MIDDLE WAY
ACUPUNCTURE INSTITUTE

Please complete the health questionnaire below. All of your answers are completely confidential. The student clinic is a part of the required training for licensure in this state. Therefore, your information will be shared only by authorized faculty members and students. If you have questions, please contact Joe Rothstein, Executive Director, at 360-336-6129.

Health History Questionnaire

Today's date_______________

Name	*Phone Number*	
Address	*City/State/Zip*	
Email	*Occupation*	
Emergency Contact	*Emergency Contact Phone*	*Relationship*
How did you hear about Middle Way Acupuncture Institute? ☐ website ☐ family/friend ☐ advertisement ☐ other:		
For communication purposes (appt reminders, etc.), please mark the method(s) you prefer: ☐ cell phone ☐ home phone ☐ email	*Have you had acupuncture before?* ☐ yes ☐ no	

Date of Birth ___________________________*Age*______________ *Height* ______________ *Weight* _____________
Family Physician ____ *Date of your last Physical Exam* ______________
Results ____
Surgeries/Significant Trauma (include dates) ____
____
*Reason for visit today:*____
Please list medications you are currently taking. Include vitamins, herbs, etc. (continue on back if needed)
____
____

Personal Current/Past Medical History (include date)

☐ AIDS/HIV	☐ Diabetes	☐ Migraines	☐ Tonsillectomy
☐ Alcoholism	☐ Emphysema	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Allergies	☐ Epilepsy	☐ Mumps	☐ Tuberculosis ☐ Typhoid Fever
☐ Appendicitis	☐ Goiter	☐ Pacemaker	☐ Ulcers
☐ Arteriosclerosis	☐ Gout	☐ Pleurisy	☐ Venereal Disease
☐ Arthritis	☐ Heart Disease	☐ Pneumonia	☐ Whooping Cough
☐ Asthma	☐ Herpes	☐ Polio	☐ Other (Specify) ____________
☐ Birth Trauma	☐ Hepatitis	☐ Rheumatic Fever	____________
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever	____________
☐ Chicken Pox	☐ Malaria	☐ Seizures	
☐ Depression	☐ Measles	☐ Stroke	

Family Medical History

☐ Allergies	☐ Cancer (type)	☐ Heart Disease	☐ Other (Specify)
☐ Arteriosclerosis	____________	☐ High Blood Pressure	____________
☐ Asthma	☐ Depression	☐ Seizures	____________
☐ Alcoholism	☐ Diabetes	☐ Stroke	

Do you exercise? (what type and how often?) ____
Do you smoke cigarettes? (YES / NO) If yes, how many a day? __________ In the past? (YES / NO) _______________
Do you drink alcohol? (YES / NO) If yes, how much per? (WEEK / MONTH) ___________
Do you take recreational drugs? (YES / NO) Have you in the past? (YES / NO)
How much coffee/tea/cola do you drink per day? _________ Are you pregnant? (YES / NO)
Are you under any significant stress? (YES / NO) _____________________________________

Middle Way Acupuncture Institute - Student Clinic

Notice of Health Information Practices

<u>Please read carefully</u>. This notice describes how information about you may be used and disclosed and how you can get access to this information.

Understanding Your Health Record/Information: Each time you visit Middle Way Acupuncture Institute Student Clinic, a record of your visit is made. Generally, this includes a health history, a review of your symptoms, diagnostic testing, acupuncture treatment and plan for further care. This information is referred to as your medical record and serves as:

- the basis for planning your care, treatment and follow-up.
- an education tool for reviewing, assessing and improving the care rendered at the student clinic.
- a means of communication among students, faculty other health care professionals who contribute to your care.
- a legal document describing the care you have received.
- a potential resource for medical research data.
- a tool for educating health professionals.
- a source of information for public health officials charged with improving the health of the nation.

Understanding what is in your health record and how this information is used will assist you in:

- ensuring its accuracy.
- better understanding who, what, when, where and why others may access your health information.
- making informed decisions when authorizing disclosures to others.

Your Health Information Rights: Your health record is the physical property of this office. However, the information contained in it belongs to you. You have the right to:

- Request a restriction on certain uses or disclosures of your information as provided by CFR 45 164.522(a).
- Obtain a paper copy of this notice of information practices upon request.
- Inspect and have a copy of your medical record as provided by 164.524.
- Amend and/or have a "statement of disagreement" placed in your medical record as provided by 45 CFR 164.528 and the Washington State Uniform Health Care Information Act.
- Obtain an accounting of disclosures of your health information outside the scope of normal student clinic operations as provided by CFR 45 164.528. If an individual requests a copy of the PHI or agrees to a summary of care, Middle Way Acupuncture Institute Student Clinic may impose a reasonable, cost-based fee. (Fees set by the Department of Human and Health Services)
- Request communications of your health information by alternative means or at Alternative sites.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities: This office is required by law to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms contained within this notice.
- Notify you if we are unable to accept your request for limiting or restricting certain uses and disclosures.
- Accommodate reasonable requests you may have for communication of your health information through alternative means and/or alternative locations.

We reserve the right to change or modify our practices and to make new provisions effective for all protected health information (PHD we maintain. Should our practices change, a reasonable attempt will be made to notify you. We will not use or disclose your PHI without your authorization, except as described in this notice.

For More Information or to Report a Problem: If you need any further assistance, please contact: Joe Rothstein, EAMP, 360-366-6129. If you believe your privacy rights have been violated, you can file a complaint with the above individual or with the local Department of Health and Social Services. **<u>There will be no retaliation or penalty for filing a complaint</u>**.

Types of Disclosures for Treatment, Payment and Healthcare Operations: These disclosures and uses do not require your authorization, but are required to facilitate your care, and/or required by other State and Federal laws.

Treatment: Health information obtained by the acupuncture student is recorded in your medical record and is used to determine what type of health treatment should be provided. The acupuncture student will be under the direct supervision of a faculty member who will review the medical information obtained by the student, approve the proposed treatment plan, and review the medical records following the treatment for educational purposes and to ensure that quality of care was rendered.

Communication with Family Members: With your written consent, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health care information relevant to that person's involvement in your care.

Marketing: We may contact you to remind you of your appointment.

Public Health: As required by law, we may disclose your PHI to public health officials or legal authorities for the following reason:
● To prevent or control disease, injury or disability.
● To notify a person who may be at risk for contracting or spreading a disease or condition.
● To notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

As Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be disclosed to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate reasonably believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering patients, workers or the public.

Child or Elder Abuse Reporting: Child or elder abuse or neglect reported to us is not protected healthcare information. This information may be disclosed to the appropriate state agency officials who are empowered to facilitate the care and management of the care of children and elders.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system and compliance with civil rights laws.

Updated: February 11, 2021

Acknowledgement of Health Information Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about Middle Way Acupuncture Institute's "Notice of Health Information Practices." For more details, please read the "Notice of Health Information Practices" that the Student Clinic has provided for you.

I. How we may use and share health data about you:

a) Treatment – To give you acupuncture treatment
b) Educations –To use your medical information as an educational tool for improving care.
c) To use among students and faculty who contribute to your care.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child/elder abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Persons involved in your care or payment for your care. We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the law that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to receive communication from us about your health information in alternate ways
e) Right to a paper copy of the complete Notice of Privacy Practices

GROUP EXPOSURE WAIVER FORM

Privacy is something almost everyone is concerned about when receiving any form of healthcare. All information revealed during an individual acupuncture appointment is protected by the healthcare provider-patient privilege. However, in this particular group setting, confidentiality is partially lost due to:
(1) The group appointment schedule,
(2) Visibility of patients participating in the student clinic, and
(3) Health care information shared and disclosed by other participants.
By signing below, you agree that Middle Way Acupuncture Institute will not be considered liable for financial or other damages resulting from any breach of confidentiality committed by other persons in this location. Along with the students, faculty and Middle Way Acupuncture Institute's commitment to maintain your privacy, you will also have a responsibility to protect each other's privacy. Nothing in this waiver shall affect the privacy or confidentiality of individual medical records maintained by Middle Way Acupuncture Institute.

I hereby acknowledge that I have received a copy of this office's Notice of Health Information Practices. I understand that if I have any questions or complaints regarding my privacy rights, I may contact Joe Rothstein, Executive Director, at 360-336-6129 and/or the Department of Health and Social Services. I further understand that this office will provide me with updates to the Notice of Health Information Practices should it be amended, modified or changed

Patient Signature **Date**

______________________________ ____________________

Print Patient Name **Patient Date of Birth**

______________________________ ____________________

COVID-19 Informed Consent to Treat

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. ________
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. ________
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. ________
- I will comply with MWAI's policy to wear a mask at **all times**. ________
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline or train. ________
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. ________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

I give MWAI permission to record **video** during the treatment for educational and training purposes

YES ☐ NO ☐

Date: ____________________

Patient signature: ____

Printed name: ____

MIDDLE WAY ACUPUNCTURE INSTITUTE

PATIENT INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

Your Student Practitioner: Your student practitioner is currently in her/his third year at Middle Way Acupuncture Institute. As part of the licensing requirements for acupuncture, students must successfully complete 500 hours of clinical training and 160 hours of clinical observation.

Your Clinic Supervisor:

Qualifications: supervisor; educational institute; license #

- Catherine Dayhoff; Oregon College of Oriental Medicine; License # AC60330666
- Matthew Van Dyke; Five Branches University; AC 00002999
- Linda Munson; Northwest Institute of Acupuncture and Oriental Medicine; AC 00002124
- Elsa Del Toro; Middle Way Acupuncture Institute; AC 60197009
- Anna Palucci Young; Pacific College; License #AC60858717
- Alan Llyod; Bastyr University; Licence # AC60327727
- Serena Emerson; Middle Way Acupuncture Institute; License # AC60694145

Treatment and scope of practice: Feel free to ask your student practitioner or the student clinic supervisor questions regarding treatment techniques. Your treatment may include the following techniques:

- **Acupuncture**—the insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Moxibustion (Moxa)—**the burning of prepared herbs on or near the body to warm, strengthen and relieve symptoms. Moxa comes in several forms such as stick, string, ball, cone or rice grain.
- **Cupping**—a technique used to relieve symptoms by applying cups made of glass or plastic to the skin with a vacuum created by heat or suction.
- **Electro Acupuncture**—the use of very low electrical current applied to specific acupuncture points.
- **Acupressure**—a technique of Chinese medical pressure based on acupuncture theory, used for a variety of common disorders.
- **Gua Sha**—rubbing on an area of the body with a blunt, round instrument.
- **Plum Blossom or Seven Star Hammer**—A light tapping of an area of the body with a small sterile, disposable hammer which has seven points.
- **Dietary Advice**—Food and herbal advice guided by traditional Chinese theory.
- **Infrared Lamp**—the use of heat to warm the body and increase circulation to an area.
- **Press Seeds/Beads/Magnets**—a self-adhesive seed, bead or magnet is applied to specific acupuncture points on the body or ears for stimulation.

Purpose of Treatment: The purpose of your treatment is to resolve your complaint, i.e., the reason you are seeking treatment. Acupuncture is a comprehensive health care system that is based on East Asian medicine theory and practices. Diagnosis and treatment based on these theories and practices are used to promote your health and treat both organic and/or functional disorders.

Potential Benefits: Potential benefits from the above procedures can lead to relief of presenting symptoms, and the rebalancing of internal systems so as to lead to the elimination and/or prevention of the main complaint, reduction of stress, and an awareness of dietary and life-style changes in order to maximize health and well-being. Many conditions may be alleviated very rapidly; others, especially those, which have developed and/or existed over the course of many years, may be relieved only through a slow and steady treatment protocol.

Risks of Treatment: Acupuncture has been shown to be relatively safe. However there are some uncommon but potential risks, including:

- Needle "sickness" (dizziness, fainting, nausea after insertion of needles)
- Localized, minor bruising or swelling
- Minor burns with the use of moxa
- Possible aggravation of symptoms that existed prior to treatment
- Broken needle (very rare with the use of disposable needles)
- Infection (very rare with the use of disposable needles)

Some acupuncture points are contra-indicated during pregnancy. Please inform your student practitioner if you are or might be pregnant. In addition, patients with severe bleeding disorders or pacemakers should inform the student practitioner and faculty supervisor prior to treatment.

CONTINUE ON BACK OF PAGE

Use of disposable needles: To reduce the possibility of infection, all needles used by your student practitioner are pre-sterilized, one-time-use needles made of surgical stainless steel. After each treatment needles are disposed of as medical waste. Needles are never reused.

Confidentiality of Medical Records: all medical records will be kept confidential as provided by law. Your medical records will not be released to anyone without your written consent. Your privacy will be protected.

Requirement of Washington State Law: Washington State Law does not permit acupuncturists to treat certain disorders without the consultation of a medical doctor, such as:

- Cardiac conditions including uncontrolled hypertension
- Acute abdominal symptoms
- Acute undiagnosed neurological changes
- Unexplained weight loss in excess of 15% of body weight within a 3-month period
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Any serious undiagnosed hemorrhagic disorder
- Acute respiratory distress without previous history or diagnosis

Patient Consent: With this knowledge, I voluntarily consent to the above treatment procedures by a student that is supervised by a licensed acupuncturist listed above, realizing that no guarantees have been given to me regarding the resolution or improvement of my condition. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. My signature on this form indicates that I have read and understand the preceding information. If I have any questions about this information or about my treatment, I will ask my student practitioner and/or student clinic supervisor. I hereby release the above named student practitioner and Middle Way Acupuncture Institute from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Patient Name____Date______________

Patient Signature____

For Patients under 18 years of age:

Guardian Name_____________________________________Date__________

Guardian Signature____

Witness Name____

Witness Signature____