

LOTUS HEALING WELLNESS CENTER REGISTRATION FORM

(Please Print)

Today's date:				E-mail:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Cell phone no.: ()		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Internet	<input type="checkbox"/> Other		
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Vivian Chou, L.Ac., Ph.D. or Lotus Healing Wellness Center. I understand that I am financially responsible for any balance. I also authorize Lotus Healing Wellness Center or insurance company to release any information required to process my claims.</p>							
<hr style="border: 0; border-top: 1px solid black; margin: 0;"/> <i>Patient/Guardian signature</i>						<hr style="border: 0; border-top: 1px solid black; margin: 0;"/> <i>Date</i>	

Patient Name: _____

Please state your present complaint, injury, or illness and give a brief account of its history with date & development:

Is your condition due to: Accident Illness

Is it work related: Yes No Date of Onset:

Have you seen any Medical Doctor? Yes No

If yes, what was the diagnosis by your M.D.?

Describe history of any previous illness, including type of treatment and results:

Check any of the following illnesses you have had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other, please list: |

Surgeries/scars:

Trauma (car accident, fall, etc.):

Allergies (to drugs, chemicals, foods):

Current medications (include vitamins, drugs, herbs, etc.):

Occupational stresses:

Menstruation:

Normal Irregular None

Painful Low back pain Breast tenderness Abdominal cramps

Amount: Excessive Normal Little

Other:

Discharge: Discharge between periods None

Discharge amount: _____ Color: _____ Other: _____

History of pregnancy:

Patient Name: _____

<input type="checkbox"/> Number of pregnancies	<input type="checkbox"/> Number of births				
<input type="checkbox"/> Premature births	<input type="checkbox"/> Abortion	<input type="checkbox"/> Miscarriage			
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much/often: _____			
Alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much/often: _____			
Coffee/caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much/often: _____			
Drug use	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much/often: _____			
Taking a restricted diet <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe diet and indicate dates: _____					
Do you exercise: <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes, how often & length: _____					
Please check any of the following symptoms you have:					
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Excessive dreams	<input type="checkbox"/> Palpitation		
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Night sweating	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Easy awoken	<input type="checkbox"/> Oversleep		
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Swelling of hands or feet				
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma		
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Loss of voice	<input type="checkbox"/> Common cold		
<input type="checkbox"/> Sinus problem	<input type="checkbox"/> Phlegm	<input type="checkbox"/> Skin problem	<input type="checkbox"/> Depression		
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Difficult in breathing	<input type="checkbox"/> Spontaneous sweating			
<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Gasfullness	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Over acids		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Belching		
<input type="checkbox"/> Foul breath	<input type="checkbox"/> Prolapse	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Fatigue		
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Loose stool	<input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Thirsty	<input type="checkbox"/> Abdominal distension	<input type="checkbox"/> Abdominal pain or cramps			
<input type="checkbox"/> Easily upset	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Easily sigh	<input type="checkbox"/> Dizziness		
<input type="checkbox"/> Headaches	<input type="checkbox"/> Bitter taste in mouth	<input type="checkbox"/> Pain in ribs	<input type="checkbox"/> Numbness		
<input type="checkbox"/> Eye problem	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Twitching or spasm of muscle			
<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Back pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Joint pain	
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Frightening	<input type="checkbox"/> Impotence	<input type="checkbox"/> Edema	<input type="checkbox"/> Night urination	
<input type="checkbox"/> Urinary problem	<input type="checkbox"/> Decreased sexual drive				
Family history: has anyone in your immediate family ever had: (please check all that apply)					
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other, please list:		
Anything else you feel I should know:					

Patient's Take Home Copy

Lotus Healing Wellness Center

2555 Flores Street, Suite 474, San Mateo, CA 94403

(650) 212-7288

Privacy Officer: Vivian Chou, L.Ac., Ph.D., CHT

Last revised: January 18, 2009

This notice describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when law requires the release. If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer that we not to share information, we may honor your written request in certain circumstances described below. If you have any questions about this notice, please contact our Privacy Officer at the address above.

Who will follow this notice This notice describes Lotus Healing Acupuncture Center regarding the use of your medical information and that of:

- Any health care professional authorized to enter information into your hospital chart or medical records.
- All departments and units of the hospitals, clinics or doctor's offices you may visit.
- Any member of a volunteer group we allow to help you while you are in the hospital
- All employees, staff and other personnel who may need access to your information
- All entities, sites and locations of Lotus Healing Acupuncture Center follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care purposes described in this notice.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Lotus Healing Acupuncture Center, whether made by health care professional or other personnel. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: keep medical information that identifies you private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the hospital/clinic who may be involved in your medical care after you leave the hospital/clinic or that provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, and insurance company for a third party. For example, your insurance may need to know about surgery you received so they will pay us or reimburse you for the surgery. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover the treatment.

For Health Care Purposes. We may use and disclose medical information about you for health care purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, training doctors, medical students, and other hospital/clinic personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health -Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release of medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital/clinic. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital/clinic. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the hospital/clinic.

As Required By Law. We will disclose medical information about you when required to do so by Federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Fundraising Activities. We may use medical information about you in an effort to raise money for the physician clinical practices and its operations. We may disclose medical information to a foundation related to the hospital/clinic so that the foundation may raise money for the hospital/clinic. We only would release contact information, such as your name, address and phone number. If you do not want Lotus Healing Acupuncture Center to contact you for fundraising efforts, if you must notify our Privacy Officer in writing at the address above.

Special Situations If

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Patient's Take Home Copy

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or controlled disease, injury or disability;
- to report birth and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or maybe at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena and, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of the law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify the deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties. (If applicable)

Protective Services for the President, National Security and Intelligence Activities. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institute or under the custody of a law enforcement official, we may release medical information about you to the correctional institute or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About you. You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address above. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Vivian Chou, L.Ac., Ph.D. will review your request and the denial. The person conducting the review will not be the person who denied the request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Lotus Healing Acupuncture Center;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs or incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment for health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer at the address above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address above.

Changes To This Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer, Vivian Chou, L.Ac., Ph.D., or with the Secretary of the Department of Health and Human Services. To file a complaint with our Privacy Officer, contact her at the address and phone number above. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Lotus Healing Wellness Center

2555 Flores Street, Suite 474, San Mateo, CA 94403

(650) 212-7288

Part I. Privacy Practices Acknowledgement

Acknowledgement Form

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

Name: _____

Signature: _____

Date: _____

If signing as a parent or guardian, please note the name of the patient: _____

Part II. Consent of communication methods

Often times we would like to remind you upcoming appointments, sending you informative newsletters, seasonal greetings and so on. Please provide us the best ways to reach you:

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detail information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detail information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> E-mail
<input type="checkbox"/> O.K. to send e-mails to my e-mail address
_____ |
| <input type="checkbox"/> Cellular Telephone _____
<input type="checkbox"/> O.K. to leave message with detail information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other _____
_____ |

Patient signature: _____ Date: _____