

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.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- 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 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 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 regard 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)

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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 10/10/2022 of Notice of Privacy Practices.

Name of Patient: _____

Signature of Patient _____ Date _____

Fee Schedule and Cancellation Policy

Initial visit and treatment- \$225.00

Follow-up treatments- \$165.00

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 hour's 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 advice 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

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Gender identity: _____ Pronouns: _____

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Digestive Disorders _____ | <input type="checkbox"/> Immune Disorder _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Eating Disorders _____ | <input type="checkbox"/> Kidney Problems _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Weight Issues _____ |
| <input type="checkbox"/> 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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough
___acute
___chronic
___acute
___phlegm, white, clear
___phlegm, green, yellow
___blood | <input type="checkbox"/> Allergies
___seasonal
___year-round
___pollen
___dust
___mold
___pets
___chemicals
Other _____ | <input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Post-nasal drip
___white, clear
___green, yellow |
| <input type="checkbox"/> Sore throat
___itchy
___burning | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sinus pain |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Mild fever, comes & goes |
| <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Nasal discharge
___white, clear
___green, yellow
___odor | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Swollen glands | | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Painful lymph nodes | | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Fever/chills | | <input type="checkbox"/> Chest oppression/tightness |
| <input type="checkbox"/> Dry mouth/nose/throat | | <input type="checkbox"/> Grief/sadness |
| <input type="checkbox"/> Snoring | | <input type="checkbox"/> Crave spicy foods |
| | | <input type="checkbox"/> Skin rashes, eczema, hives |
| | | <input type="checkbox"/> Spontaneous sweating |
| | | <input type="checkbox"/> Do you crave: Pungent |

Part B:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> # of bowel movements per day ____ | <input type="checkbox"/> Bruises easily |
| <input type="checkbox"/> Vomiting | ___loose | <input type="checkbox"/> Slow wound healing |
| <input type="checkbox"/> Bloating | ___hard | <input type="checkbox"/> Frequently fatigued |
| <input type="checkbox"/> Gas | ___painful | Time of day ____ |
| <input type="checkbox"/> Belching | ___blood or mucus | <input type="checkbox"/> Difficult to get up in the morning |
| <input type="checkbox"/> Acid regurgitation
___sour | ___difficult | <input type="checkbox"/> Organ prolapse |
| ___burning | ___odororous | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Stomach pain | ___burning | <input type="checkbox"/> Crave carbohydrates |
| <input type="checkbox"/> Ulcers | ___alternating diarrhea &
constipation | <input type="checkbox"/> Heavy limbs/body |
| <input type="checkbox"/> Bad breath | ___hemorrhoids | <input type="checkbox"/> Weak muscles |
| <input type="checkbox"/> Gum bleeding | <input type="checkbox"/> Fatigue or discomfort after
eating | <input type="checkbox"/> Easily worried, over thinking |
| <input type="checkbox"/> Large appetite/Excessive hunger | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Cloudy / Foggy headed |
| <input type="checkbox"/> Difficulty digesting fatty food | <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Edema, water retention |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Varicose / spider veins |
| <input type="checkbox"/> Diarrhea | | <input type="checkbox"/> Do you crave: Sweet |

Part C:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Night sweating | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Thirst | ___Racing thoughts |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Dry mouth / throat | ___Overwhelm |
| <input type="checkbox"/> Wake during night | <input type="checkbox"/> Mouth sores / sore tongue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vivid dreams | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Lack of joy |
| <input type="checkbox"/> Restless / Agitated | <input type="checkbox"/> Jittery, easily startled | <input type="checkbox"/> 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 _____
- Ears 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

- Fears / phobias / inventing Worst case scenarios
- Lack of will / drive / determination
- Poor memory
- Crave salt
- Swollen ankles
- Birth disorders/defects
- Childhood developmental problems
- Osteoporosis
- Poor teeth
- Do you crave: Salty

GYNECOLOGICAL HISTORY:

First day of last period _____

Are you pregnant? _____

of days of 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
- Pelvic Inflammatory Disease
- STD's
- HIV

- 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 _____
- Miscariages _____
- 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

ANSWER IF APPLIES:

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 achieving erection
- ___Difficulty maintaining erection
- ___Premature ejaculation