BENNETT ACUPUNCTURE & FUNCTIONAL MEDICINE

Phone: 714 962-5031 Fax: 714 962-5031
18046 Magnolia Ave Fountain Valley, CA, 92708

Patient Name _____ **Referred By:** _____

Address _____

City _____

State _____ Zip _____

❑ patient/friend ❑ office sign ❑ newsletter
❑ spouse/family ❑ web/advert ❑ event/lecture
❑ physician ❑ direct mail ❑ health fair
❑ attorney ❑ yellow pgs ❑ _____

SSN # _____ Gender **F/M**

Marital Status _____

Spouse/Partner _____

#___ Kids/Ages _____ (expecting)

Language _____

Race/Ethnicity _____

Is this an auto or work related accident?	**Yes No**
Do you have insurance to bill?	**Yes No**
Do you have a secondary insurance?	**Yes No**
Are you currently employed?	**Yes No**
Do you have an employer or union policy?	**Yes No**
Is your spouse employed?	**Yes No**

Date of Birth _____ Age _____

Home Phone _____

Work Phone _____

Cell Phone _____

cell provider (VZ, AT&T) _____

E-Mail _____

I.C.E. Contact _____

Phone _____

PCP Referral _____

NPI# _____

Phone/Fax _____

Occupation _____

Employer _____

Phone _____

City/State _____

Phone _____

Initials Financial Policy (all patients)

__ **My portion** is due at the time of service to avoid an $**8** fine.

__ **Supplies and supplements** are due at the time of service as they are typically not reimebursed by insurance benefits.

__ **If my check is returned** as NSF a $**50** fee is charged. I understand a cash or credit payment is required to replace the balance due and future visits.

__ **Missed appointments** are charged $**50** for each instance, if I fail to reschedule or cancel 24 hours prior to my appointment. Payment is due at the time of reschudeling a new appointment.

__ **Late Fees** are charged $**12** per bill, per monthly statement and accounts are delquint at 90 days and subject to collections.

__ **Accounts sent to Collections,** are charged a $**250** filing fee.

__ **Financial arrangments** are renewed annualy, per case, and account status and appointment history.

Initials (if you have INSURANCE)

__ **When this office verifies my insurance**, I understand this is not a guarantee or authorization that my claims will be paid and I may be required to pay the balance.

__ **I am responsible for paying** my deductibles and coinsurance at the time of service including any services, supplies, supplements, and any other fees my insurnace does not cover or process in a timley manner.

__ **I understand my insurnace has 45days to process** and settle my claims. I am ultimately responsible for paying any unpaid balances due to the doctor at 46 days.

__ **I understand it is my responsiblity** to review incomimg insurance mail, complete insurance requests or resolve unpaid claims within **48 hrs**, as well as notify this office of any delay in claims processong or changes in insurance coverage.

I, _____ , read, understood the "Financial Policy" and "Insurance Benefits". My personal information listed is true and correct and I will notify this office of any changes in, my personal information and/or medical coverage. I will pay my portion due today by… ❑cash ❑check ❑ credit card.

Signature: _____ **Date:** _____/_____/_____

Patient Name: _____ **Date of Birth:** _____

WE ARE PARTNERS IN YOUR HEALTH CARE

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

We take pride in the quality of care the doctor provides our patients. In order to server all of our patients, we require a 24-hour rescheduling or cancellation notice prior to your scheduled appointment time to avoid a cancellation fee. A $50 fee will be collected at the time of rescheduling.

INSURANCE PATIENTS:

Your immediate participation in processing your insurance claims are mandatory. It is important to address any mail correspondence or phone calls you may receive regarding pending claims, such as:

- Insurance requesting more information.
- Primary Care Physicians pre-authorization, referral or pre-certification.
- Submitting or completing policy holder or coverage information.

There may be times when our office has received misquoted insurance information. When we verify insurance we are also quoted a similar clause, such as "… this is not a guarantee or authorization to pay…". You are responsible for paying your deductible, coinsurance and any other balances your coverage will not pay at the time of service. An additional balance may be due on claims that have been processed differently than quoted in the verification process. These balances are due upon notice at the time of service, via statement and/or phone calls notifying you of an additional balance due. Delays in settling any balances due could result in additional late fees and suspension of care.

Please note your insurance coverage and contract is an agreement between you and your health insurance company and delays in processing pending claims are your responsibility. We submit claims usually weekly and expect payment within 30 days. If claims are not processed and settled within 45 days payment is expected from you the patient and you will need to resolve the unpaid claim directly with your insurance company. Please remember to open all mail correspondence from insurance company promptly. Insurance statements, such as explanation of benefits (EOB's) and can be confusing and misleading. By all means call us or bring them if you have any questions. We are here to help.

You authorize any and all payment from your insurance company directly to "Bennett Acupuncture, Inc." with the understanding that all monies be credited to your account upon receipt.

Signature: _____ Print: _____ Date: _____

TEXT/EMAIL:

I hereby authorize Bennett Acupuncture Inc., doctors and staff to send email reminders relating to my care. We will sometimes want to send you information by way of email about conditions you are dealing with, health news and updates. You may choose to unsubscribe from our email list at any time. We will not sell or distribute your information. [ ] Please check here if you want to opt out. As for phone texting, I will be responsible if any fees are charged by my cell phone carrier to receive text messages.

Signature: _____ Print: _____ Date: _____

BENNETT
ACUPUNCTURE
& FUNCTIONAL MEDICINE
18046 Magnolia Ave., Fountain Valley, Ca 92708
Phone: 714-962-5031 Fax: 714-962-5039

Healthcare Questionnaire

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

First Name_____ M._____ Last Name_____

Health Care Providers-- please list those you work with.

Physicians: GP/Primary Care:_____ seeking one? [ ] Y [ ] N

OB- GYN:_____ seeking one? [ ] Y [ ] N

Specialist (describe):_____ seeking one? [ ] Y [ ] N

Chiropractor: _____ seeking one? [ ] Y [ ] N

Massage therapist: _____ seeking one? [ ] Y [ ] N

Physical therapist:_____ seeking one? [ ] Y [ ] N

Psychotherapist: _____ seeking one? [ ] Y [ ] N

Personal Trainer:_____ seeking one? [ ] Y [ ] N

Midwife:_____ seeking one? [ ] Y [ ] N

Other:_____ seeking one? [ ] Y [ ] N

May I contact these providers to ensure coordination of your care? [ ] Y [ ] N

Previous experience with acupuncture? [ ] Y [ ] N With whom and Results:_____

Have you had your tonsils removed? _____ Appendix_____ Gallbladder?_____

When was the last time you have taken antibiotics?_____

If you have had chemotherapy, when_____

If you have had radiation therapy, when_____

Major Symptoms: Please listen or importance what symptoms are of concern to you.

1._____

2._____

3._____

4._____

5._____

Health History

Please list your major health concerns in order of importance to you: _____

_____

_____

_____

Check those that apply to your past medical history:

- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth Trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STD
- ☐ Other_____

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____

_____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/_____Event_____Date____/_____ Event_____

Date____/_____Event_____Date____/_____ Event_____

Date____/_____Event_____Date____/_____ Event_____

Family History (List any family physical or mental illnesses and age of death):

Mother_____

Father_____

Grandparents_____

Siblings_____

Children_____

Medications, Herbs, Supplements (List those you are currently taking):

Name_____Reason _____How long and Dose_____

Name_____Reason _____How long and Dose_____

Name_____Reason _____How long and Dose_____

Name_____Reason _____How long and Dose_____

Name_____Reason _____How long and Dose_____

Name_____Reason _____How long and Dose_____

Lifestyle Habits

Describe your typical daily diet:

Breakfast_____ Lunch_____

Dinner_____ Snacks_____

Special diet_____ 3 worst foods you eat_____

Do you:	Yes	No	
Average 6-8 hours sleep?			What is the major source of joy in your life? _____
Have a supportive relationship?			_____
Have a history of abuse?			What is the major source of stress in your life? _____
Enjoy your work?			_____
Take vacations?			_____
Spend time outside?			
Exercise?			Describe exercise: _____
Watch TV?			How many hours weekly?
Read Books?			How many hours weekly
Computer games/browsing?			How many hours weekly
Spiritual/religious practice?			Describe:
Smoke cigarettes?			How much?
Smoke cigarettes in the past?			How many years? How many packs?
Eat out often?			How many meals a week?
Drink coffee?			How many cups a day?
Drink tea?			How many cups a day?
Drink soft drinks?			How many a day?
Use sugar?			How much?
Drink alcohol?			How many drinks a week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and how long?
Been outside the U.S. in past 12 months?			Where?

What are your goals for your health?

_____

_____

_____

Please circle your level of commitment to correcting your health issues? (10 = highest level)

1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray _____ Sigmoidoscopy _____ EKG _____ Stool Blood Test _____

Mammogram _____ TB Skin Test _____ Pap Smear _____ Complete Physical _____

GI Series _____ Flu Shot _____ Pneumonia Shot _____ Other _____

Dear Patient, we are sorry for a few redundant areas/questions. Pleae answer all the best you can, thank you.

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

Bennett Acupuncture, Inc.

*** Patient Signature Required on Last Page ***

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.
This notice takes effect on and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

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, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: in addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation; if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:
1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights; please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

HIPAA PRIVACY & SECURITY OFFICER
Bennett Acupuncture
18627 Brookhurst Street, #507
Fountain Valley, CA 92708

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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

Thank you for choosing us as your Healthcare Provider.

_____ _____
Patient Name (Please Print) Birth Date