

# Acupuncture & Skin Rejuvenation Center

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
(month) (day) (year)

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ # of Children \_\_\_\_\_

Social Security Number: \_\_\_\_\_ (optional)

Driver's License or  
Photo ID REQUIRED: \_\_\_\_\_  
(State) (ID Number)

Home Address: \_\_\_\_\_

Home Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Number: \_\_\_\_\_

### WHO WOULD WE CALL IN CASE OF EMERGENCY?

NAME: \_\_\_\_\_

EMERGENCY TELEPHONE NUMBER: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Please list any known allergies \_\_\_\_\_

\_\_\_\_\_

**Acupuncture by Fran Ammons**  
**121 Edinburgh Dr. South, Suite 202**  
**Cary, NC 27511**  
**919-481-6777**

**Notice of Patient Privacy Practices**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

A complete, detailed copy of HIPAA is available to read in our lobby. If you wish to take a copy for your records please ask the receptionist and they would be glad to assist you.

**Authorization to use and disclose your protected health information for a special purpose**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I authorize my Protected Health Information to be used or disclosed for:**

Yes	No	Situation
		Health Insurance Claim Processing
		Updating my primary care physician
		Leaving test results on my answering machine
		Leaving appointment reminders on my answering machine
		Leaving billing messages on my answering machine
		Leaving messages via email. Email address:

**I authorize the following people to receive my protected health information:**

**(Examples include another doctor besides your primary care physician, your spouse, another family member)**


I understand that if my health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that my revocation is not effective to the extent that the persons I have authorized to use and or disclose my protected health information have acted in reliance on this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. However, I understand I will be responsible to pay for my medical care in full and file claims myself if I refuse disclosure to my health insurance company.

I have had the chance to read the content of this authorization form and I agree with all statements made herein. I give this authorization voluntarily.

This authorization expires one year from date below unless revoked.

\_\_\_\_\_  
Signature of patient or patient's personal representative                      Relationship to patient

Date: \_\_\_\_\_

**You Have A Right To A Copy Of This Form After You Sign It – Please Ask And One Will Be Created**

# Fran Ammons, Licensed Acupuncturist

## Practices Regarding Disclosure of Patient Health Information

*Your health information will be routinely used for treatment and insurance reporting, and your consent, or the opportunity to agree or object, is not required in these instances:*

- **Treatment-** Information obtained by your practitioner by this office will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- **Insurance-** You may receive a receipt from this office upon request, in order to file for insurance re-imbusement or for other record keeping. This receipt is written documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.

*In addition, the following disclosures are required by law and do not require your consent:*

- **Food and drug Administration (FDA)-** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation-** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health-** This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by to report communicable disease, injury, or disability.
- **Law Enforcement-**(1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of health information to appropriate health agencies, public health authorities, or attorneys.

*It is Fran Ammons' practice to consider the following as routine uses and disclosures for which specific authorization will not be requested.* You have the right to request restrictions on these uses. Otherwise, the office will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Communications with family -** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible with your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

Notice of Cancellation

From: Acupuncture by Fran Ammons  
121 Edinburgh Dr. South  
Suite 202  
Cary, N. C. 27511  
919-481-6777

To: New Patients

Please be advised that any appointments scheduled in your behalf have been scheduled specifically for you to enjoy the gift of acupuncture/massage and have an opportunity to experience a new level of wellness.

It is very important that a **48 hour notice of cancellation/rescheduling** be given **Monday-Friday during office hours between 11:15am-5:00pm. Please do not leave cancellation notices on the answering service.**

In the event a 48 hour notice is not given, your account will be charged for the amount of the scheduled office visit. Reminder calls will be attempted but not guaranteed in order to avoid any fees. The appointment made is **YOUR** responsibility to keep. **This office policy is very important and will be enforced.**

**Your appointment date can be changed once.** Any/all changes after that will carry an additional \$10 fee. Due to the increase in patient load, if an appointment date is cancelled/changed, there may be a delay of two or more weeks in rescheduling your appointment. **Please do not leave rescheduling notices on the answering service.**

**It is most important to speak with the office personnel directly for any cancellation/rescheduled appointments.**

Thank you for choosing the Acupuncture Clinic for your healthcare. We look forward to working with you. Be well.

Blessings,

Fran Ammons, LAc,B.S.,MSOM  
Facial Specialist

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Permission to use photos for marketing  
purposes and publications**

I, \_\_\_\_\_, give to The Acupuncture  
and Skin Rejuvenation Center of Cary, NC, permission

to use my photos for marketing and advertising purposes and  
publications. With this permission, no names, addresses, and/or any

personal information will be published or sold by the above Center.

**Thank you in advance!**

**Fran Ammons, Owner and  
Licensed Acupuncturist**

**Signed on this date** \_\_\_\_\_

**Signature of skin rejuvenation patient** \_\_\_\_\_

The Acupuncture and Rejuvenation Center

Cary, N.C.

CONSENT FORM

1. I, \_\_\_\_\_, hereby give my consent for a series of face/body rejuvenation massage treatments to be administered by Fran Ammons, Licensed Acupuncturist.
2. I understand that face/body rejuvenation massage uses micro-current radio waves along with a high frequency energy light emitting technique used for lymphatic drainage of various toxins trapped in the various layers of skin in the face and body. NO SIDE EFFECTS HAVE OCCURRED WITH THIS FACE/BODY REJUVENATION MASSAGE PROCEDURE.
3. I do not have or wear any mechanical devices, ie, pacemakers, spinal stimulators, or any other devices that could be effected or malfunction during the treatments due to the use of the use of the massage equipment devices.
4. I AM ALLERGIC to the following facial/body products, ie, creams, lotions, or any other foods/products:
5. I AM NOT allergic to any facial/body products, ie, creams, lotions, or other facial or body products.
6. I have removed MY CONTACT LENSES & JEWELRY. \_\_\_yes (please check)
7. I understand and accept that no guarantee has been made by The Acupuncture and Skin Rejuvenation Center or its employees, independent contractors, or skin therapy cosmetologists or specialists, concerning the outcome of face/body rejuvenation massage treatments.

DATE \_\_\_\_\_

Patient Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_