NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that

we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Kimberly Sperling
Shén {Wellness Studio}
1144 Canton Street
Ste 102
Roswell GA 30075
404.545.1600

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of Shen Wellness Studio's Notice of Privacy Practices with an effective date of 12/1/2010 of Notice of Privacy Practices.

Name of Patient: _____

Signature of Patient _____ Date _____

Fee Schedule and Cancellation Policy

Initial visit and treatment-	$170.00
Follow-up treatments-	$120.00

Payment is expected at the time of treatment unless other arrangements have been made in advance. We will be happy to provide you with the appropriate form so that you can bill your insurance company for reimbursement.

CANCELLATION POLICY

We look forward to working with you. The time you schedule has been set aside to address your needs. If you need to cancel or reschedule your appointment, please provide 24 hours notice to avoid a cancellation fee.

I have read, understand, and agree to this policy.

Printed Name: _____

Signature: _____

Date: _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT & CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, on me (or on the patient named below, for whom I am legally responsible) by Shén {Wellness Studio}.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), Chinese or Western herbal medicine, and nutritional counseling.

I understand that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after acupuncture and cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs I will inform the practitioner.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known, is in my best interest.

I understand that the practitioner is not making a medical diagnosis of the person's disease or medical condition. If the person wants to obtain a medical diagnosis, the person should see a licensed physician and seek medical advise from a licensed physician.

I understand the practitioner may review my medical records, and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient: *To be completed by the patient's representative, if necessary, e.g., if the patient is a minor, is physically or legally incapacitated.*

Patient's Name (please print)_____

Patient's Signature_____ Date Signed_____

Patient's Representative (please print)_____

Patient's Representative's Signature _____

Relationship or Authority of Patient _____

ARE YOU PREGNANT? YES NO

Shén Wellness Studio Forms - *Please PRINT & complete the forms as thoroughly as possible. This information will be kept confidential.*

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: M / F

Address:_____

City: _____ State: _____ Zip: _____ Marital Status: _____

PHONE: Work _____ Home _____ Cell _____

Email: _____ Referred by: _____

Occupation: _____ Emergency contact/Phone:_____

Reason(s) for your visit –

1. _____
2. _____
3. _____

Please list the Medications you are currently taking: (please use the back to add additional information)

1. _____ Purpose: _____Dosage: _____
2. _____ Purpose: _____Dosage: _____
3. _____ Purpose: _____Dosage: _____
4. _____ Purpose: _____Dosage: _____

Please list any major surgeries/accidents/hospitalizations: (please use the back to add additional information)

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____

Please list any vitamins or supplements you might be taking – _____

_____

Personal and Family History: Have you or anyone in your family had the following? If yes, please indicate who:

□ AIDS/HIV _____ □ Diabetes _____ □ Hepatitis _____

□ Allergies _____ □ Depression _____ □ High Blood Pressure _____

□ Anxiety _____ □ Digestive Disorders _____ □ Immune Disorder _____

□ Arthritis _____ □ Eating Disorders _____ □ Kidney Problems _____

□ Asthma _____ □ Headaches _____ □ Thyroid Disorder _____

□ Cancer _____ □ Heart Disease _____ □ Weight Issues _____

□ Pacemaker? Y or N

Please list any allergies – medications, seasonal, environmental, foods

_____

Please check (√) all that apply & include amounts.

□ exercise _____ □ nicotine _____ □ water _____

□ alcohol _____ □ soda _____

CURRENT SYMPTOMS – please check all that apply

Part A:

- ❑ Cough
  - __ acute
  - __ chronic
  - __ dry
  - __ phlegm, white, clear
  - __ phlegm, green or yellow
  - __ blood
- ❑ Sore throat
  - __ itchy
  - __ burning
- ❑ Hoarseness
- ❑ Frequent colds/flus
- ❑ Swollen glands
- ❑ Painful lymph nodes
- ❑ Fever/chills
- ❑ Dry mouth/nose/throat
- ❑ Snoring
- ❑ Allergies
  - __ seasonal
  - __ year round
  - __ pollen
  - __ dust
  - __ mold
  - __ pets
  - __ chemicals
  - other _____
- ❑ Itchy eyes
- ❑ Sneezing
- ❑ Nasal discharge
  - __ white, clear
  - __ green, yellow
  - __ odor
- ❑ Sinus congestion
- ❑ Post Nasal Drip
  - __ white, clear
  - __ green, yellow
- ❑ Sinus pain
- ❑ Mild fever comes & goes
- ❑ Bronchitis
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Chest oppression/ tightness
- ❑ Grief/ sadness
- ❑ Crave spicy foods
- ❑ Skin rashes, eczema, hives
- ❑ Spontaneous sweating
- ❑ Do you crave: Pungent

Part B:

For following symptoms indicate if daily, weekly or monthly:

- ❑ Nausea _____
- ❑ Vomiting _____
- ❑ Bloating _____
- ❑ Gas _____
- ❑ Belching _____
- ❑ Acid regurgitation_____
  - __ sour
  - __ burning
- ❑ Stomach pain
- ❑ Ulcers
- ❑ Bad breath
- ❑ Gum bleeding
- ❑ Large appetite/Excessive hunger
- ❑ Difficulty digesting fatty food
- ❑ Constipation
- ❑ Diarrhea
- ❑ # of bowel movements per day ___
  - __ loose
  - __ hard
  - __ painful
  - __ blood or mucus
  - __ difficult
  - __ odorous
  - __ burning
  - __ alternating diarrhea & constipation
  - __ hemorrhoids
- ❑ Fatigue or discomfort after eating
- ❑ Poor appetite
- ❑ Recent weight gain
- ❑ Recent weight loss
- ❑ Bruises easily
- ❑ Slow wound healing
- ❑ Frequently fatigued
  Time of day _____
- ❑ Difficult to get up in the morning
- ❑ Organ prolapse
- ❑ Loss of taste
- ❑ Crave carbohydrates
- ❑ Heavy limbs/body
- ❑ Weak muscles
- ❑ Easily worried, over thinking
- ❑ Cloudy/ Foggy-headed
- ❑ Edema, water retention
- ❑ Varicose/spider veins
- ❑ Do you crave: Sweet

Part C:

- ❑ Heart Palpitations
- ❑ Chest Pain
- ❑ Difficulty falling asleep
- ❑ Wake during night
- ❑ Vivid dreams
- ❑ Restless/Agitated
- ❑ Night sweating
- ❑ Thirst
- ❑ Dry mouth/throat
- ❑ Mouth sores/sore tongue
- ❑ Poor memory
- ❑ Jittery, easily startled
- ❑ Anxiety
  - __ Racing thoughts
  - __ Overwhelm
- ❑ Depression
- ❑ Lack of joy
- ❑ Do you crave: Bitter

Part D:

- ❑ Irritability
- ❑ Frustration
- ❑ Easily stressed/tense
- ❑ Depression
- ❑ Easily angered
  __ frequent outbursts
- ❑ Frequent sighing
- ❑ Sensation of something in throat
- ❑ Clenching teeth at night
- ❑ Headaches/Migraines
- ❑ Dizziness
  __ postural
  __ empty headed
  __ heavy headed
- ❑ Vertigo
- ❑ Dry hair, skin, nails
- ❑ Soft, brittle nails
- ❑ Dry eyes, floaters, blurred vision
- ❑ Red eyes
- ❑ Eye pain/strain/sensitivity
- ❑ Neck and shoulder tension
- ❑ Muscle cramping/twitching
- ❑ Tremors
- ❑ Numbness
- ❑ Rib side pain
- ❑ Hiccups
- ❑ Poor circulation
- ❑ Bitter taste in mouth
- ❑ Clearing throat often
- ❑ Gall Stones
- ❑ Do you crave: Sour

Part E:

- ❑ Low back, knee pain
- ❑ Poor hearing/hearing aid
  # of years _____
- ❑ Ear ringing
- ❑ Hair loss
- ❑ Premature graying
- ❑ Cold hands & feet
- ❑ Feels cold easily
- ❑ Generalized cold feeling
- ❑ Warm body temperature
- ❑ Hot flashes/night sweats
- ❑ Frequent urination
- ❑ Scanty urination
- ❑ Night urination
- ❑ Urgent urination
- ❑ Profuse urination
- ❑ Color of urination
  __ Dark __ Straw
  __ Light/clear__ Cloudy
  __ Bloody__ Painful
- ❑ Hesitant urination/dribbling
- ❑ Dropped bladder
- ❑ Incontinence
- ❑ Sex drive/libido
  __Low __High
- ❑ Puffy beneath eyes
- ❑ Dark circles under eyes
- ❑ Fear/ phobias/ inventing worst case scenarios
- ❑ Lack of will/drive/motivation
- ❑ Poor memory
- ❑ Crave salt
- ❑ Swollen ankles
- ❑ Birth disorders/defects
- ❑ Childhood developmental problems
- ❑ Osteoporosis
- ❑ Poor teeth
- ❑ Do you crave: Salty

FOR WOMEN:

First day of last period_____
Are you pregnant?? _____
# of days in menstrual cycle_____
# of pads/tampons per day_____

Color of blood: pale__ purple __
bright red __ dark red __ brown __

- ❑ Clots
  __ red
  __ purple
  __ brown/grainy
  __ small (cottage cheese)
  __ large
  __ stringy
- ❑ Cramping
  __ before
  __ during
- ❑ Pelvic Inflammatory Disease
- ❑ STD's
- ❑ HPV
- ❑ Pain
  __ end
  __ during ovulation
  __ in low back
  __ in groin area
  __ mild
  __ moderate
  __ severe
- ❑ PMS symptoms
  __ mood changes
  __ irritable
  __ fatigue
  __ breast tenderness/swelling
  __ food cravings
  __ headaches
  __ loose stools
- ❑ Acne with period
- ❑ Bleeding in between periods
- ❑ Fibroids
- ❑ Mastitis
- ❑ Yeast infection, Vaginitis/ Other vaginal discharge
- ❑ Breast lumps/fibrocystic
- ❑ Hot flashes

# of pregnancies ____
# of live births _____
Miscarriages _____
Type of birth control
_____

- ❑ Nursing
- ❑ Abnormal pap test
- ❑ History of vaginal warts
- ❑ Vaginal pain
  ___with sexual intercourse
- ❑ Vaginal dryness
- ❑ Infertility
- ❑ Endometriosis
- ❑ GYN surgeries (date/type)
  _____
  _____
  _____
- ❑ Ovarian cysts
- ❑ PCOS

FOR MEN:

Last prostate exam:
_____
PSA Results: _____

- ❑ Prostatitis/BPH
- ❑ Testicular pain or lump
- ❑ Low sex drive
- ❑ Infertility
- __Low sperm count
- __Poor sperm mobility
- __Low sperm progression
- ❑ Erectile Dysfunction (ED)
- __ Difficulty <u>achieving</u> erection
- __ Difficulty <u>maintaining</u> erection
- __ Premature ejaculation