



Patient Information	
Full Name: _____	
Address: _____	
City: _____	Zip Code: _____
Email: _____	Cell Phone: _____
Birth Date: _____	Gender: _____
How did you hear about Herb Folk: _____	
Emergency Contact	
Name: _____ Relationship: _____	
Cell Phone: _____	

Signature
The information on this form is accurate to the best of my knowledge. I will inform Herb Folk Community Medicine if any pertinent personal or health-related information changes.
Patient Signature: _____ Date: _____
For Minors Only
Guardian Signature: _____ Date: _____
Guardian: _____ Relationship: _____
Alternate contact info: _____

Health History

Please list your primary reasons for seeking treatment:

- 1.
- 2.
- 3.

Goals for your health:

Have you used herbal medicine before? Self prescribed or from a herbalist?

List your current medications and supplements*:

List any allergies or hypersensitivities to food, drugs or medications (with severity of reaction):

List serious illness, hospitalizations and surgeries*:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

* continue on the back side of this form if necessary

Medical Diagnosis

Please **circle** if you are experiencing now and **underline** if you have experience in the past:

<p>Pain/Weakness/ Numbness Arms/Hands Back/Hips Legs/Feet Neck/Shoulders</p> <p>Muscle/Joint/Bones Arthritis Cramps Gout Trauma/Broken Bones Tremors Sprains/Strains</p> <p>Eyes/Respiratory/ENT Asthma COPD Dry Eyes Earache Eye Pain Gum Issues Hay fever Hoarseness/Sore Throat Impaired Hearing Impaired Vision Persistent Cough Ringing in Ears Shortness of Breath Sinus Issues Teeth Grinding Tearing</p> <p>Skin Cysts, Boils Dry Skin Eczema Itching/Rash/Hives Non-Healing Sores Psoriasis Sweats</p>	<p>Genito/Urinary Blood/Pus in Urine Burning Urination Difficult Urine Frequent Urination Frequent UTI Incontinence Kidney Infection/Stones Nighttime Urination Painful Urination</p> <p>Cardiovascular Athero/Arteriosclerosis Bleeding Disorders Chest Pain/Angina Heart Disease High Cholesterol High or Low Blood Pressure Pace Maker Palpitations Irregular Heart Beat Stroke Swollen Ankles</p> <p>Energy/Immunity/ Endocrine Cancer Chronic Fatigue Chronic Infections Diabetes Fatigue Frequent Cold/Flu Hepatitis A B C D E HIV/AIDS Insomnia Hypo/Hyper Thyroid Hypo/Hyper Parathyroid Malaria Seasonal Allergies</p>	<p>Gastrointestinal Acid Reflux Belching/Gas/Bloat Chron's Constipation Diarrhea/Loose Stools Difficulty Swallowing Diverticulitis/losis Eating Disorder Excess Hunger Gall Bladder Issues Hemorrhoids IBS Nausea/Vomiting Poor Appetite Stomach Pain Ulcerative colitis</p> <p>Mental/ Emotional Health Anger/Irritability Anxiety Bipolar Confusion Depression Mental Sluggishness Mental Tension Mood Swings Nervousness Phobia</p> <p>Neurological Dizziness/Vertigo Headache Loss of Balance Migraine Numbness/Tingling Paralysis Seizure</p>	<p>Women's Health Bleeding btwn Periods Breast feeding issues Excessive Menstrual Flow Infertility Irregular Menst. Cycles Lowered Libido Mastitis Menstrual Pain PMS Scanty Menstrual Flow Post-partum Peri-menopausal Pre-Conception Pregnancy</p> <p>Men's Health Abnormal Discharge BPH Erection Difficulties Infertility Lowered Libido Testicular Pain/Swelling</p> <p>Other (Please List)</p>
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Informed Consent, Office Policies and Privacy Policy

I, _____, agree to receive holistic health consultations, herbal medicine, acupuncture and/or related therapies by Herb Folk Community Medicine (Herb Folk). Treatment methods may include, but are not limited to herbal medicine, nutritional supplements, heat and moxibustion therapy, acupuncture, massage and bodywork, cupping therapy, guasha, as well as lifestyle and nutrition counseling.

I have been informed that the herbs and nutritional supplements used in traditional Chinese medicine and folk herbalism are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I understand that acupuncture is very safe, but it may have side effects, including temporary lethargy, bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include organ puncture and infection. Massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising/skin discoloration is a common side effect of cupping & gua sha, and will fade in a few days. **I do not expect the practitioner(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known. I will notify Herb Folk immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.**

- Herb Folk is not responsible for any lost or stolen personal items.
- We have a **24-hour cancellation policy**. Patients who cancel or no-show with less than 24-hours advance notice will be charged 100% of the service rate for that appointment. If you are more than 15 minutes late, your appointment will be considered cancellation. If purchased in a package, the missed appointment will be deducted from the number of remaining appointments in that package.
- Payment for all services and apothecary items is due at the time of service. All published rates are "time of service" rates for the uninsured and under-insured.
- I give permission for Herb Folk staff to contact me via telephone, email and text, and to leave a message that may contain appointment and medical information if I am not available. I give permission to Herb Folk to send me newsletters with updates, specials and educational information, and have the right to unsubscribe from receiving these at any point in time.
- I acknowledge receipt of the "Notice of Privacy Policy" for healthcare services in this office. I understand that my signature does not authorize disclosure, but only confirms that I have received a copy of the full notice.

By signing below, I acknowledge that I have read and understood this consent to treatment. I understand the risks and benefits of herbal medicine, acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature: _____ Date: _____

Notice of Privacy Practices & Patient Acknowledgement

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.

NOTICE OF YOUR RIGHTS:

You have the following rights regarding medical information that we maintain about you:

- **Right to inspect and get a copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. You must submit your request in writing to Herb Folk Community Medicine's (Herb Folk) Privacy Officer (see below). We will provide a copy or a summary of your health information, usually within 30 days of your request. We are entitled to charge a reasonable, cost-based fee.
- **Right to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete for as long as the information is kept by or for our office. You must submit your request in writing to Herb Folk's Privacy Officer (see below). We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Right to request confidential communications:** You can ask us to communicate with you about medical matters in a certain way or at a certain location (ie. home or office phone). We will comply with all reasonable requests.
- **Right to request restrictions:** You can request that we not to use or share certain health information for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend (ie. not use or disclose a surgery you had). If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We are not required to agree to your request, and we may say "no" if it would affect your care. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or a law requires us to share that information. To request restrictions, you must make your request in writing to Herb Folk's Privacy Officer (see below). In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.
- **Right to an accounting of disclosures:** This is a list of those with whom we've shared medical information about you and why. To request an accounting of disclosures, you must submit your request in writing to Herb Folk's Privacy Officer (see below). Your request must state a time period, which may not be longer than six years prior; and indicate in what form you want the list (ie. paper or electronically). We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Right to a copy of this notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Right to have someone act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Right to file a complaint:** If you believe your privacy rights have been violated, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

NOTICE OF YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; and
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We never share your information, unless you give us written permission, for marketing purposes, sale of your information, and most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES:

We typically use and disclose your patient information, without obtaining specific authorizations, in the following ways:

- **For Treatment:** We can use and share your health information with other professionals who are treating you, other acupuncturists or personnel who are involved in taking care of you at our office, and people outside the clinic who may be involved in your medical care, such as family members or other persons that are part of your care.
- **For Payment:** We can use and share your health information to bill and get payment from health plans, insurance companies, and other third party administrators. We also use it to submit insurance claims and obtain benefits authorizations;
- **For Health Care Operations:** We can use and share your health information to run our clinic, improve your care, contact you when necessary, and in correspondence with other health care providers, insurance companies, worker's compensation, and other third party administrators.

Under HIPPA, there are certain exceptions to these general rules which are described in the notice. Disclosures that can be made without patient authorization: subject to professional judgement, for public health and safety purposes, for government functions, law enforcement and based on judicial request for subpoena. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. You may revoke that permission, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission.

OUR RESPONSIBILITIES:

The law requires us to:

- Maintain the privacy and security of your protected health information;
- Promptly inform you if a breach occurs that may have compromised the privacy or security of your information;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect and provide you with a copy of it.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE:

We reserve the right to change the terms of this notice, and the changes will apply to all information we have about you. The notice will contain on the first page, in the top right-hand corner, the effective date. The new notice will be available upon request, in our office, and on our website.

The staff of Herb Folk, its affiliates and contract providers understand that information about you and your health is personal. We are committed to protecting your health information. If you have questions about our privacy guidelines, please call us during regular business hours at 707-285-7259.

Submit all written requests to:
Privacy Officer
Herb Folk Community Medicine
117 Washington Street
Petaluma, CA 94952