

OHTC Health Care System, PLLC

Patient Questionnaire

(If you are unable to answer the question, please leave the space blank)

Patient's Name: _____ Sex: _____ Birth Date: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Tel (Home): _____ Tel (Office): _____
Occupation: _____ Insurance: Yes No If the answer is yes, which one? _____
Referred by: _____

How did your pain begin? (Answer below)

Following an accident Following surgery Following an illness

Began without any relation to anything It is related to other circumstances

(Explain) _____

How long ago did the pain begin? _____ Where did it start? _____

Where does it hurt now? _____ What type of work do you do? _____

Is your pain related to your job? Yes No (If the answer is yes,
please explain) _____

How many hours do you sleep a day? _____ How many hours do you work a day? _____

Have you ever had related present pain before? Yes No

Did you receive any other treatment from another doctor with the same symptoms? Yes No

(If the answer is yes, please explain) _____

Do you take any kind of medication or drugs? Yes No (If the answer is yes,

Please explain) _____

Are you allergic to any of the following: Foods Plants Medicine Other

If you are allergic to any of the above, please explain: _____

Any other diseases? Yes No (If the answer is yes, please explain)

Are you currently pregnant? Yes No If answer is yes, how many months? _____

I have been evaluated by another physician for the condition being treated within six months before the
acupuncture was performed. Yes No

I understand that the acupuncturist is required to refer me to an other physician if no substantial
improvement occurs in the condition being treated after thirty (30) days or (20) treatments, whichever comes
first. It is my responsibility and choice to follow this advice.

Signed: _____ Date: _____

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except
when you have authorized us to do so.

OHTC Health Care System, PLLC

Eastern Medicine has been practiced for over five thousand years throughout the world and its effects have been approved for treating many conditions.

Consent for Eastern Medicine Treatment

I, the undersigned, realize that these techniques of acupuncture, which may be applied to me, including herbal remedies, needles with or without electric stimulation, moxibustion, acupressure and tai chi therapy, electrical devices, and cupping (phlebotomy) may be from Korea, China, Japan, or America.

1. **Acupuncture or Electric Stimulation:** A method of treatment using well-sterilized disposable needles to pierce the skin. There will be no risk factors or serious side effects.
2. **Moxibustion, Heating or Cold Pack:** Moxa wool is used to warm the Acupuncture points. When moxibustion is used, there is no chance of any burn.
3. **Acupressure or Tai Chi Therapy:** Acupressure is used with the following methods such as pressing acupuncture points with the fingers, elbows, or palms, and manipulation of the joints. This method works with four groups including the meridian group, the acupoint group, the muscle group, and the joint group. Tai Chi therapy is a modified exercise that is provided to the patient for certain disorders.
4. **Herbal Remedies:** Uses herbs to help with some internal disorders, cleansing, and improving general health conditioning remedies. There is no hazard to your health. The tea is provided in disposable packs using a well sterilized process to extract the herb. Also, the pills provided are well sterilized and safe, personally produced for certain disorders.
5. **Cupping (Phlebotomy):** Cupping techniques are used for certain problems such as sprains or strains. Phlebotomy draws blood to be sent to a lab for analyzing certain diagnosis.
6. **Insurance:** This office will be happy to complete your insurance forms. However, each patient is responsible for payment of the fees to the clinic and any reimbursement by the insurance company will be strictly between the patient and their company.

Patient Billing Acknowledgement "Non-Covered Services"

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment. The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products. I agree to pay for these non-covered services.

I understand that I must be diligent and follow the instructions given by the doctor to protect myself and maximize treatment of my condition. The nature of the treatment has been explained to me and I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment, or series of treatments. Of course, every effort will be made to achieve success.

I realize that I may withdraw from the treatment at any time. Therefore, I, the above patient, do hereby for myself, and my Doctors, waive, release, and forever discharge any and all rights and claims whatsoever, for any damages which I may have.

Patient's Signature: _____

Date: _____

OHTC Health Care System, PLLC

PATIENT CONFIRMATION OF RECEIPT AND NOTICE OF PRIVACY PRACTICES

Note: Signing This Acknowledgment is at the Patient's Discretion

I, _____ have received a copy of this Clinic's Notice of Privacy Practices.

Please Print Name
Signature
Date

PATIENT'S CONSENT REGARDING USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A:

PATIENT AUTHORIZING THIS CONSENT:

Name:	Patient #:
Address:	Tel: E-mail:
	Social Security #:

SECTION B:

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare treatments, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the following Privacy

Officer:

Dr. Edward Song, OHTC Health Care System, PLLC
2625 Old Denton Rd., Suite 546, Carrollton, TX 75007 Tel: 972-608-8877

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care treatment.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's or Legal Guardian's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

OHTC Health Care System, PLLC

E-mail or fax Authorization Agreement

The _____ May choose to discontinue e-mail or fax communication at any time.

Do not use e-mail or fax

Privacy and security of e-mail

Do not use e-mail or fax to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer 'system may be viewed by your employer.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Do use e-mail or fax

The OHTC Health Care System, PLLC cannot and does not guarantee the privacy or security of any messages being sent over the internet or by fax. There is the potential that e-mail sent over the internet or by fax can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail or fax.

This document along with OHTC Health Care System, PLLC's "Notice of Privacy Practice" constitutes a notice of privacy practices for e-mail use as required by the Texas State Board of Medical Examiners.

Physician e-mail address: Doctor@ohtc.com

Office Fax Number: 972-245-8888

Patient e-mail address: _____ Patient Fax: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail or fax. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail or fax as one form of communication with my physician and his/her associates, technicians and other health care providers.

You will be given a copy of this signed form to keep for your records.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____