RICHMOND NATURAL MEDICINE
Thriving in Health

2201 West Broad Street, Suite 107
Richmond, VA 23220
T/F (804) 977-2634
www.richmondnaturalmed.com

Acupuncture - New Patient Intake

Name:_____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home):_____ cell: _____ other: _____

E-mail address: _____ Age: _____

Date of Birth: _____

Live: ❑ Alone ❑ w/Partner ❑ w/Parents ❑ w/Children ❑ Other family ❑ Friends

Occupation: ❑ Work ❑ Unemployed ❑ Disabled ❑ Retired ❑ Volunteer ❑ Student

Current Occupation: _____ # of Hours Work/Volunteer_____

If retired, disabled or unemployed, list last occupation: _____

Next of kin or emergency contact: _____

Relationship: _____ Phone: _____

Address: _____

How did you hear about our clinic? _____

Are you under the current care of a physician? ❑ Yes ❑ No If so, with whom: _____

If not receiving healthcare, when did you last receive health care? _____

What is/was the reason? _____

Do you currently have any contagious diseases? ❑ Yes ❑ No Please list: _____

Do you have any allergies? ❑ Yes ❑ No Please list: _____

What are your most important health concerns and what treatments have been used?

1. _____treatments used _____

2. _____treatments used _____

3. _____treatments used _____

What service(s) are you here for today? _____

I give the professionals at RNM permission to assist in my care. I understand that such professionals may include RNM employees, members, and independent contractors. I agree to indemnify and hold harmless RNM, its officers, members, independent contractors, directors, and employees from any and all damages and/or liability arising out of or related to services rendered. I also understand that if I do not give a 24-hour notice for an appointment cancellation or if I do not show for the appointment, I will be charged an insufficient notice fee.

_____ _____ / _____ / _____

SIGNATURE DATE

1) What led you to choosing this clinic?

2) What do you know about us and how we work?

3) What **three** expectations do you have from today's visit at our clinic?

4) What **three** long-term expectations do you have from working with our clinic?

5) At this present time, how committed are you to addressing the underlying causes of your signs and symptoms that may relate to your lifestyle? (0= not committed and 10= completely committed). Please circle.

0 1 2 3 4 5 6 7 8 9 10

6) What types of daily or weekly lifestyle habits do you feel support or strengthen your health?

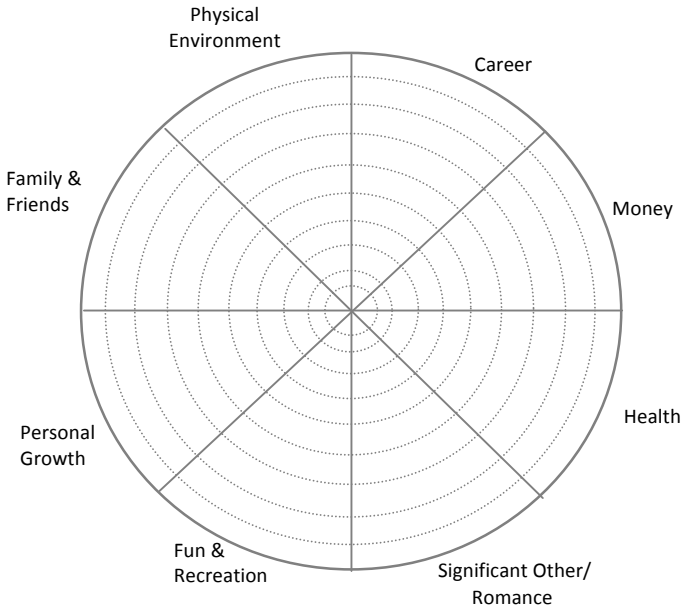
7) What types of daily or weekly lifestyle habits do you feel do not fully support your health?

8) What obstacles or challenges do you potentially anticipate that may undermine your health and following through on your treatment?

9) Who do you know that will sincerely support you consistently with the lifestyle change you will be making to regain your health and vitality?

10) What do you love doing; what brings you joy?

11) Wellness is achieved through various aspects of our lives. Using this pie chart, please shade your level of satisfaction of each area. Start shading from the center out to the edge of the circle. For example if you are 50% satisfied in your career you will shade starting from the center out and fill in half of that section of the pie chart (5 rings or bands). If you are 100% satisfied in your financial/money then shade all 10 bands or rings on the chart.



FAMILY HISTORY

Do you have a family history of any of the following (please check all that apply)?

- ❑ Cancer
- ❑ Kidney Disease
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Stroke
- ❑ Hay Fever
- ❑ Heart Disease
- ❑ Arthritis
- ❑ Anemia
- ❑ Hives
- ❑ High Blood Pressure
- ❑ Glaucoma
- ❑ Mental Health Illness

Any other relevant family history? _____

_____

CHILDHOOD/EARLY ADOLESCENT ILLNESSES

Which of the following have you had as a child?

- ❑ Scarlet fever
- ❑ Mumps
- ❑ Chicken pox
- ❑ Diphtheria
- ❑ Measles
- ❑ Shingles
- ❑ Rheumatic fever
- ❑ German measles
- ❑ EBV (mononucleosis)
- ❑ CMV (cytomegalovirus)

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG or EKG's have you had?

_____Year_____

_____Year_____

_____Year_____

_____Year_____

_____Year_____

ALLERGIES

Any drugs? _____

Any foods? _____

Any environmental or chemical products? _____

CURRENT MEDICATIONS

Please list **all** prescription medications, over the counter medications, vitamins and supplements you are taking (including herbs):

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

GENERAL INFORMATION

Height: _____Weight:_____ lbs. Weight 1 year ago: _____lbs.

Maximum Weight ever: _____ When was this:_____

When during the day is your energy the best? _____ Worst? _____

Blood Type: _____ ❑ Unknown

FOOD

Please list the most typical foods you eat for each meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

LIFESTYLE

For this section, PLEASE CIRCLE

Y=Yes (a condition you have now), **N**=No (never had) and **P**= in the Past (significant problem of past).

Main interests or hobbies: _____

Do you exercise? Y N If so, what kind and how often? _____

Do you get an average of 6-8 hrs. of sleep?	Y N	Do you enjoy your work?	Y N
Sleep well?	Y N	Do you take vacations?	Y N
Awaken rested?	Y N	Do you spend time outside?	Y N
Do you have a supportive relationship(s)?	Y N		
How many hours do you watch TV?	_____		
Any major traumas?	Y N P		
Do you eat 3 meals a day?	Y N P		
Do you go on diets often?	Y N P		
Do you drink cola/other sodas?	Y N P		
Do you have a spiritual practice?	Y N P		

-If yes, what? _____

REVIEW OF SYSTEMS

MENTAL/EMOTIONAL

Rate your stress level on a scale of 0-10: _____

Sources of stress: _____

What practices do you have for stress management? _____

IMMUNE SYSTEM

Reactions to vaccinations?	Y N P	Autoimmune?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow healing?	Y N P
Lyme Disease	Y N P		

ENDOCRINE

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

NEUROLOGICAL

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

SKIN

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

HEAD

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

EYES

Spots in eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

EARS

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

NOSE and SINUSES

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

MOUTH and THROAT

Frequent sore throat?	Y N P	Large amount of saliva?	Y N P
Teeth grinding?	Y N P	Sores in mouth or throat?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

NECK

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

RESPIRATORY

Cough?	Y N P	Sputum/phlegm?	Y N P
Spitting up blood?	Y N P	Wheezing?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Breathing worse with lying?	Y N P
Tuberculosis?	Y N P	Lung cancer?	Y N P

CARDIOVASCULAR

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

GASTROINTESTINAL

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcers?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a change	Y N
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

URINARY

Pain with urination?	Y N P	Increased frequency?	Y N P
Do you urinate often at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

MUSCULOSKELETAL

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

BLOOD/PERIPHERAL

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

MALE REPRODUCTIVE

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Discharge or sores?	Y N P	Impotence?	Y N P
Any sexually transmitted diseases?	Y N P	Premature ejaculation?	Y N P
-If yes, please explain _____		Are you sexually active?	Y N P
_____		Sexual orientation _____	

FEMALE REPRODUCTION

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal)	_____	Are cycles regular?	Y N
Length of cycle in days?	_____	Abnormal bleeding?	Y N P
Duration of menses in days?	_____	Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting issues?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms? _____		What type? _____	
_____		Number of pregnancies: _____	
Breast pain/tenderness?	Y N P	Number of live births: _____	
Nipple discharge?	Y N P	Number of miscarriages or abortions: ____	
Endometriosis?	Y N P	Menopausal symptoms?	Y N P
Ovarian cysts?	Y N P	Abnormal PAP?	Y N P
Difficulty conceiving?	Y N P	Sexual difficulties?	Y N P
Cervical dysplasia?	Y N P	Do you do self breast exams?	Y N P
Are you sexually active?	Y N	Breast lumps?	Y N P

Sexual orientation: _____
Any sexually transmitted diseases? Y N P
-If yes, please explain _____

DRUG/ALCOHOL/TOBACCO HISTORY:

Please indicate any substances used over the last 6 months as current use. Include amount used at one time, how many times used per day/week, and the length of time you have been using or have used in the past.

Substance	Current Use	Amount	Frequency	Past Use	Length of Use
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Pain Killers					
Tranquilizers					
Inhalants					
Sleeping Pills					
Diet Pills					
Laxatives					
Steroids					
Methamphetamines					
PCP/LSD/Mushrooms					
Ecstasy					
Cocaine/Crack					
Heroin					

MENTAL HEALTH HISTORY

Have you ever been in counseling/therapy before? Yes No
If yes, did you find it helpful or effective?

Have you ever sought any alternative treatment for mental health? Yes No
If yes, what type of treatment?

Was it helpful or effective?

Are you currently receiving mental health services? Yes No
If yes, please list practitioner(s) name and type of service you are receiving:

Have you ever been diagnosed with a mental illness? Yes No
If yes, please list illness(es) and date(s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness? Yes No
If yes, please list relationship(s) and diagnosis:

Have you ever been hospitalized for mental health concerns? Yes No
If yes, list date(s), length of stay, and reason for hospitalization:

Have you ever, or are you currently engaging in self-harm? Current Past Never
Have you ever, or are you currently contemplating suicide? Current Past Never
Have you ever attempted suicide Yes No
If yes, please list date(s) and method(s) of attempt:

Has anyone in your life ever attempted suicide? Yes No
If yes, what was their relationship to you?

Has anyone in your life committed suicide? Yes No
If yes, what was their relationship to you?

Have you contemplated harming someone else? Current Past Never

Have you ever been the victim of abuse(verbal, physical, sexual)? Yes No
If yes, at what age(s)

Please circle all symptoms/behaviors that you've experienced and indicate if they're currently problematic or have been in the past.

Distractibility	Current	Past
Hyperactivity/Excessive Energy	Current	Past
Impulsivity	Current	Past
Wide Mood Swings	Current	Past
Over Confidence	Current	Past
Shy/Timid	Current	Past
Changes in Appetite/Eating Behavior	Current	Past
Suspicion/Paranoia/Jealousy	Current	Past
Aggression/Fights	Current	Past
Hearing Voices	Current	Past
Visual Hallucinations	Current	Past
Irritability/Anger	Current	Past
Increased/Decreased Need for Sleep	Current	Past

Delusions	Current	Past
Sexual Problems/Promiscuity	Current	Past
Lack of Motivation	Current	Past
Loss of Pleasure/Interest	Current	Past
Withdrawal From People	Current	Past
Sadness/Depression	Current	Past
Low Self-Worth	Current	Past
Crying Spells	Current	Past
Loneliness	Current	Past
Guilt/Shame	Current	Past
Fatigue	Current	Past
Racing Thoughts	Current	Past
Anxiety/Worry	Current	Past
Poor Memory/Confusion	Current	Past
Panic Attacks	Current	Past
Fear Away From Home	Current	Past
Nightmares	Current	Past
Social Discomfort	Current	Past
Obsessive Thoughts	Current	Past
Compulsive Behavior	Current	Past
Thoughts of Death	Current	Past
Relationship Problems	Current	Past
Flashbacks	Current	Past
Reoccurring Disturbing Memories	Current	Past

APPOINTMENT & CANCELLATION POLICY

New patient visits are 120 to 180 minutes in duration and return visits are 60 minutes. If you are unable to make an appointment you will need to provide at least a 24-hour notice. This allows us to meet the needs of other patients who need an appointment. Due to this, follow-up appointments that are cancelled without providing a 24-hour notice will be charged a $75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a $100 insufficient notice fee. We charge your credit card on file if you do not call and cancel your appointment within the timeframes below. Notification allows the practitioners to see other clients who need to be cared for that day.

COMMUNICATING WITH RICHMOND NATURAL MEDICINE AND YOUR PRACTITIONER

Email Policy

We recognize that many of our clients prefer to use email as a quick and easy way to communicate with a health care provider. We would like to offer this as a method to communicate for business and healthcare matters. You may contact your practitioner by email at the following address: patients@richmondnaturalmed.com. Here are some points we would like our clients to be aware of regarding email communications:

1) This type of communication is not always secure or confidential so to help ensure your privacy
    a. Please do not send medical emails from your work email account
    b. Please do not send information which you do not want shared; as email is never a guaranteed secure communication tool.
2) All medical email communications may be kept in your chart as part of your medical record.
3) Employees of Richmond Natural Medicine other than your provider, such as other health care providers and support staff, may have access to your e-mail address and e-mail content.
4) We will do our best to reply to emails within 48 hours, but there is always a chance that an email is not properly sent or received. If you do not hear from us within 2-3 days, please follow up with another email or by telephone.
5) In cases where an email response would not be appropriate or sufficient, you may be asked to schedule a phone or in-office appointment to ensure that your concerns get properly addressed.

Email Billing Policy

We recognize that for many clients, a quick medical question is sometimes easier to send through email. We would like to continue to welcome your questions this way, but due to an increasing volume of emails of this nature, and the amount of time practitioners are spending on email patient care, we have implemented an email billing policy. You may be billed for time spent responding to your email inquiries related to your health care depending on the complexity of and time spent responding to your inquiry.

Time will NOT be billed for:

1. Scheduling questions
2. Billing questions
3. Supplement refills
4. Clarification of your most recent treatment plan

If you would like to send us a health update that does not require a reply please type “No Reply Necessary” in the subject line of the email. This will ensure you will not be billed. We appreciate your consideration in following these policies. If you have any questions or concerns, please contact us at your convenience.

Phone Policy

At Richmond Natural Medicine, we have found that follow ups can be effectively managed over the phone, allowing us to take on many long distance patients.

We do ask, however, that you come in for your initial visit. The initial intake is a time for gathering pertinent information that will be useful throughout the course of treatment, therefore being there in person is an important factor in receiving the best care possible. Also, meeting you face to face allows us the opportunity to get to know you as a whole person, and allows you to get a feel of how we practice.

Appropriately timed follow ups are very important to your healing process, and we would love to be informed of significant health changes, or if you get acutely ill so that we can adjust your support plan as your health needs change. Phone consultations can be very useful in this way, as you do not have to come to the office for a last minute appointment or if you're not feeling well enough to travel.

Phone Billing Policy

Your practitioner spends an equal amount of time and effort on your care over the phone as they do during in-office appointments, and therefore phone consultations will be billed at our normal follow up rate.

Your practitioner may call you for a quick check in after you begin a new remedy or make changes to your support plan. You will not be billed for these short (5-10 min) phone consultations, however if the call ends up requiring additional time or extensive decision making, you may be billed for the consultation or asked to schedule a follow up appointment at a later date.

Below are a few things we have found necessary to provide the most effective care for our clients, particularly those who are long distance or following up by phone:

1. You will need to have a local physician to perform examinations and manage prescription medications that are needed during the course of seeing your practitioner at Richmond Natural Medicine.
2. It is ideal if you have a close family member or friend who is willing and able to speak with us on occasion. This helps us gather observational details about your symptoms that may be missed in a phone consultation. It's also helpful if this person is willing and able to contact us on your behalf should a circumstance arise when you may be unable to do so.
3. We ask that you include us in all medical decision-making such as starting/stopping other therapies that may affect the progress of our therapies.

CONSENT TO TREATMENT

I agree to abide by the guidelines of Richmond Natural Medicine, LLC ("RNM"). I understand that the Commonwealth of Virginia does not license or otherwise recognize naturopathic medical doctors. Therefore, neither Dr. Allen, Joy Black, Dr. Bloomingdale, Dr. Casey, Dr. Hollon, Lindsay Kluge, Dr. Lundberg, Dr. Reckers nor any other naturopathic doctor participating in my care at RNM are permitted to diagnose or treat a given diagnosis of a disease/illness. The role of my naturopathic doctor is supportive, adjunctive and consultative in nature to assist in my health and well-being. I further understand that my naturopathic doctor may work with other physicians or health care providers. I further understand, if I need additional assistance or medical care, I will be referred to others within the community.

I hereby request and consent to the performance of naturopathic care and related procedures on me by the naturopathic doctor and/or any RNM personnel authorized by the naturopathic doctor. I further understand my naturopathic care may be performed by Dr. Allen, Joy Black, Dr. Bloomingdale, Dr. Casey, Dr. Hollon, Lindsay Kluge, Dr. Lundberg, Dr. Reckers, and or any other naturopathic doctor who may care for me or consult with me now or in the future at RNM. I have had an opportunity to discuss with Dr. Allen, Joy Black, Dr. Bloomingdale, Dr. Casey, Dr. Hollon, Lindsay Kluge, Dr. Lundberg, Dr. Reckers and/or other RNM personnel the nature and purpose of naturopathic care and related procedures. I understand that results are not guaranteed and that

neither RNM, nor Dr. Allen, Joy Black, Dr. Bloomingdale, Dr. Casey, Dr. Hollon, Lindsay Kluge, Dr. Lundberg, Dr. Reckers, or any other RNM personnel warrant or guarantee any result or outcome.

In agreement with federal and state law, I agree to allow RNM to deliver the necessary care to me in order to provide continuity of care and treatment. RNM and/or my naturopathic doctor may obtain from any source and examine and use, or discuss and disclose, my medical records and information to RNM personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I may revoke this consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my naturopathic doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at RNM. I understand RNM's fee, appointment, and cancellation policies as well.

_____

Signature of individual or guardian **Date**

_____

RNM Representative **Date**

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Payment Policy

Richmond Natural Medicine strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and products.

Payments: Payment for services rendered is due at the time of service. We accept cash, Visa, MasterCard, Discover and American Express. We also accept payment by check and debit cards. We hold a credit card number on file to secure your appointment and to secure necessary fees for breach of our cancellation policy. Richmond Natural Medicine will send clients accounts to collections for balances not paid after two failed attempts to collect on balances past due by 60 days or more. Payment plans are offered at management's discretion. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients who have large balances or are not making regular payments on their balance. If you have an unpaid balance at the end of a billing cycle, we may apply a $5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an "insufficient fund" check, there will be a $25 insufficient funds charge added to the balance due.

Cancellations: We charge your credit card on file if you do not call and cancel your appointment within the time frames listed below. Notification allows the practitioners to see other clients who need to be cared for that day.

New Client and Follow-up appointments: Follow-up appointments that are cancelled without providing a 24-hour notice will be charged a $75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a $100 insufficient notice fee. Failure to show for an appointment will also result in a charge to your credit card.

Dependents: You are responsible for payment of services rendered to your dependents on your account.

I authorize Richmond Natural Medicine to keep my signature on file and to charge my credit card (held in our secure system) for:
1. Charges associated with appointments that are not cancelled within the timeframes listed above.
2. Charges associated with payment arrangements. Contact management to make payment arrangements.

Attestation Statement:
I have read, understand, and agree to the above Richmond Natural Medicine Payment Policy. I understand that charges are my responsibility. I acknowledge that these policies do not obligate Richmond Natural Medicine to extend credit.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

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Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. Copies are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you come to Richmond Natural Medicine for a treatment or consultation. Your symptoms, the practitioner's assessment, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of Richmond Natural Medicine, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibility: Richmond Natural Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Richmond Natural Medicine reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Richmond Natural Medicine agrees not to use or disclose your health information without your consent.

Contact information:

Richmond Natural Medicine
2201 West Broad St.
Suite 107
Richmond, VA 23220
804-977-2634

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Practices Regarding Disclosure of Client Health Information

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment/Consultation: Information obtained by your practitioner at Richmond Natural Medicine will be entered in our record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectation and those of others involved in your care may also be recorded.

Payment: Your record will be used to receive payment for services rendered by Richmond Natural Medicine. A bill may be sent to either you or received directly upon services rendered.

Quality Monitoring: Richmond Natural Medicine will use your health information to assess the care you received and compare the outcome of your care to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services provided.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA): This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Public Health: This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.

Law Enforcement: As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member of business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is Richmond Natural Medicine' practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Richmond Natural Medicine will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here:

Business Associates: Some or all or your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Communications with Family: Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given

information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Consent

I consent to the use or disclosure of my protected health information by RNM for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of RNM. I understand that analysis, diagnosis or treatment of me by RNM may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RNM is not required to agree to the restrictions that I may request. However, if RNM agrees to a restriction that I request, the restriction is binding on RNM.

I have the right to revoke this consent, in writing, at any time, except to the extent that RNM has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of RNM and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RNM. The Notice of Privacy Practices for RNM is also available at the front desk at 2201 West Broad St. Suite 107, Richmond, VA. This Notice of Privacy Practices also describes my rights and duties of RNM with respect to my protected health information.

RNM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of RNM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of individual or guardian **Date**

_____

Print Name

RICHMOND NATURAL MEDICINE
Thriving in Health

2201 West Broad Street, Suite 107
Richmond, VA 23220
T/F (804) 977-2634
www.richmondnaturalmed.com

HIPAA Privacy Authorization Form

This form is required by the Health Insurance Portability and Accountability Act (HIPAA), Section 45 C.F.R. Parts 160 and 164 Authorization

I, _____, authorize Richmond Natural Medicine (RNM) to use and disclose the protected health and demographic information to the individuals working within the establishment. Also, this authorization will expire one year from today's date: ____/___ /____.

You have the following rights:

1. I have a right to refuse sign this authorization.
2. I have a right to receive a notice about my privacy policies.
3. I have a right to request and access my medical information.
4. I have a right to limit the uses and disclosure of my medical information.
5. This medical information will only be used by the person I authorize to receive this information health care and health consultation or other purpose I may authorize.
6. I understand that I have a right to withdraw this authorization, in writing, at any time during my care. I acknowledge that a withdrawal is not effective to the extent that any person or entity has already acted in reliance on my authorization.

□ I do not give anyone (family, caregiver, friends) access to my medical information related to my care
□ I do give the following individuals access to my medical information related to my care:

Name(s): _____

Expiration of access: _____

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative

Date ____ /____ /_____

Recommendation for Examination by a Physician

I, Dr. Micah Allen, ND, Lac, MSAOM or Dr. Katie Lundberg, ND, Lac, MSAOM, recommend to you
(licensed acupuncturist)

_____ that you be examined by a
(patient)

Physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Patient Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).

_____ _____
Acupuncturist Date
