New Patient Intake Form

Today's Date______/______/______

Name | SS# | Birthdate / /
Marital Status | Age
Address | ❑ M ❑ F | Ht | Wt

Email

City, State, Zip | Occupation

Home Phone | Work | Cell

Emergency Contact's Name & Phone

Referred by

Reason for visit today | Have you had acupuncture before? ❑ Yes ❑ No | Chinese herbal medicine? ❑ Yes ❑ No

How long have you had this condition?

Is it getting worse? | Does it bother your ❑ Sleep ❑ Work ❑ Other (specify)

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ❑ Yes ❑ No | If yes, for what?

Physician's name | Physician's phone

Other concurrent therapies

Health Insurance Info:

Insurance Co. Name | Policy #

Address | Phone

City, State, Zip

Medicare Info:

Insurance Co. Name | Policy #

Address | Phone

City, State, Zip

Family Medical History

- ❑ Allergies (list) ________________ ________________
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Cancer (type) ________________
- ❑ Depression
- ❑ Diabetes (Type:)
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Seizures
- ❑ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

- ❑ AIDs/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth trauma (your own birth)
- ❑ Cancer
- ❑ Chicken pox
- ❑ Diabetes (Type:)
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis (Type:)
- ❑ Herpes (Type:)
- ❑ High blood pressure
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker (Date:)
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Stroke
- ❑ Surgery (list) ________________ ________________ ________________
- ❑ Thyroid disorders
- ❑ Major trauma (Car, fall, etc--list) ________________ ________________ ________________
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Whooping cough
- ❑ Other (Specify) ________________ ________________ ________________ ________________

Your Diet

Appetite ❑ Low ❑ High | ❑ Coffee/Tea ❑ Soft Drinks/Fruit Juices | Protein Intake ❑ Low ❑ High | ❑ Artificial Sweeteners | ❑ Sugar ❑ Salty foods | Thirst for water: # glasses per day:____________

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months:

Vitamins/supplements taken in the last 2 months:

Practitioner Use Only

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational hazards

Regular Exercise
Type________________ Frequency________________
Type________________ Frequency________________

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (Describe)

____
____
____

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses (What age:)
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Myopia or Presbyopia
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm
  Color:
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nosebleeds
- ❑ Ringing in ears (High or Low?)
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems
____
____
____

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Difficult inhalation? exhalation?
- ❑ Cough
  Wet or Dry?________________
  Thick or thin?________________

Color of phlegm
____

- ❑ Coughing up blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Hemorrhoid
- ❑ Itchy anus
- ❑ Intestinal pain or cramping
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Anal fissures
- ❑ Laxative use
  What kind?
  How often?

Bowel movements:
Frequency________________ Texture/form________________
Color________________ Odor________________

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (Describe)
____

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems
____
____

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (Specify)
____
____

Genitourinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began
  ____

Length of cycle (day 1 to day 1)
____

- ❑ Duration of flow
  ____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)________________
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps

Pregnancies________________
Live births________________
Premature births________________
Age at menopause________________

Date of last PAP
____

Date last period began
____

Other

____
____
____
____

© Copyright Blue Poppy Enterprises Inc, 2021

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Allied Professionals' Insurance Services All Rights Reserved, Rev. 9/4/20

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): ________________________ Signature: ________________________________ Date: ______________

Parent or Guardian (print): ____________________ Signature: ________________________________ Date: ______________

Office Name: ______________________________ Signature: ________________________________ Date: ______________

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

© Allied Professionals' Insurance Services All Rights Reserved, Rev. 9/4/20

PATIENT ADVISORY TO CONSULT A PHYSICIAN

Jing Acupuncture Service LLC. is committed to your health and well-being. All of us affiliated with Jing Acupuncture Service LLC. believe that Oriental Medicine is a valuable part of a holistic approach to wellness; however, it cannot completely replace the resources available through western physicians. Consequently, we recommended that you consult a Western Medicine Physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Acupuncture Examining Board Laws 45:2C-5 of New Jersey Administrative Code, we request that you read and sign the following statement.

We, the undersigned, do affirm that (patient) ____
has been advised by (L.Ac. name) ____ **to consult a physician regarding the condition or conditions for which such patient seeks Acupuncture treatment.**

Patient signature: ____________________________ Date: ____/____/____

L. Ac. Signature: ______________________________ Date: ____/____/____

ACKNOLEGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices for Jing Acupuncture Service LLC., detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: ____ **Date:** _____________

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient: ____

Relationship: __________________________________

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

Release of Information

By signing this form you are also authorizing this upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

______________________________________ ____________

Signature **Date**

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Jing Acupuncture Service LLC.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaint

Complaints about your privacy rights, or how Jing Acupuncture Service LLC has handled your health information should be directed Shujing Dai by calling this office at (908) 210-7977. If Shujing Dai is not available; you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

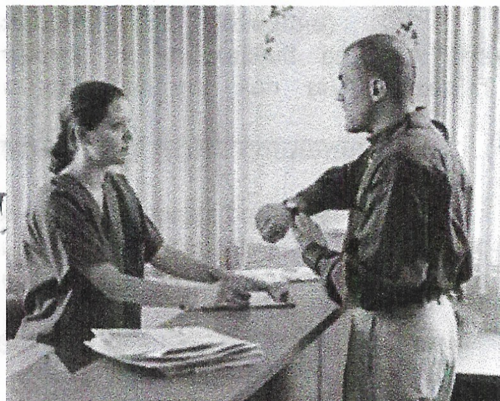
DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT:

www.hcfa.gov/medicaid/hipaa

JING ACUPUNCTURE SERVICE LLC

NOTICE OF PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOR-MATION. PLEASE REVIEW IT CAREFULLY.

JING ACUPUNCTURE SERVICE LLC. *is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.*

Disclosure of your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"It is our policy to provide a substitute health care provider, authorized by Shujing Dai to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation & Research

Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing & Other Communication

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your schedule appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."