VCA COVID19 Screening Questionnaire

In the past 24 hours have you experienced any of the following new or worsening symptoms:

◯ fever (over 100◦) ◯ shortness of breath ◯ runny nose

◯ chills ◯ diarrhea ◯ fatigue

◯ body aches ◯ loss of smell/taste ◯ sore throat

◯ cough ◯ nasal congestion ◯ nausea or vomiting

In the past 2 weeks have you been exposed to someone who has tested positive for COVID19?

◯ Yes ◯ No ◯ I don't know

◯ Yes, in a healthcare facility with adequate PPE

Have you been tested for COVID19 last week?

◯ Yes, and I tested positive ◯ Yes, and I tested negative

◯ Yes, and I am awaiting results ◯ No

Voluntary Consent: I understand that by coming to a public space like Vermont Community Acupuncture I may be exposed to transmissible viruses like COVID19 despite efforts by VCA staff to reduce exposure.

◯ I understand and accept this risk, and voluntarily consent to treatment.

◯ I do NOT consent to treatment and will contact the clinic to cancel my appointment.

Name: **Date:**

Signature:

ACUPUNCTURE

INFORMED CONSENT

Please <u>initial</u> at each of the following points and sign at the bottom:

_____ I agree to receive treatments by Julie Suarez Cormier, Matt Stone, Amy Lafayette and Libby Ruby, licensed acupuncturists at Vermont Community Acupuncture. Treatments may include, but are not limited to, the insertion of sterilized, disposable acupuncture needles into my body, the use of moxa, (a therapeutic herb), pressballs, gua sha, cupping, a heat lamp, electro-acupuncture, laser acupuncture, or the insertion of intradermal needles. I understand that each of these therapies will be explained to me before they are performed, and that I may verbally revoke my consent to receive any of these therapies at any time.

_____I understand that acupuncture is a safe method of treatment, but occasionally there may be some bruising, numbness, or tingling near the treatment site that lasts a few days. I understand that gua sha and cupping may cause bruising that will subside after a few days.

_____I understand that certain types of therapies are contraindicated if I become pregnant, and I will inform the staff if I am or become pregnant.

_____I agree to remain lying down or sitting down in the position decided upon by myself and the acupuncturist for the duration of my treatment and not to remove, manipulate, or reinsert any of the needles used for my treatment. I understand that if any of my needles cause me discomfort, I may ask the acupuncturist to remove them.

_____I agree not to come to the clinic under the influence of alcohol or recreational drugs.

_____I understand that I am expected to arrive at my appointment at the scheduled time, and that if I am unable to come in for my treatment, I am expected to call the clinic 24 hours before my treatment is scheduled to begin or pay $50 for the time that was reserved.

_____I understand that my medical record will not be released without my written consent.

_____I agree to maintain the confidentiality of all other patients in the clinic.

_____I understand that if my behavior does not comply with the policy of the clinic that I may be refused treatment, suspended from treatment, or asked not to return to the clinic.

I have read, or have had read to me, the above consent to treatment and clinic policy. I have had an opportunity to ask questions, and by signing below I agree to the above.

Name (Print)_____ Signature_____

Date_____

Vermont Community Acupuncture

Health History Questionnaire

Please help us to provide you with a complete evaluation by taking the time to fill out this form carefully. All of your answers will be kept completely confidential. If you have any questions, please ask. If there is anything you wish to discuss that is not included on this form, please note it in the comments section. Thank you.

Name:_____ Date of Birth:_____
Address: _____
City/Zip_____
Phone:_____Email: _____
Height:_____Weight:_____
Occupation:_____
Family Physician:_____
Emergency Contact Name and Phone:_____

Please describe the main problem you would like to have treated: _____
_____
_____
_____

How long ago and under what circumstances did this problem begin?_____
_____

To what extent does this problem interfere with your daily activities (work, sleep, exercise, emotions, etc)?_____
_____

Have you been given a medical diagnosis for this problem?_____
_____

What kinds of treatment have you tried?_____
_____

Have you used Acupuncture or Chinese Herbal Medicine before? _____
_____

Patient's Medical History

Hepatitis _____	Diabetes _____	Cancer _____	Cardiovascular _____
HIV/AIDS _____	Hypertension _____	Stroke _____	Thyroid _____

Family Medical History

Hepatitis _____	Diabetes _____	Cancer _____	Cardiovascular _____
HIV/AIDS _____	Hypertension _____	Stroke _____	Thyroid _____

Are you currently taking any medications? If so please list: _____

_____

_____

Any vitamins or herbal supplements? _____

_____

_____

Please describe your average Daily Diet: _____

_____

_____

_____

Comments: _____

_____

_____

_____

_____

_____

Notice of Privacy Practices (updated 1/1/20)

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

You have the right to…

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. 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. 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.

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.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting 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.

Our Uses and Disclosures

We can use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals treating you.

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

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

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, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your anonymized information for health research.

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.

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, and 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 by letting us know in writing.

• 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.

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent to Vermont Community Acupuncture to access, use, and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). This includes accessing records from other medical organizations, such as UVM Medical Center.

With this consent, Vermont Community Acupuncture may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assists the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Vermont Community Acupuncture may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as patient billing statements.

I have the right to request that Vermont Community Acupuncture restrict how it uses or discloses my PHI to carry out treatment, payment, or health care operations. The practice is not required to agree to the requested restrictions, but if it does agree it is bound by this agreement.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

By signing this form, I am consenting to Vermont Community Acupuncture's use and disclosure of my personal health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my previous consent.

Signature of Patient or Legal Guardian:_____

Printed Name: _____

Date of Birth: _____ Today's Date: _____

Statement of Understanding:

Footwear in the Clinic

Wearing hard-soled shoes in the clinic is a precautionary measure. We have sandals available for your use. They are located in the bins near the water dispenser in the reception area. All sandals provided by VCA are sanitized after every use. During snowy, muddy, or rainy weather please change into the provided sandals or bring your own hard-soled shoes or slippers to change into. Thank you for your cooperation.

I have read this memo and I agree to wear clinic sandals or my own hard-soled shoes in the treatment room.

Sign:_____

Print:_____ Date:_____

Signature on File form

Responsibility statement:

Your insurance is a method for you to receive reimbursement for fees you have paid to Vermont Community Acupuncture or elsewhere for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or cover percentages based on your contract with them, not with our office. It is your responsibility to pay for the deductible, coinsurances, copays, or any other balances not paid for by your insurance at the time of your treatment. If your insurance does not cover a treatment you have received at VCA, you are responsible for charges not paid.

Financial Responsibility:

By signing this statement, I agree to be financially responsible for all charges.

Authorization to release medical information:

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as the original.

Patients Signature _____

Patient Print Name: _____ Date _____

Witness _____ Date _____