KOSA Acupuncture

Patient Registration

531 E A St. Ste 100B, Jenks, OK 74037

Tel: (918) 995-1100

Patient ☐ Parent ☐ Guardian ☐

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ (mm/dd/yyyy) Gender: M ☐ F ☐

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____ lbs.

Children (Age & Gender): _____

Primary Physician: _____ Phone: _____ Referred by: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Health conditions related to work or auto accident? Y ☐ N ☐ If so, Date of Loss:_____ (mm/dd/yyyy)

I. Goals: What would you like to address through treatment?

_____

_____

_____

_____

_____

_____

II. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (to medications, chemicals or foods):_____

III. Lifestyle

1. What is your occupation? _____ How many hours do you work weekly? _____

2. How many servings per day do you use of the following?

Coffee _____ Tea _____ Soft drinks _____ Alcohol _____ Water _____ Cigarettes, cigars, or other tobacco _____

3. Do you have a known history of any exposure to toxic substances? Yes ☐ No ☐

4. Please describe your current exercise regimen: Hours per week: _____ Activities: _____

5. How many hours of sleep do you usually get per night? _____

Do you awake feeling rested? Yes ☐ No ☐ Do you sleep soundly? Yes ☐ No ☐

Do you get up at night to urinate? Yes ☐ No ☐ If so, how often? _____

6. Frequency of bowel movement: _____ per day or _____ per week

What is the color of stool? _____

For Women:

1. Age: First period ____ Menopause: Yes ☐ No ☐

a) Average number of days of flow: _____ days The flow is: Normal ☐ Heavy ☐ Light ☐

c) The color is: Normal ☐ Dark ☐ Purple ☐ Light Brown ☐ Brown ☐

d) Time between periods: _____ Days

2. Are you pregnant now? Yes ☐ No ☐ Unsure ☐

3. Indicate number of occurrences: Live Births _____ Pregnancies _____

4. Dates: Last Pap Smear_____ (dd/mm/yyyy) Last Mammogram _____ (dd/mm/yyyy)

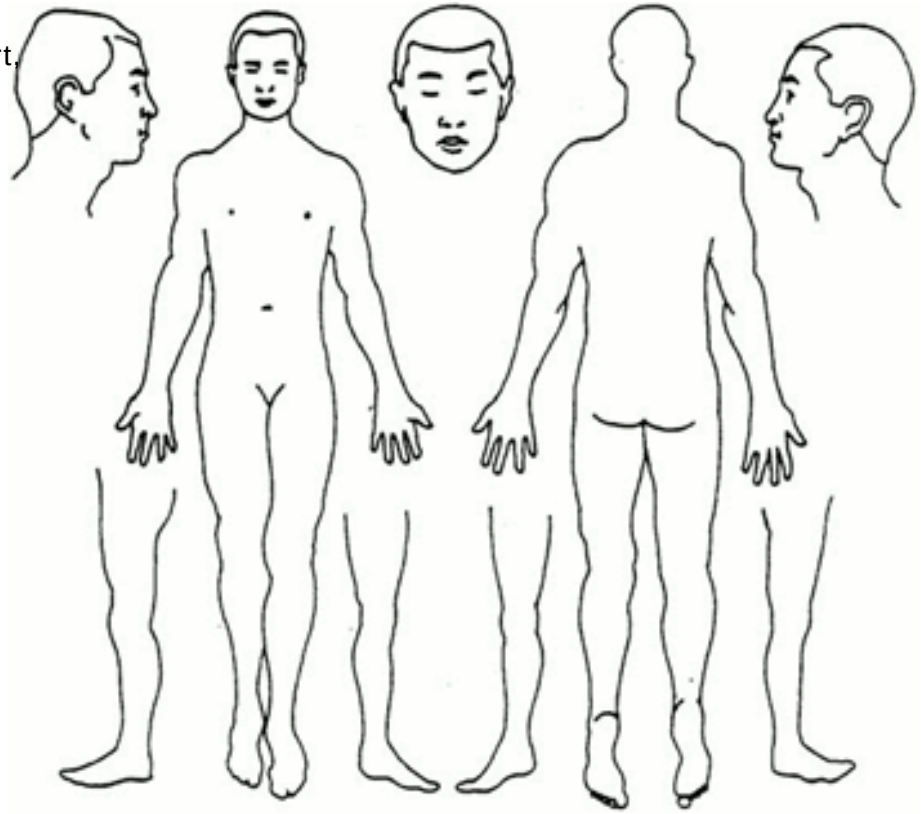
For Men:

Do you have any bothersome urinary, genital, or sexual symptoms? Yes ☐ No ☐

If yes, please describe: _____

IV. Pain

If you are experiencing pain/discomfort, using the models to the right, please indicate the location of the discomfort by using the below symbols that best describes the feeling.



A	Aching
B	Burning
C	Cramps
D	Dull
E	Effusion (Swelling)
N	Numbness
S1	Sharpness
S2	Shooting
S3	Sprain
S4	Stiffness
S5	Strain
T1	Tingling
T2	Throbbing
O	Other

Please describe pains in the order of the severity. **Top priority first, please.** For example, Headache, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Upper Back, Lower Back, Sciatica, Abdominal, Hip/pelvis, Thigh, Knee, Calf, Foot, Ankle, Toe and etc.

_____

_____

_____

V. HEALTH: Please check all that apply, left for past right for current

Head (Face and Eyes)	
R51	Headache
G43.111	Migraine with aura
G43.011	Migraine without aura
G43.711	Chronic migraine without aura
G43.911	Migraine, unspecified
J34.89	Other disease of nasal cavity and sinuses (pain)
H92.09	Otalgia, unspecified ear (ear pain)
R68.84	Jaw pain
Z98.89	Other specified postprocedural states (dental with pain)
Neck	
M54.2	Cervicalgia (Neck pain)
M25.50	Pain in unspecified joint (spine, cervical)
R07.0	Pain in throat
M50.31	Cervical disc degeneration occipito-atlanto-axial region
M50.32	Cervical degeneration mid-cervical
M50.33	Cervical disc degeneration cervicothoracic region
M47.813	Thoracic spondylosis without myelopathy or radiculopathy cervicothoracic region
M47.814	Thoracic spondylosis without myelopathy or radiculopathy thoracic region
Shoulder	
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M25.611	Stiffness of right shoulder, not elsewhere classified
M25.612	Stiffness of left shoulder, not elsewhere classified
M25.419	Effusion (swelling), unspecified shoulder
M25.411	Effusion (swelling), right shoulder
M25.412	Effusion (swelling), left shoulder
S43.50XA	Sprain of unspecified acromioclavicular joint, initial encounter
Muscle	
M79.1	Myalgia
M79.7	Fibromyalgia
Nausea	
R11.0	Nausea
R11.11	Vomiting without nausea

Thoracic Spine	
M54.6	Pain in thoracic spine
M20-M25	Pain in unspecified joint (spine, thoracic)
M47.814	Thoracic spondylosis without myelopathy
S29.012A	Strain of muscle and tendon of back wall of thorax initial encounter
Lower Back (lumbosacral)	
M54.5	Low back pain (lumbago)
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M25.50	Pain in unspecified joint (spine, lumbar or lumbosacral)
M54.89	Other dorsalgia
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
Pelvis	
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.651	Stiffness of right hip, not elsewhere classified
M25.652	Stiffness of left hip not elsewhere classified
M25.451	Effusion (swelling), right hip
M25.452	Effusion (swelling). Left hip
S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequela
Abdomen	
R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.31	Right lower quadrant pain
R10.32	Left lower quadrant pain
R10.84	Generalized abdominal pain, Abdominal pain, other specified site (multiple sites)
Arm and Elbow	
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M70.21	Olecranon bursitis, right elbow
M70.22	Olecranon bursitis, left elbow
M25.421	Effusion (swelling), right elbow
M25.422	Effusion (swelling)., left elbow
M25.431	Effusion, right wrist (forearm)
M25.432	Effusion, left wrist (forearm)
M25.621	Stiffness of right elbow, not elsewhere classified
M25.622	Stiffness of left elbow, not elsewhere classified

Wrist and Hand	
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.644	Pain in right finger(s)
M79.645	Pain in left fingers(s)
M70.11	Bursitis right hand
M70.12	Bursitis left hand
M25.631	Stiffness of right wrist, not elsewhere classified
M25.632	Stiffness of left wrist, not elsewhere classified
Knee and Thigh	
M25.561	Pain in right knee
M25.562	Pain in left knee
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M70.51	Other bursitis of knee, right knee
M70.52	Other bursitis of knee, left knee
M25.461	Effusion (swelling), right knee
M25.462	Effusion (swelling), left knee
M25.661	Stiffness of right knee not elsewhere classified
M25.662	Stiffness of left knee, not elsewhere classified
Ankle and Foot	
M25.579	Pain in unspecified ankle and joints of right foot
M25.672	Pain in unspecified ankle and joints of left foot
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M25.471	Effusion (swelling), right ankle
M25.472	Effusion (swelling), left ankle
M25.474	Effusion (swelling), right foot
M25.475	Effusion (swelling), left foot
M25.671	Stiffness of right ankle, not elsewhere classified
M25.672	Stiffness of left ankle, not elsewhere classified
Pain - Acute and chronic	
G89.0	Central pain syndrome
G89.11	Acute pain due to trauma
G89.21	Chronic pain due to trauma
G89.29	Other chronic pain
Respiratory	
R05	Cough
R07.0	Pain in throat
J45.20	Intrinsic asthma, unspecified (mild intermittent asthma, uncomplicated)
J45.991	Cough variant asthma
J45.998	Other asthma

VI. Recent Hospitalizations / Surgical History

_____Date _____

_____Date _____

_____Date _____

Other relevant information:

_____

_____

_____

_____

_____

_____

I am receiving acupuncture and related treatments from Byoung Soon Kim MSc.AAOM.

I hereby authorize KOSA Acupuncture to verify information required for processing payment, and to collect payment directly from my insurance.

I understand that if my insurance fails to cover for my treatments or pays me less than the prefixed price (mutually agreed), or pays me directly, I am responsible for making payments. I also authorize the clinic to obtain any medical information on me as needed.

By signing below, I certify that all information I have provided are accurate and to the best of my knowledge.

Client's Name: _____

Client's Signature: _____ **Date:** _____

For Office's Use Only

Treatments: Acupuncture		Duration:	Hr	Min	
Office visit (New patient):	99201 ☐	99202 ☐	99203 ☐	99204 ☐	99205 ☐
Acupuncture w/o Electric	1 SET ☐	2 SET ☐	3 SET ☐	4 SET ☐	
Electrical Acupuncture	1 SET ☐	2 SET ☐	3 SET ☐	4 SET ☐	
Manual Therapy: (Guasha, Tuina)	15 min ☐	30 min ☐			
Moxa & Cupping:	15 min ☐	30 min ☐			
Massage:	15 min ☐	30 min ☐			
Infrared Heat:	15 min ☐	30 min ☐			
Electrical Stimulation:	15 min ☐	30 min ☐			
Application of Hot or Cold Packs:	15 min ☐	30 min ☐			

A SUMMARY OF YOUR PRIVACY RIGHTS UNDER HIPAA

KOSA Acupuncture **(918) 995-1100**
531 E A St. Ste 100B, Jenks, OK 74037

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INOFRMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a rule, I will disclose no information obtained from your contacts with me, or the fact that you are my client, except with your written consent. However, there are some important exceptions to this rule of confidentiality – some arising from my office policies, some required by law.

If you wish to receive health services from me, then under the Federal HIPAA regulations, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I. Uses and Disclosures Requiring Authorization or Consent

I may need to use or disclose your protected health information **(PHI)** for treatment, payment and health care operations purposes. This will require your consent in advance, either at the onset of our relationship or at the time of the need for disclosure arises. You may revoke your permission to release PHI, in writing, at any time, by contacting me. If there is an emergency and I cannot ask you permission, I am allowed to share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

Patient Registration is the term used for my formal record of the services provided to you, and contain the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. "Therapy notes" are notes I have made about our conversation during a private, group, joint, or family session, which I have kept separate from the rest of your medical record. (Under HIPAA Regulations, such notes are given a greater degree of protection that the PHI or formal record, and they are considered my own private communication. However, state law does not make this distinction, and these are included in the category of "protected health information" which can be released without your consent in circumstances such as those described in the next section.

II. Users and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI **without** your consent or authorization in the following circumstances if legally required:

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Department of Social Services.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by law to immediately make a report and provide relevant information to the Department of Welfare of Social Services.

Health Oversight: State law requires that I report misconduct by a health care provided of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, I am required to explain to you how to make such a report if you describe unprofessional conduct by another health provider. If you are yourself a health care provider, I am required by law to report that you are in treatment if I believe that your condition places the public at risk. State Licensing Boards have the power, when necessary, to subpoena relevant records.

Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or a court order. If I receive subpoena for records or testimony, I will notify you and you can file a motion to quash (the block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court of the appropriate jurisdiction. In this state, parents' therapy records may not be used as evidence in child custody cases. However, therapy information or records are not protected by patient-therapist privilege in child abuse cases, in cases in which your health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." The state has not statute granting therapist-patient privilege in criminal cases. The protections of privilege also do not apply if I do an evaluation for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: Under state law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victims(s), if under 18; 2) notifying a law enforcement officer; or 3) seeking your hospitalization. By policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant healthcare information to you, your employer, the insurer, or a certified rehabilitation provider.

Records of Minors: This state has a number of laws that limit the confidentiality of the records of minors. For example, parents regardless of custody may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Definitions

To help clarify the terms, here are some definitions:

"PHI" (Protected Health Information) refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

- *Payment* is when I obtain reimbursement for your healthcare. Examples of disclosure for payment purposes are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Treatment* is when I provide, coordinate or manage your health care and other service related to your healthcare. An example of a disclosure related to treatment would be when I consult with another health care provider, such as your psychiatrist.
- *Health Care Operations* are activates that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement, business-related matters such as audits and administrative services, and case management and care coordination.
- *Business Associates:* My co-workers have no access to my records.

"Use" applies only to within my office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

"Disclosure" applies to outside of my office, such as releasing, transferring or providing access to information about you to other parties.

"*Consent*" is a general permission that allows me to use and disclose your health care information for routine purposes of treatment, payment and operations. For example, **under the law, <u>you must sign this consent form</u> before I can begin to see you for treatment or provide other health services.**

"Authorization" is required by law and involves your written permission to use and disclose information not covered by the consent form. There are a few cases (see above) in which I am allowed, even required to use and disclose your information without your consent or authorization. I will keep a record of disclosures, and this will be available to you.

IV. Patient's Rights and Provider's Duties:

Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information that I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make you request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures - You generally have the right to receive an accounting of disclosures of neither PHI for which you have neither provided or consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.

Right to Inspect and Copy - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If your request a copy of the information, I may charge a fee for costs of copying and mailing. *I may deny your request to inspect and copy in some circumstances.* I may refuse to provide you access to certain notes or to information compiled in reasonable anticipation or, or use in, a civil criminal, or administrative proceeding.

Right to Amend - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; and 4) is accurate and complete.

Right to a copy of this notice - You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

<u>Changes to this notice:</u> I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the <u>effective date.</u> A new copy will be given to you or posted in the waiting room. I will copies of the current notice available on request.

<u>Complaints:</u> I f you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>

Please print, sign your name and date below.

I have been provided a copy of the privacy practices that will apply to services provided by KOSA Acupuncture. I consent to these policies as a condition of receiving services.

Printed Name: _____ **Patient ☐ Parent ☐ Guardian ☐**

Signature: _____ Date: _____

Consent

KOSA Acupuncture
Phone: (918) 995-1100
531 A St. Suite 100B, Jenks, OK 74037

Byoung Soon Kim
MSc. AAOM
www.saahm.net
info@saahm.net

- Acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat body dysfunctions, diseases, pains and/or combined, to modify or prevent the body of pain and to make normal the body's physiological functions. The acupuncturist manipulates some needles incurring the pain from manipulating them. The procedure has been fully explained to me. Certain side effects may result. These could include, but are not limited to, some local bruising, slight bleeding and temporary aggravation of symptoms existing prior to acupuncture treatment.
- If there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, that I should consult a licensed physician.
- Acupuncture treatment may not be covered by certain health insurance companies and I understand that it is my responsibility to check with my health insurance company for the acupuncture coverage and I am financially responsible for charges like copay, deductible and differences, which my insurance does not cover. Although my insurance company pays more than preset price I am still financially responsible for copay and deductible.
- Although it is very rare, the acupuncturist may ask patients to show groin and/or anus to treat and I have rights to refuse. Any treatments provided by acupuncturists are deemed that I have allowed and admitted.
- In case of treatment takes longer than an hour depending on severity of concern, KOSA Acupuncture will add additional cost to preset price as per the mutual agreement between me and KOSA Acupuncture.
- Treatment of cancer, epilepsy, or acquired immune deficiency syndrome is solely to alleviate pain and during the entire period of treatment, the patient is under the care of a licensed physician for the condition or disease and KOSA Acupuncture does not interfere with the course of treatment recommended by such patient's treating physician. The Federal Government considers Acupuncture "experimental" at this time. 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 and the result may vary individually.
- The patient shall pay $35.00 extra for the returned check. KOSA Acupuncture will no longer accept the patient with a history of two returned checks.
- Patients need to inform KOSA Acupuncture at least 24 hours of notice if I would not be able to keep my appointment. If I fail to give 24 hours cancellation notice, I will be charged for the cancellation penalty of 100%. Late show up will be charged prorated in addition to preset price.
- **Emergency Procedure:** In a life threatening situation, I am required to call "911".

I have read and understand these office policies, do hereby voluntarily consent to be treated by Acupuncture administered by KOSA Acupuncture and I agree to enter treatment under the prescribed conditions.

Date: _____ (MM/DD/YYYY)

Name: _____ Signature: _____

Patient ☐ Parent ☐ Guardian ☐