		
Blurry vision		
Poor Night Vision		
Floaters		
Eye Strain		
Glasses/contacts		
Cataracts		
Ear ringing		
Ear aches		
Poor hearing		
Runny nose/post nasal drip		
Sinus pain		
Sinus congestion		
Nose bleeds		
Sore throat		
Hoarse voice		
Lump in throat		
Teeth grinding		
Tooth pain		
TMJ popping/pain		
Mouth sores/ulcers		
Excessive saliva		
Bleeding gums		
Facial pain		
Bad breath		
Swollen tongue		

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Cardiovascular	Yes	Description
High Blood pressure		
Low blood pressure		
Irregular Heart beats		
Heart palpitations		
Chest pain		
Left arm pain		
Cold hands/feet		
Swelling of hands/feet		
Fainting		
Varicose veins		
Phlebitis		
Respiratory		
Dry cough		
Wet cough		
Bronchitis		
Pneumonia		
Asthma		
Pain when breathing deeply		
Shortness of breath		
Chest tightness		
Phlegm		
Gastrointestinal		
Nausea		
Vomiting		
Gas		
Bloating		
Hiccups		
Acid reflux		
Belching		
Indigestion		
Abdominal pain/cramps		
Hemorrhoids		
Rectal pain		
Anal fissures		
Anal itching		
Genitourinary		
Frequent urination		
Wake up to urinate		
Painful urination		
Incomplete urination		
Decreased urinary flow		
Decreased stream power		
Unable to hold urine		
Bedwetting		
Urinary tract infection		
Smelly urine		
Dark urine		
Enlarged prostate (Men)		
Impotence (Men)		
Premature ejaculation (Men)		
High libido		
Low libido		
Genital itching		
Genital sores		

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11. Family History: Please check all conditions that run in your family and identify the relationship

Condition	Yes	Family Member
High Blood Pressure		
Heart Attack		
Heart Rhythm disease		
Stroke		
Migraine Headaches		
Glaucoma		
Cataracts		
Thyroid disease		
Diabetes		
Asthma		
Emphysema (COPD)		
Lung cancer		
Cystic fibrosis		
Breast cancer		
Gastritis		
Ulcers		
Gallbladder disease or stones		
Irritable Bowel Syndrome		
Colon cancer		
Kidney disease		
Kidney infections		
Kidney stones		
Bladder infections		
GYN cancer		
Infertility		
Prostatitis or Prostate cancer		
Anemia		
Leukemia (Blood cancer)		
Osteoarthritis		
Rheumatoid Arthritis		
Multiple Sclerosis		
Muscular Dystrophy		
Restless leg syndrome		
Sleep Apnea		
Dementia		
Depression		
Anxiety disorder		
Alcoholism		
Drug dependence (Rx or Recreational)		
Other:		
Gynecology (Women)		
Currently pregnant		
Irregular menses		
Menstrual clots		
No menses		
Vaginal itching		
Genital sores		

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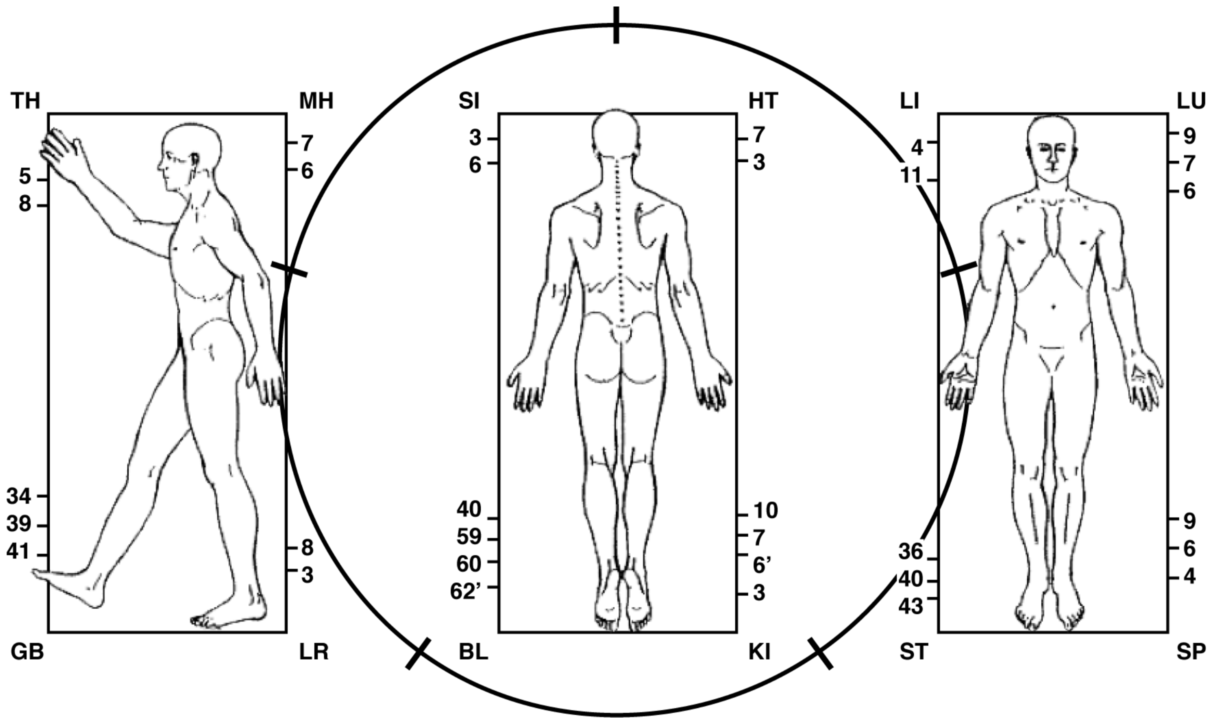
12. On the anatomical figures below mark the area or areas where you have pain or other problems. Please be as accurate as possible about the locations.



JUE YIN / SHAO YANG **SHAO YIN / TAI YANG** **TAI YIN / YANG MING**

Pain Assessment - Side	Pain Assessment - Back	Pain Assessment - Front
Location: Left / Right / Both	Location:	Location:
Onset:	Onset:	Onset:
Made better with: Made worse with:	Made better with: Made worse with:	Made better with: Made worse with:
Associated symptoms:	Associated symptoms:	Associated symptoms:
Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning	Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning	Quality: ☐ constant ☐ intermittent ☐ sharp ☐ dull ☐ pressure ☐ burning
Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10

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Instructions:
Please circle the answers that apply to you at least 80% of the time. Be nonjudgmental and don't think about the answers too much. Leave blank any boxes that do not apply to you or that you are unsure of. There are no correct answers. Your honesty will result in a better treatment.

13. Please circle one answer for each of the following questions.

Five phase questions	**Wood**	**Fire**	**Water**	**Earth**	**Metal**
My favorite season	Spring	Summer	Winter	Harvest (late summer)	Autumn
My favorite color	Blue – Green (turquoise)	Red	Dark Blue or Black	Yellow (earth tones)	White
My favorite flavor	Sour, citrus, acidic	Bitter, roasted	Salty	Sweetness	Spicy, flavorful
My predominant emotional tendency	I tend to get angry.	I am excitable.	I get scared.	I tend to worry.	I tend to feel sad
My predominant psychological characteristic	I tend to be anxious and irritable.	I am joyful and creative.	I am willful and ambitious.	I often find myself in deep thought.	I tend to get depressed.
My usual reaction to stress	I clench. My muscles get tight.	I tend to cry.	I tremble. My body feels shaky.	My stomach feels upset.	My chest feels tight.

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14. Please check any statements that apply to you at least 80% of the time. Be nonjudgmental and don't think about the answers too much. Leave blank any boxes that do not apply to you or that you are unsure of. There are no correct answers. Your honesty will result in a better treatment.

Shao Yin Fire (HT - LRF)		I can be characterized as creative, passionate, dramatic, and impulsive.
		I frequently exude heat and often feel flushed and sweaty.
		I tend towards sexual hyperactivity.
		I have experienced chest pains or palpitations.
		I tend to be talkative or noisy. I am the life of the party.
Tai Yang Fire (SI - CGN)		I can be characterized as authoritative, imposing, and impatient.
		I am competitive. I like to win.
		I have neck or lower back pain.
		I have insomnia.
		I occasionally have headaches.

Tai Yang Water (BL - BAA)		I can be characterized as intelligent and hyper-analytical, but often indecisive.
		I have a history of recurrent urinary tract infections, urethritis, and kidney problems.
		I tend to have poor stamina and tired easily.
		I have diffuse low back pain.
		I sometimes have digestive problems.
Shao Yin Water (KI - SB)		I can be characterized as private, cautious, and secretive.
		I have problems with motivation, self-discipline, and making decisions.
		I tend to have recurrent sore throats, tonsillitis, kidney infections, or kidney stones.
		I tend to be chilly with cold hands. I dislike cold.
		I experience lower back pain, knee pain, and achy joints when I am tired.

Jue Yin Fire (MH - KM)		I can be characterized as irritable, anxious, and emotionally volatile at times.
		I tend to harbor grudges and have explosive anger.
		I get tension headaches or stress-related headaches.
		I get muscle cramps and often have insomnia.
		I am sensitive to many foods. I get stomach cramps and diarrhea or slow digestion.
Shao Yang Fire (TH - KT)		I can be characterized as clear thinking and decisive.
		When I get agitated, I can't sleep.
		I tend to grind my teeth and have tight jaws.
		I have muscle aches and cramps.
		I need to exercise, move, and stretch or I don't feel right.

Shao Yang Wood (GB - CR)		I can be indecisive. I wish I were more self-confident.
		I am sensitive to ridicule or criticism.
		I have neck pain and shoulder tension. This can cause headaches.
		I tend to have lateral or side hip pain.
		I have digestive problems due to my gall bladder.
Jue Yin Wood (LR - AM)		I can be characterized as timid or introverted.
		I am sensitive to caffeine, and I need it as a pick-me-up.
		I get migraine headaches and tension headaches.
		My palms tend to be sweaty requiring a handkerchief.
		I have sensitive eyes. I'm near-sighted.

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Tai Yin Earth (SP - DW)		I can be characterized as round and fleshy with full lips, calm, and peaceful.
		I often have abdominal bloating and diarrhea.
		I have had anemia and menstrual or fertility problems.
		I have varicose veins or cold feet.
		I take care of others, even at my own expense.
Yang Ming Earth (ST - EWP)		I enjoy life, food, and drink. I am a pleasure seeker.
		I have been diagnosed with heartburn, gastroesophageal reflux disease (GERD), or peptic ulcer disease (PUD).
		I sometimes overindulge in food and drink. I gain weight easily.
		I develop digestive problems during times of stress or anxiety.
		My mood can swing from pleasant to angry and irritable.

Yang Ming Metal (LI - FG)		I have recurrent sinus infections, colds, or respiratory infections.
		I have poor digestion and experience stomachaches. I focus on my bowel habits.
		I tend to be thin.
		I have a strong belief in honor, duty, responsibility, and respect for the law.
		I tend to feel tired and a little sad. I get depressed easily.
Tai Yin Metal (LU - NC)		I have a history of respiratory problems such as bronchitis, pneumonia, asthma, or COPD with cough and phlegm.
		I have constipation alternating with diarrhea or have been diagnosed with Irritable Bowel Syndrome (IBS).
		I have skin problems and allergies.
		I am organized and methodical.
		I am honest and obey the rules.

I have tried these treatments:

☐ Chiropractic ☐ Massage ☐ Psychotherapy

☐ Injections ☐ Physical therapy ☐ Other ___________________________

Additional information that will be important for the doctor to know:

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Balanced Living Acupuncture

Blanca O. Lopez, M.D.

Informed Consent for Acupuncture

I, _______________________, do voluntarily, knowingly and willingly give my consent to acupuncture treatment for ☐my condition or ☐my minor child, _______________________. Acupuncture is an art of healing involving the stimulation of specific points of the body to treat disease and relieve pain. It works by increasing the body's energy and helping the energy to flow better. When energy does not flow well, we may suffer from illnesses. Acupuncture treatments will strengthen your body and your immune system.

Potential Risks

The possible risks, which I understand and accept, include, but are not limited to, fainting, infection, bleeding, lung puncture, other organ puncture, nerve damage, including spinal cord trauma, local bleeding, swelling and broken needles. I recognize that significant sickness or even death could occur as a very remote but real possibility of this therapy, which places needles through the skin and uses either manual or electrical stimulation.

I am also aware that acupuncture may mask an underlying condition or retard a more exact diagnosis where alternative therapy may be known to be indicated.

What We Should Know to Make Treatment Safer

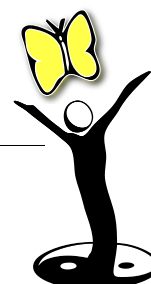
Contraindications for acupuncture include a history of a bleeding disorder or current anticoagulant therapy, implanted pacemaker or prosthetic valve, pregnancy, or seizure disorder. I understand and have informed or will inform my acupuncturist if any of these conditions exist.

Although acupuncture has been used in Asia for thousands of years and in Europe as an authentic therapeutic modality, acceptance by the U.S. medical community is developing slowly. While it is still considered complementary or alternative by many, the National Institutes of Health (NIH) has recognized acupuncture as a reasonable clinical option for postoperative pain as well as myofascial pain and lower back pain. NIH has also recognized positive clinical reports for treatment of addiction, stroke rehabilitation, carpal tunnel syndrome, osteoarthritis, and headache. Acupuncture is used to treat a much wider variety of conditions, and I am informed that the scientific evidence for its efficacy for my condition may not have been established.

Certain medications or social habits are known to lessen the potential results of acupuncture. These include alcohol, tobacco, steroids, and narcotics. I understand and have informed or will inform my acupuncturist of any substances taken by me included in this list.

Informed Consent to Receive Treatment

I hereby consent to such treatment and release the practitioner from any and all claims of damages for injury which may result from such treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction, and I have carefully read and understand this consent form. I understand the hazards and potential dangers involved in treatment by means of acupuncture. The nature and consequences of the above treatment have been fully explained to me, and I am convinced that the treatment is in my best interest. I confirm that no guarantee of results have been made to me. I represent that I am seeking acupuncture in order to further my own health and for no other reason. I am aware that I may withdraw this consent and stop treatment at any time.



_______________________________	_______________________________	___________________
Signature or Patient or Guardian	Printed Name	Date

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Required

Balanced Living Acupuncture

Blanca O. Lopez, M.D.

Payment Agreement

Patient Name (Last, First, Middle):		
Date of Birth:	Telephone:	
Street Address:		
City:	State:	Zip:

I, ________________________________, as the patient or the patient's guarantor, understand that I am and agree to be responsible for all charges for any and all services rendered by Balanced Living Acupuncture, LLC, ("BLA") in the treatment of the above named patient, according to the terms set forth below.

1. I understand that BLA will charge fees according to its usual and customary rates, and that payment is due on the date of service.

2. I am responsible for filing any claims with my insurer or any other third-party payer, including the submission of any records requested by said insurer or third-party payer.

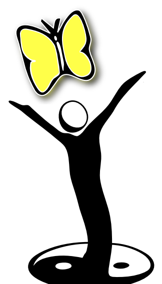
3. I understand that BLA may charge me a fee for missed or canceled appointments according to its policy, and I agree to pay said fees.

4. I understand that BLA will charge me a $35.00 fee for all checks returned for insufficient funds.

5. I understand that all charges and fees incurred by me constitute a debt to BLA that must be paid. I further agree to reimburse BLA for any costs incurred in attempting to collect said debt, including but not limited to legal fees, collection agency fees, etc.

6. I understand that should I incur an excessive balance, as determined in the sole discretion of BLA, that BLA may deny or refuse the patient and any other patients for which I may be the guarantor, any additional appointments until a payment plan has been executed.

______________________________	______________________________	____________________
Patient/Guarantorn Printed Name*	Signature	Date



Required

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Blanca O. Lopez, M.D.

P.O. Box 844
Perry, Georgia 31069-0844
(478) 952-1719 (phone)
(478) 216-3437 (fax)
office@ balancedlivingacupuncture.com
www.balancedlivingacupuncture.com

Your Information. Your Rights. Our Responsibilities.

HIPAA Privacy Disclosure Notice

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record, usually within 30 days of your request.
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

More About Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This policy is effective June 1, 2020.

If you have any questions concerning this policy or feel that your rights under this policy may have been violated, please contact the Office Manager/Privacy Officer.

You may mail a written complaint to the Office Manager at the address listed on page 1. You may also request a phone conversation by calling the office, making a request in-person, or by emailing officemanager@balancedlivingacupuncture.com. **Email is not secure. Please don't include any personal details in your email except for your name, preferred callback phone number and the general nature of your question or concern.**

We never market or sell personal information.

I have read and understand the policies listed above:

____________________	____________________	____________
Patient Name (Print)	Patient or Guardian Signature	Date

Required

Balanced Living Acupuncture
Blanca O. Lopez, M.D.

Patient Rights & Responsibilities

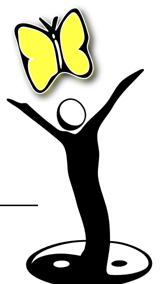
Balanced Living Acupuncture strives to provide quality, affordable care. In order to meet this goal, it is our policy to support the rights and responsibilities of our patients.

As a patient, or when appropriate, the patient's representative as allowed by law, you have the following rights:

- To be treated with dignity and receive considerate care that is respectful of your personal beliefs and cultural and spiritual values;
- To receive care in a safe setting;
- To have your information kept private, within the law;
- To know who the staff is providing your care, their license status, and the doctor in charge of your care;
- To complete and current information about your diagnosis, treatment, and outcome;
- To receive information in a manner you can understand;
- To access your medical records within a reasonable time frame and have them explained unless restricted by law;
- To be involved with your care and ask questions!
- To refuse treatment to the extent permitted by law;
- To obtain a full explanation of the bills related to your health care services;
- To complain about care or treatment or suggest changes without fear of mistreatment;
- Involve family in continuing care.

As a patient, or the patient's representative as allowed by law, you and/or your designees have the responsibilities:

- To provide accurate information about your present illness and past medical history, including medications;
- To ask questions when you do not understand information or instructions;
- To participate as best you can in making decisions about your medical treatment and carry out the plan of care agreed upon by you and your caregivers;
- To be reasonable in requests for medical treatment and other services;
- To make sure the financial obligations of your health care are fulfilled as soon as possible;
- To be knowledgeable of what treatments your insurance policy covers and to file your own claims with your insurer(s);
- To observe facility policies and procedures, including those on patient safety;
- To be considerate of the rights of other patients, visitors, and staff;



I have read and understand the policies listed above:

______________________	______________________	______________
Patient Name (Print)	Patient or Guardian Signature	Date

Balanced Living Acupuncture
Blanca O. Lopez, M.D.

Will Insurance Cover My Visit?

Dr. Lopez is not a participating provider with any insurance companies for acupuncture; full payment is required at the time of service. We will, upon request, provide you with a superbill, which you may then submit to your insurance company; many insurance policies reimburse some of our services such as acupuncture and naturopathic medicine.

Currently insurance companies do not cover integrative medicine, prolotherapy, or allergy elimination. Payment is required at the time of service. Consequently, Balanced Living Acupuncture does not provide a superbill with diagnostic and procedural codes for these services. We will, however, provide a receipt for the office visit. In many cases, a flexible spending account may be used to cover some or all of the integrative medical services. Your plan manager can explain what is and is not covered in your flexible spending plan.

Integrative medical care does not replace the need for a primary care physician. You must maintain an on-going relationship with a primary care physician.

If specialty lab tests are required, it is the patient's responsibility to contact their insurance company regarding coverage. It is the patient's responsibility to pay the laboratory directly. Our office will not be involved with laboratory payment or insurance reimbursement.

I have read and understand the policies listed above.

____

Patient Name (Print)   Patient or Guardian Signature   Date

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Required

Balanced Living Acupuncture

Blanca O. Lopez, M.D.

Missed/Canceled Appointments Policy

Balanced Missing Acupuncture wishes to make appointments available to as many patients as possible. Missed and/or canceled appointments impact everyone. Due to the limited number of available appointments and an increasing number of appointments missed, canceled, or rescheduled on short notice, the followed *Missed/Canceled Appointments Policy* is being implemented, **effective June 1, 2020.**

1. Patients wishing to cancel or reschedule an appointment should notify Balanced Living Acupuncture at least 24 hours in advance, by calling our office and either speaking with staff or leaving a voicemail message stating the desire to cancel or reschedule an appointment.
2. Any appointment canceled or rescheduled with less than 24-hours notice shall be considered a "missed appointment."
3. Each missed appointment shall be tracked in the patient's file.
4. After the second "missed appointment," Balanced Living Acupuncture will provide the patient with a written notice.
5. Beginning with the third "missed appointment," there will be a **$35.00** missed appointment charge that must be paid prior to the next visit.
6. After 5 "missed appointments," Balanced Living Acupuncture may refuse to schedule additional appointments.
7. In its sole discretion, Balanced Living Acupuncture may choose to waive this policy of an individual patient's circumstances warrant it.

By signing, I acknowledge that I have been informed of and agree to the above policy:

____

Printed Patient Name

____

Patient or Guarantor's Signature Date

Balanced Living Acupuncture

Blanca O. Lopez, M.D.

HIPAA Disclosure Authorization

I, ________________________________, direct Balanced Living Acupuncture, LLC, to disclose and release my protected health information described below to (Note: Any information disclosed to a party not covered by HIPAA may no longer be protected from further disclosure by that party):

Name	Relationship	Phone Number

Health Information to be disclosed upon the request of the person named above — (Check either A or B):

A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

Mental health records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Other (please specify):

____

____

____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

An electronic record or access through an online portal
Hard copy

This authorization shall be effective until (Check one):

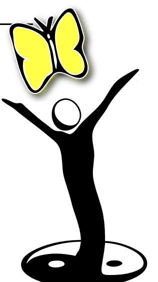
All past, present, and future periods, OR
Date or event: ____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Balanced Living Acupuncture, LLC, preferably in writing. This will not impact the release of any information released prior to revocation.)

______________________________ ______________________________ ________________

Patient Name (Print) Patient or Guardian Signature Date

Relationship to Patient if
Other than Patient: ______________________________



Note: Treatment will not be impacted in any way, whether or not this form is or is not completed and/or signed.
HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

Balanced Living Acupuncture
Blanca O. Lopez, M.D.

Telephone Message Authorization

Balanced Living Acupuncture, LLC, may not divulge details concerning your treatment to any person without your express authorization, including leaving you messages by telephone. This form tells us how we may leave telephone messages. You have the right at any time to revoke this consent, preferably in writing. Completion of this form is voluntary and will no way impact the treatment you receive. **Any personal information disclosed to a third party may no longer be protected from further disclosure by that party.**

If you wish for a friend, family member, or other person to be able to access more detailed information concerning your health and treatment than described below, you will need to complete the HIPAA Disclosure Authorization form or complete a Request for Medical Records. Likewise, if you would like for a friend or family member to be able to discuss your health or treatment with Balanced Living Acupuncture, LLC, you will need to complete the HIPAA Disclosure Authorization form.

I authorize Balanced Living Acupuncture, LLC, to (check all that apply):

leave a detailed message on my home or cell number regarding appointments

leave a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information

leave a detailed message regarding appointments with anyone who answers the phone

to only leave message with ____

____________________________	____________________________	________________
Patient Name (Print)	Patient or Guardian Signature	Date