GroundSpring Healing Center, PC
8283 SW Barbur Blvd
Portland OR 97219

S. Frances Butler L. Ac, MAcOM
Phone: 503-877-5633
Fax: 971-244-0248

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by S. Frances Butler, LAc. and GroundSpring Healing center staff (hereafter noted as practitioner and staff) 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 GroundSpring Healing Center may be conditioned upon my consent as evidenced by my signature on this document.

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. My practitioner is not required to agree to the restrictions that I may request. However, if my practitioner agrees to a restriction that I request, the restriction is binding upon her.

I have the right to revoke this consent, in writing, at any time except to the extent that S. Frances Butler or GroundSpring Healing Center have 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 understand I have the right to review S. Frances Butler, LAc.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.youngpineacupuncture.com under the link "Privacy Practices". This Notice of Privacy Practices also describes my rights and the duties of S. Frances Butler, LAc. with respect to my identifiable health information.

S. Frances Butler, LAc. and GroundSpring Healing Center reserve the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient_____ Date:_____

-OR-

Signature of Patient Representative _____ Description of Authority:_____

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by S. Frances Butler L.Ac. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I acknowledge that my insurance plan does not cover supplements and agree to be financially responsible should I choose to use them. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the practitioner who prescribed them to me as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

INITIAL INTAKE FORM

NAME: _____ DATE: _____

SSN: _____ Gender: M F Birth date: _____Age: _____

PHONE NUMBERS: [1.] home work cell _____ best time: _____

(in order of preference) [2.] home work cell _____ best time: _____

Please circle [3.] home work cell _____ best time: _____

Is it okay to leave a detailed message concerning your appointment at these numbers? (please circle) Y N

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____Employer: _____

Emergency contact: _____ Phone: _____

E-mail address: _____

Would you like to receive our electronic newsletter? Y or N (circle) Your address is confidential!

Please list health concerns that have brought you to this clinic for treatment:

[1.] _____ [2.] _____

[3.] _____ [4.]_____

Please list medications, supplements, vitamins and herbs that you have been prescribed and /or are currently taking:_____

When did you last receive medical care? _____

Please list prior surgeries, injuries or traumatic events: _____

_____

Do you have any contagious diseases? _____

Allergies: _____

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH EXCELLENT AND AFFORDABLE HEALTH CARE. The following policy is designed to help us continue to do so.

BILLING:, Our patients are expected to make payments in the office at the time of service, unless payment arrangements have been approved in advance by our staff. Pharmacy items such as herbs and supplements must be paid for upon receipt. Payment can be in the form of check, cash, or credit card.

INSURANCE: As a courtesy, we may bill your insurance company for services you receive at your request. **However, you are ultimately responsible for payment in full should your insurance company deny the claim.** Many insurance companies have particular specifications that may affect your alternative medicine coverage.

CANCELLATIONS: If unable to keep an appointment, please give us 24 hours notice. **If you fail to keep your appointment or cancel without 24 hours prior notice, you will be charged the full price of the scheduled visit.**

I have read and understand the above information and agree to the conditions set forth.

SIGNATURE:_____DATE:_____

Symptom Review

Please rate your symptoms on a scale of 1-3. ONE indicates a symptom that you sometimes experience, TWO indicates a symptom that you often experience, THREE indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

Head & Neck:
__Headaches
__ Migraines
__ Dizziness / Vertigo
__ Fainting
__ Swollen glands
__ Memory Loss
__ Poor Concentration

Eyes:
__ Poor Vision
__ Blurred vision
__ Eye pain
__ Spots or floaters
__ Dry/ red eyes

Ears:
__ Ringing
__ Poor Hearing
__ Discharge
__ Earache
__Other

General:
__Insomnia
__Dreams/ nightmares
__Irritability
__Depression
__Mood swings
__ Fatigue
__ Chills
__ Fever

Nose, Throat & Mouth:
__ Sinus infection
__ Hay fever/ allergies
__ Sore throat
__ Difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Excessive thirst
__ Never thirsty
__ Excessive phlegm
__ TMD
__ Facial pain
__ Gum problems
__ Dry mouth
__ Unusual taste

Skin:
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easy bruising
__ Changes in moles, lumps
__ Itching
__ Excess sweat
__ Rarely sweat
__Night sweating

Respiratory:
__ Difficulty breathing
__ Wheezing
__ Asthma
__ Chronic cough
__ Coughing up blood
__ Tight chest
__ History of smoking

Cardiovascular:
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitations
__ Cold hands & feet
__ Swollen ankles
__ Anemia
__ History of heart attack
__Bruise/ bleed easily

Gastrointestinal:
__ Bad breath
__ Nausea
__ Hiccups
__ Vomiting
__ Acid regurgitation
__ Poor appetite
__ Excessive hunger
__ Digestive pain
__ Diarrhea
__ Constipation
__ Gas
__ Bloating
__ Bloody stool
__ Mucus in stool
__ Hemorrhoids
__ Gall Bladder disorder

Neurological:
__ Seizures
__ Tremors
__ Numbness or tingling
__ Nerve Pain
__ Paralysis
__ Poor coordination
__ Loss of Balance
__ Other_____

Genito-urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones

Symptom Review Continued

NAME: _____ **DATE:**_____

WOMEN:

Are you pregnant? (Circle One) Yes No Not Sure If yes, what month?

What method of birth control do you use?

Number of Pregnancies (if any):_____ Number of live births:_____

Number of miscarriages (if any):_____ Number of abortions (if any):_____

Abnormal pregnancy, labor or delivery? Yes No If yes, please explain:

Please rate your symptoms on a scale of 1-3. **ONE** indicates a symptom that you sometimes experience, **TWO** indicates a symptom that you often experience, **THREE** indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

MENSTRUAL CYCLE								**GYNEOCOLOGICAL**			
Irregular	1	2	3	Clotting	1	2	3	Bleeding Between Cycles	1	2	3
Excess Blood	1	2	3	Water Retention	1	2	3	Menopausal Symptoms	1	2	3
Lack of Blood	1	2	3	Breast Tenderness	1	2	3	Vaginal Discharge	1	2	3
Dark Colored Blood	1	2	3	Emotional Changes	1	2	3	Difficulty Conceiving	1	2	3
Light Colored Blood	1	2	3	Painful (cramping)	1	2	3	Sexual Difficulties	1	2	3
Other _____								Pelvic Pain	1	2	3

MEN:

Please rate your symptoms on a scale of 1-3. **ONE** indicates a symptom that you sometimes experience, **TWO** indicates a symptom that you often experience, **THREE** indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

MALE REPRODUCTIVE							
Erectile Dysfunction	1	2	3	Prostate Problems	1	2	3
Sexual Difficulties	1	2	3	Penile Discharge	1	2	3
Testicular Pain	1	2	3	Other:_____			
Testicular Swelling	1	2	3				

The information contained within this box is confidential and may not be released under any circumstances unless the patient has signed a special release specific to this information.

MENTAL HEALTH			
Depression	1	2	3
Schizophrenia	1	2	3
Manic-Depression	1	2	3
Anxiety	1	2	3

Recreational drug use (past and present): _____

_____

Have you ever been treated for chemical dependency? Yes No

Do you have any history of abuse (physical, psychological, substance)? Yes No

If yes, briefly explain:_____

PERSONAL LIFESTYLE HABITS (please fill in how much, how many, or how often)

Cigarettes (packs/week)____ Coffee/energy drinks (cups)____ Alcohol (drinks per week)_____

How many hours do you exercise per week? ____ What forms of exercise? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

_____

How many hours of sleep do you get on average?_____ Do you feel rested in the morning? Yes No

Compared to the people around you, do you tend to feel (subjectively) : Cold Warm Neutral

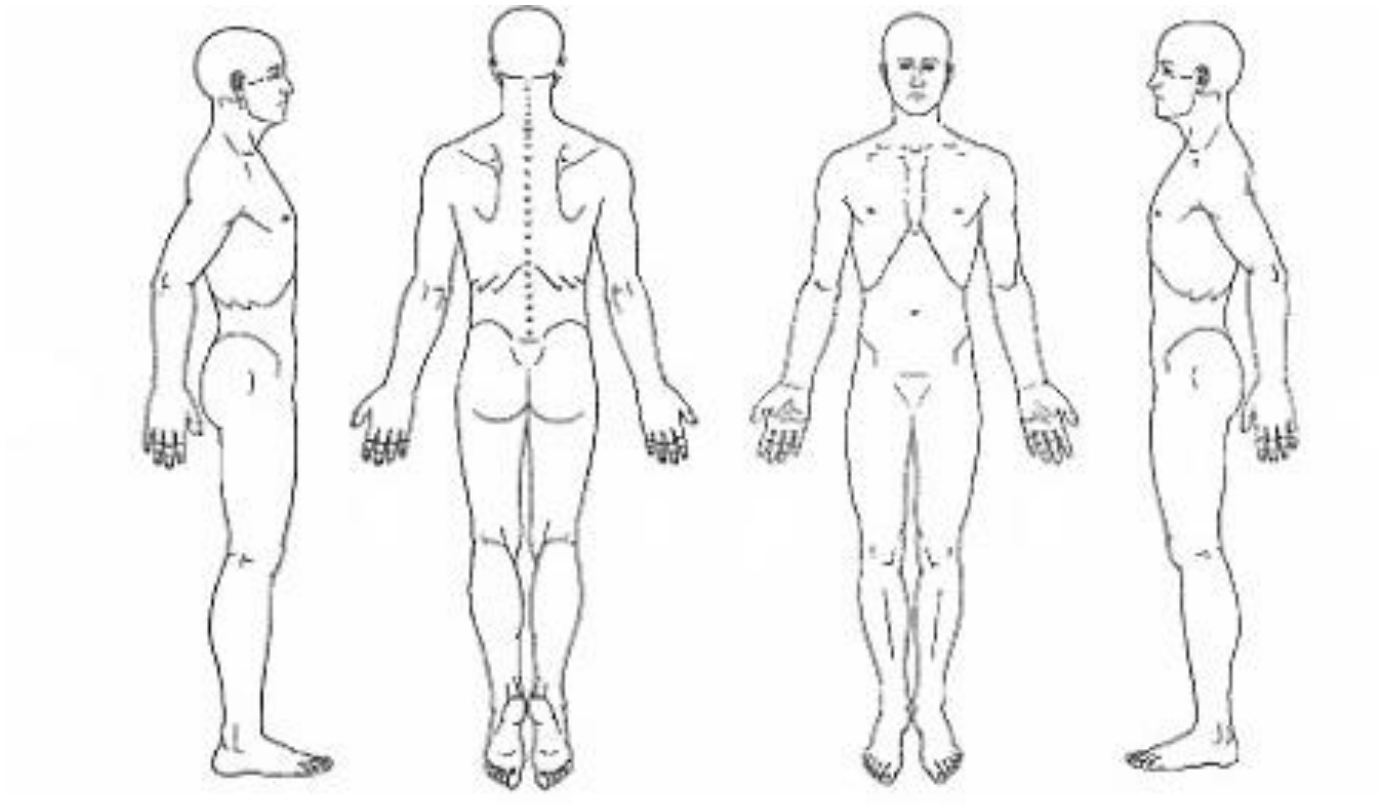
Have you received acupuncture before? Yes No Have you ever used Chinese Herbs before? Yes No

Please describe how long you have had your main complaint and how it affects your life: (sleep, work, relationships etc.)

_____

_____

If your condition includes pain or numbness, please put an P over the location of the pain or an N over the numb area on the diagram below.



Is there anything else we should know about you? _____

_____

Thank you for your time!

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The Health Insurance Portability and Accountability Act (HIPAA)

- Revised: January 2011

YOUNG PINE ACUPUNCTURE LLC PATIENT PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may gain access to this information. We will ask you to sign an Acknowledgment that you have received this notice of our Patient Privacy Practices. In accordance with the HIPAA Privacy Regulation, this Notice describes how Young Pine Acupuncture LLC may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The Notice also describes your rights and Young Pine Acupuncture's requirements to protect your health information.

Treatment, Payment, and Health Care Operations

For purposes of treatment: We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. Your treatment may include acupuncture, massage and herbs. We may also, for the purpose of treatment, disclose your protected health information to another health care provider when needed by the provider to render treatment to you.

For payment services: We will use your health care information to receive payment for services and products. We will bill you and/or a third party payor for the cost of treatment and herbs provided to you. The information on or accompanying the bill may include your identification, as well as the herbs you are taking.

For health care operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal Privacy Regulations.

Other uses and disclosure of protected health information permitted or required by regulation:
The following is a description of other possible ways we may use and/or disclose your protected health care information:

Friends and family: We may disclose your protected health care information to friends and family in case of an emergency to the extent necessary to help with your health care or with payment of your health care. Using their judgment as health care professionals, our acupuncture staff may disclose protected information with a family member, other relative, close personal friend, or any person you identify as being involved in your health care.

Reminder calls: We may contact you to provide reminders of herbal refills or appointments or other health related services that may be of interest to you.

Other covered entities: We may disclose protected health information to another covered entity to conduct health care operations in the area of quality assurance activities, or accreditation, certification, licensing or credentialing.

Disclosure to the U.S. Department of Health and Human Services: When the U.S. Department of Health and Human Services is investigating or determining our compliance with the federal Privacy Regulations, we are required to disclose your protected health information to the DHHS.

Abuse or neglect: We may disclose your protected health care information to appropriate authorities if we believe that you may be a possible victim of abuse, domestic violence, neglect, or other crimes.

Serious threat to health or safety: We may disclose your protected health information if we believe that the disclosure is necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person.

Public health and safety: We may release your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we may use information in your health record to the Food and Drug Administration relative to adverse events regarding drugs, foods, supplements, and other health products or to post marketing surveillance to enable product recalls, or replacements.

Law enforcement: We may disclose to law enforcement agencies in response to a court order, subpoena, discovery request, administrative order, or other lawful process by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health care information.

Other required or permitted disclosures: We may disclose your health care information to the following entities under given circumstances: Whenever required to do so by law;

- To a correctional institution or its agents, if a patient is or becomes and inmate of such an institution, when necessary for the patient's health or the health and safety of others;
- To notify, or assist in notifying a family member, personal representative, or another person responsible for the patient's care, or the patient's location, or general condition;
- To the military authorities under certain circumstances when the patient is a member of the Armed Forces;
- To authorized federal officials for intelligence, counterintelligence, and other national security activities.

Authorized use and disclosure: We will obtain your written Authorization before using or disclosing your protected health care information for purposes other than those listed above or otherwise permitted or required by law. You may revoke an Authorization in writing at any time. Upon receipt of this revocation we will stop using or disclosing your protected health care information except to the extent that we have already taken action in reliance on the Authorization.

Patient Rights

Requests for Restrictions: You have the right to request that we restrict how your protected health information is used or disclosed in carrying out treatment, payment, or health care operations. Such requests must be made in writing to our clinic (see address above).
In your request tell us: 1) the information of which you want to limit our use and disclosure and 2) how you want to limit our use and/or disclosure of the information. We are not required to agree to the requested restrictions, but if we do, we will abide by our agreement except in an emergency.

Access to protected health information: You have the right to look at or obtain a copy of your protected health information.
You must make a request in writing to obtain access to your protected health information. If you request copies, we may charge you a reasonable fee for copies and postage (if you want them mailed). We may denv your request to inspect and copv your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed.

Accounting of Disclosures: You have the right to receive an accounting of the disclosures we have made on or after April 14, 2003, of your protected health information (PHI). We will provide the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information.

Amendments to Health Care Information: You may request that we amend your protected health information if you feel that it is incomplete or incorrect. Your request must be in writing, and it must explain why the information should be amended. If we did not create the information you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide you with a written explanation. If denied, you have the right to file a statement of disagreement with the decision.

For More Information or to Report a Problem

If you would like additional information or have questions about our privacy practices, you may contact the S. Frances Butler at 503-877-5633 or by writing to the address above. You may also file a written complaint at this address. If you believe your privacy rights have been violated, you may file a complaint with Young Pine Acupuncture LLC or with the Department of Health and Human Services. We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.