INTAKE AND HEALTH HISTORY FORM

Please complete the questionnaire as thoroughly as possible. Although some of the questions may appear unrelated to your health concerns, they play key roles in helping us better understand you as an individual, as well as help identify the factors influencing your overall state of health so that we may better assist you in the diagnosis and treatment of your condition(s). All information is confidential and compliant with HIPAA privacy rules. It will not be released, except when you have provided written authorization for us to do so.

(Please Print Clearly)

Today's Date: _____/_____/_____

GENERAL INFORMATION	
Name (Last, First, Middle):	
Nickname/Preferred Alias:	DOB: _____/_____/_____
SSN:	Gender (Specify if needed):
Occupation:	
Employer/School:	Hours/week:
Marital Status: ☐ Single/Never Married ☐ Separated/Not Divorced ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnership	Children and their ages:
Race: ☐ Asian ☐ Black/African-American ☐ Caucasian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Mixed Race ☐ Other ☐ Unknown	Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino Preferred Language: ☐ English ☐ Portuguese ☐ Spanish ☐ Other: _____
Have you received massage therapy before? ☐ Yes ☐ No When was your last session? Did you enjoy your treatment? (Why or why not?)	Have you received acupuncture before? ☐ Yes ☐ No Have you received Chinese herbs before? ☐ Yes ☐ No When was your last session? Did you enjoy your treatment (Why or why not?)

CONTACT INFORMATION

Street Address: _____ City: _____ State:___ Zip: _____

Mailing Address: _____ City: _____ State:___ Zip: _____
May we mail confidential information to you? ☐ Yes ☐ No

Phone Number 1: _____-_____-_____ ☐ Home ☐ Cell ☐ Work
Phone Number 2: _____-_____-_____ ☐ Home ☐ Cell ☐ Work
Phone Number 3: _____-_____-_____ ☐ Home ☐ Cell ☐ Work
Mark at which #(s) we may leave confidential voicemails: ☐ Home ☐ Cell ☐ Work

Email 1: _____ ☐ Personal ☐ Work

Email 2: _____ ☐ Personal ☐ Work
Mark at which email(s) we may send confidential correspondence ☐ Email 1 ☐ Email 2

Emergency Contact:

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone_____ Work Phone: _____ (ext)_____

Guardian Information (if under 18):

Guardian 1 Name: _____ Relationship: _____

Address: _____ City: _____ State ____ Zip _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Guardian 2 Name: _____ Relationship: _____

Address: _____ City: _____ State ____ Zip _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

HOW DID YOU HEAR ABOUT US?

☐ Website ☐ Yelp ☐ Printed Ad ☐ News Story
☐ Family/Friend: ☐ Medical Referral:
_____ _____
☐ Other (Please Specify): _____

CURRENT HEALTHCARE PROVIDERS

Do you currently have a Primary Care Physician? ☐ Yes ☐ No
Name: Credentials: Phone:
_____ _____ ____-_____-_____

Address: _____ City: _____ State ____ Zip _____

Are you currently under the care of any other healthcare providers? ☐ Yes ☐ No
Name: _____ Credentials: _____ Phone: ____-____-_____
Name: _____ Credentials: _____ Phone: ____-____-_____

HEALTH CONCERNS	
Overall, how would you rate your general state of health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor	
In order of importance, please list your present health concerns: *(please include date of onset and any contributing factors to the condition)*	***Please list any prior diagnoses of this health concern, whom diagnosed it, and what treatment you have already received.***
1.	1.
2.	2.
3.	3.
4.	4.
5	5
Do any of the above concerns/conditions limit your daily activities? ☐ Yes ☐ No	
Please briefly describe in what ways your activities are limited:	
☐ #1	
☐ #2	
☐ #3	
☐ #4	
☐ #5	

ALLERGIES	
Do you have any allergies that are **LIFE THREATENING**? ☐ Yes ☐ No If yes, please explain:	
Please list any allergies that are **NON LIFE THREATENING:**	
Medications: _____	Food: _____
Animals: _____	Environment: _____
Chemical: _____	Other: _____

GENERAL HEALTH HISTORY	
Diet:	
Do you follow any specific dietary regimens or restrictions? ☐ Yes ☐ No ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Diary Free ☐ Other Please Describe:	
How many meals/day do you eat?	How many cups of water/day do you drink?
Typical Breakfast:	Typical Lunch:
Typical Dinner:	Typical Snacks:
Other typical non-alcoholic beverages (other than water) consumed on a regular basis during the day (please state quantity):	
Exercise:	
How many times/week do you exercise?	On average, for how long?
Please describe your exercise routine:	
Sleep:	
How many hours/night do you sleep?	What time do you typically fall asleep?
Do you fall asleep easily? ☐ Yes ☐ No	How often do you wake during the night?
Do you wake rested? ☐ Yes ☐ No	Do you snore? ☐ Yes ☐ No
Is your energy stable during the day?	☐ Yes ☐ No
What time of day is your energy the best?	What time of day is your energy the worst?
Other:	
Do you use tobacco? ☐ No ☐ Current ☐ Past Method? ☐ Smoke ☐ Other How often? How much? Year Began? Year Quit?	
Do you drink alcohol? ☐ Yes ☐ No Type? ☐ Beer ☐ Wine ☐ Liquor How many drinks: _____/day OR _____/week OR _____/month	
Do you use recreational drugs? ☐ Yes ☐ No Type? How often?	
Stress:	
How would you rate your Stress? (No Stress) 0 1 2 3 4 5 6 7 8 9 10 (High stress)	
What helps manage your stress?	

CURRENT MEDICATIONS		
Please list all current medications (Rx and OTC). Please add additional sheets if needed.		
Name	**Dosage**	**Indication**
1.		
2.		
3.		

CURRENT SUPPLEMENTS				
Name	**Brand**	**Dosage**	**Indication**	**Effective:**
1.				☐ Y ☐ N
2.				☐ Y ☐ N
3.				☐ Y ☐ N
4.				☐ Y ☐ N
5.				☐ Y ☐ N

HOSPITALIZATIONS, SERIOUS ILLNESS/INJURIES, TRAUMA		
Reason OR Incident	**Month/Year**	**Outcome**
1.		
2.		
3.		
4.		
5.		

CHILDHOOD MEDICAL HISTORY

Overall, how would you rate your state of health as a child?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

Please indicate whether you suffered from any of the following?

☐ Asthma ☐ Chicken Pox ☐ Diphtheria
☐ German Measles ☐ Measles ☐ Mumps
☐ Rheumatic Fever ☐ Scarlet Fever ☐ Whooping Cough
☐ Other (Please explain):

EXAM AND IMAGING HISTORY

Please indicate when you last received the following & document any abnormal findings:

Physical Exam:	Blood Tests:
Pap Smear:	Mammogram:
Colonoscopy:	Prostate Exam:
EKG:	Cholesterol Screen:
Chest X-ray:	Bone Density Screen:
HIV Test:	Other STD Screen:
Other (Please explain):	

PERSONAL AND FAMILY MEDICAL HISTORY				
Please indicate whether any of the following conditions apply TO YOU or one of your IMMEDIATE FAMILY MEMBERS. Please use the below abbreviations to indicate the family member afflicted with the condition, and also note the year the condition took place, and whether it is current. **M = Mother, F = Father, B = Brother, S = Sister, MGM/MGF = Maternal Grandmother/Grandfather PGM/PGF = Paternal Grandmother/Grandfather**				
Condition	**Self**	**Relative**	**Year**	**Current?**
Addiction (Specify):				☐ Y ☐ N
Allergies (Specify):				☐ Y ☐ N
Anemia (Specify):				☐ Y ☐ N
Arthritis (Specify):				☐ Y ☐ N
Asthma:				☐ Y ☐ N
Blood Transfusion:				☐ Y ☐ N
Cancer (Specify):				☐ Y ☐ N
Cataracts:				☐ Y ☐ N
Celiac Disease:				☐ Y ☐ N
Clotting Disorder (Specify):				☐ Y ☐ N
Congestive Heart Failure:				☐ Y ☐ N
COPD				☐ Y ☐ N
Crohn's Disease:				☐ Y ☐ N
Depression:				☐ Y ☐ N
Diabetes:				☐ Y ☐ N
Eczema:				☐ Y ☐ N
Emphysema:				☐ Y ☐ N
Epilepsy:				☐ Y ☐ N
GERD:				☐ Y ☐ N
Glaucoma:				☐ Y ☐ N
Headaches:				☐ Y ☐ N
Heart attack:				☐ Y ☐ N
Heart Disease (Specify):				☐ Y ☐ N
Hepatitis (Specify):				☐ Y ☐ N
HIV/AIDS:				☐ Y ☐ N
Hypertension:				☐ Y ☐ N
Irritable Bowel Syndrome:				☐ Y ☐ N
Kidney Disease (Specify):				☐ Y ☐ N
Lupus:				☐ Y ☐ N
Meningitis:				☐ Y ☐ N
Mental Illness (Specify):				☐ Y ☐ N
Multiple Sclerosis:				☐ Y ☐ N
Nerve/Muscle Disease:				☐ Y ☐ N

(Continuation of Personal and Family Medical History) **M = Mother, F = Father, B = Brother, S = Sister, MGM/MGF = Maternal Grandmother/Grandfather** **PGM/PGF = Paternal Grandmother/Grandfather**				
Condition	**Self**	**Relative**	**Year**	**Current**
Osteoporosis:				☐ Y ☐ N
Parkinson's/Alzheimer's				☐ Y ☐ N
Seizures:				☐ Y ☐ N
Sickle Cell Anemia				☐ Y ☐ N
STD (Specify):				☐ Y ☐ N
Stroke:				☐ Y ☐ N
Thalassemia (Specify):				☐ Y ☐ N
Thyroid Disorder (Specify):				☐ Y ☐ N
Tuberculosis:				☐ Y ☐ N
Ulcerative Colitis:				☐ Y ☐ N
Other (Specify):				☐ Y ☐ N
Other (Specify):				☐ Y ☐ N
Other (Specify):				☐ Y ☐ N

CURRENT SYMPTOMS ***(Grouped according to Chinese Medicine Organ Function NOT Western Medicine)***		
Liver/Gallbladder	**Heart/Small Intestine**	**Spleen/Stomach**
☐ Depression/Stress	☐ Heart Palpitations	☐ Body Heaviness
☐ Headaches/Migraines	☐ Rapid or Irregular Heartbeat	☐ Hard to wake in Morning
☐ Angry/Irritable	☐ Chest Pain	☐ Nausea/Vomiting
☐ Red/Dry/Itchy Eyes	☐ High Blood Pressure	☐ Muscles Feel Tired
☐ Blurred Vision	☐ Low Blood Pressure	☐ Over Think/Worry
☐ Dizziness	☐ Insomnia	☐ Edema
☐ Gall Stones	☐ Vivid Dreams/Nightmares	☐ Bruise/Bleed Easily
☐ Feeling of Lump in Throat	☐ Startled Easily	☐ Bad Breath
☐ Clenching Teeth at Night	☐ Dark Urine	☐ Sweetish Taste in Mouth
☐ Muscle Cramping	☐ Red Complexion	☐ Lack of Taste
☐ Neck/Shoulder Pain or Tightness	☐ Do you Crave: Bitter	☐ Excess Appetite
☐ Seizures/Tremors	☐ Anxiety/Nervous/Restless	☐ Low Appetite
☐ Brittle/Soft Nails		☐ Gas/Belching
☐ Bitter Taste in the Mouth		☐ Hemorrhoids
☐ PMS		☐ Organ Prolapse
☐ Pain Below Ribcage		☐ Chronic Loose Stools
☐ Do you crave: Sour		☐ Abdominal Pain
		☐ Heartburn
		☐ Brain Fog
		☐ Mouth Ulcers
		☐ Do you Crave: Sweet

(Continuation of Current Symptoms)	
Lung/Large Intestine	**Kidney/Urinary Bladder**
☐ Bloody Cough ☐ Dry Cough ☐ Chronic Cough ☐ Cough with Sputum ☐ Nasal Discharge? White/Yellow/Green ☐ Post Nasal Drip ☐ Sinus Infection/Congestion ☐ Itchy, Red, Or Painful Throat ☐ Dry Mouth/Nose/Throat ☐ Skin Rashes/Hives ☐ Snoring ☐ Shortness of Breath ☐ Allergies/Asthma ☐ Low Immunity ☐ Catch Colds Easily ☐ Bronchitis ☐ Black or Blood Stools ☐ Constipation ☐ Irritable Bowel Syndrome ☐ Diarrhea ☐ Colitis/Spastic Colon ☐ Do you crave: Pungent/Spicy ☐ Grief/Sadness	☐ Urinary problems? _____ ☐ Bladder Infection ☐ Incontinence ☐ Low Back Weakness/Pain ☐ Osteoporosis ☐ Feel Cold Easily ☐ Feel Hot Easily ☐ Cold Hands/Feet ☐ Low Sex Drive ☐ High Sex Drive ☐ Dark Circles under eyes ☐ Thyroid Problems? _____ ☐ Poor Memory ☐ Hair Loss/Gray Hair ☐ Hearing Problems/Tinnitus ☐ Cavities/Loss of Teeth ☐ Hot Flashes/Night Sweats ☐ Impotence ☐ Premature Ejaculation ☐ Do you Crave: Salt ☐ Fear

MALE HEALTH INFORMATION			
Are you sexually active? ☐ Yes ☐ No		Partner(s) is/are? ☐ Male ☐ Female	
Do you perform safe sex practices? ☐ Yes ☐ No		Erection Difficulty ☐ Yes ☐ No	
Do you ever experience frequency, hesitancy, pain, or dribbling with urination? ☐ Y ☐ N			
Breast Lumps? ☐ Yes ☐ No		Lumps/Pain in testicles? ☐ Yes ☐ No	
Penis Discharge? ☐ Yes ☐ No		Prostate enlargement/disease? ☐ Yes ☐ No	

FEMALE HEALTH INFORMATION	
Are you sexually active? ☐ Yes ☐ No	Partner(s) is/are? ☐ Male ☐ Female
Do you perform safe sex practices? ☐ Yes ☐ No	Gynecological Issues? ☐ Yes ☐ No
Age at onset of first menses?	Age of last menses (if menopausal)?
Periods generally last _____ days and occur every _____ days	
Bleeding is: ☐ Heavy ☐ Moderate ☐ Light ☐ Clots	
Are you on hormone replacement therapy? ☐ Yes ☐ No	Are you currently pregnant or trying to conceive? ☐ Y ☐ N
List your PMS symptoms:	
Number of Pregnancies:	Number of live births:
Number of Miscarriages:	Number of abortions:

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 acupunctures 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous miscarriage, 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 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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.

By voluntarily signing below, I show 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 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.

Acupuncturist Name: Aaron J. Bullington

Patient Signature: _____ **Date:** _____

Or Patient Representative: _____ Date: _____

Indicate relationship if signing for patient: _____

(Also sign the arbitration agreement on next page)

AAC-FED **A2004**

Patient Name: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both partiers 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 health care 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 health care provider and/or other licensed health care 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 health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

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 pro rata 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 provision of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 health care 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.

Patient Signature: _____ **Date:** _____

Or Patient Representative: _____ Date: _____

Indicate relationship if signing for patient: _____

Office Signature: _____ **Date:** _____

(Also sign the informed consent on previous page)

AAC-FED **A2004**

Patient Notification of Qualifications and Scope of Practice for Aaron J. Bullington, EAMP

East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. My qualifications include the following education and license information:
    a. Bastyr University, Kenmore, WA: Masters in Acupuncture and Oriental Medicine (includes both Acupuncture and Chinese Herbology)
    b. State of Washington: Licensed East Asian Medical Practitioner *AC60436859*
    c. NCCAOM (National Certification Association for Acupuncture and Oriental Medicine): Diplomate of Oriental Medicine *154212*
    d. NADA (National Acupuncture Detoxification Association): Certified Acupuncture Detoxification Specialist *11403*

2. The scope of practice for an East Asian Medicine Practitioner (EAMP) in the state of Washington includes the following:
    a. Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
    b. Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
    c. Moxibustion;
    d. Acupressure;
    e. Cupping;
    f. Dermal Friction Technique;
    g. Infra-red;
    h. Sonopuncture;
    i. Laserpuncture;
    j. Point Injection Therapy (aquapuncture);
    k. Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
    l. Breathing, relaxation, and East Asian exercise techniques
    m. Qi gong;
    n. East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
    o. Superficial heat and cold therapies

3. Side effects may include, but are not limited to:
    a. Pain following treatment;
    b. Minor bruising;
    c. Infection;
    d. Needle sickness; and
    e. Broken needle

4. The patient must inform the East Asian Medicine Practitioner if the patient has a severe bleeding disorder or pacemaker prior to any treatment.

Consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

Name: _____ **DOB:** _____

HIPAA Rights: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy right concerning your health care information. BodyRealms, PLLC (hereafter noted as BodyRealms) is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I consent to the use and disclosure of my identifiable health information by BodyRealms for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at BodyRealms may be conditioned upon my consent as evidenced by my signature on this document.

I understand that as part of my healthcare, BodyRealms maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. BodyRealms is not required to agree to the restrictions that I may request. However, if BodyRealms agrees to a restriction that I request, the restriction is binding upon BodyRealms.

I have the right to revoke this consent, in writing, at any time except to the extent that BodyRealms has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I acknowledge that I have received the Notice of Privacy Practices for BodyRealms.

Patient Signature: _____ **Date:** _____

Or Patient Representative: _____ Date: _____

Indicate relationship if signing for patient: _____