

NEW PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: _____ Other name records may be kept under: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ - _____ - _____ Home Phone: () _____ Work Phone: () _____
Cell: () _____
May we leave confidential voice-mail messages for you at any of the above numbers? No Yes Specify which: H W C
Email: _____ May we send newsletters to you by email? No Yes
Your Employer: _____ If student, school or college: _____
Whom may we thank for referring you? _____
Person to contact in case of emergency: _____ Phone: _____

Insurance Information (Complete only if you are not the insured)

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Date Employed: _____
Name of Employer: _____ Work Phone: _____

Responsible Party (Complete if someone other than patient is responsible for account)

Name: _____ Relationship to patient: _____
Address: _____ Home Phone: _____
Cell Phone: _____ Email: _____ Currently a patient here? Y N

I hereby authorize payment of insurance benefits directly to Dr. Goodman. I am responsible for any deductibles, copayments and retroactive fees not covered by my insurance policy.

X _____
Signature of patient or parent/guardian if minor Date

CONSENT FOR TREATMENT

General Information: Due to the diversity of modalities offered at this office, your treatment may include any or all of the following general modalities: Acupuncture, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Your clinician may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Acupuncture: (insertion of special sterilized needles at specific points on the body)

Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)

Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes; suppositories

or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment.

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Solutions for Better Health regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

Date

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

Disclosure of Your Health Care Information

Treatment

This office may disclose your health care information to other health care professionals for the purpose of treatment.

Payment

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

Emergencies

This office 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 your death,

Public Health

As required by law, this office 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

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

Law Enforcement

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

Deceased Persons

This office may disclose your health information to coroners or medical examiners.

Organ Donation

This office may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

This office may disclose your health information 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 to the general public.

Specialized Government Agencies

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

Marketing

This office may from time to time distribute post cards reminding patients of the need to update their diagnostic test information or schedule an appointment. Also, newsletters may be sent to patients providing up-to-the-minute information about matters relating to natural medicine. It is not the practice of this office to disclose patient health information in these correspondences.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- 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 the right to inspect and copy your health information.
- You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not 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 the denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by this practice.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice 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, this practice is required to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact this office.

Complaints

Complaints about your privacy rights or how this practice has handled your health information should be directed to this office. If you are not satisfied with the manner in which this office handles your request, you may submit a formal complaint to:

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

This notice is effective as of July 19, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as prescribed in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date