



**Gigi Klimick Pereira, L.Ac.**  
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### **Notice of Privacy Policies**

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Klimick Acupuncture.

**Legal Responsibilities of Klimick Acupuncture:** As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

**Protected Health Information Use and Disclosure:** Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

**Treatment:** Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

**Payment:** Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**Healthcare Processes:** We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

**Person Involved In Care:** In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare.

**Marketing Health-Related Services:** The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

**Required By Law:** Your protected health information may be used or disclosed if required by law.

**Abuse or Neglect:** As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

**National Security:** Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

**Appointment Reminders:** Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whoever referred you to our practice.

### **Patient Rights**

**Access:** At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

**Disclosure Accounting:** Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

**Restrictions:** You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**Alternative Communication:** Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

**Amendment:** You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

**Electronic Notice:** If you receive a notice electronically, you are entitled to receive the notice in writing as well.

### **Questions and Complaints**

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

## Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture by licensed acupuncturist, Angela “Gigi” Klimick Pereira. I understand that acupuncturists practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body’s physiological functions. I am aware that certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. 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.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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## **Notice of Privacy Policies and Patient Rights**

I have read and understood the HIPAA privacy policies of Klimick Acupuncture. I acknowledge that I have had an opportunity to ask questions about it and all questions I have asked have been fully answered.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient (if applicable):** \_\_\_\_\_

**Contact Information**

May we leave a message at your home voice mail/answering machine? Y N

If no, where? \_\_\_\_\_

May we send information to your home address? Y N

If no, where? \_\_\_\_\_

In case of emergency please contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

How did you hear about Klimick Acupuncture? \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

*Would you like to receive Klimick Acupuncture's quarterly e-newsletter?*

*Yes, please*     *No, thanks*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Client Health History

*The following information will be used by Gigi Klimick Pereira, L.Ac., M.Ac. as part of your confidential record. No information contained herein will be released to third parties without your expressed consent. Please let us know if you have any concerns about the privacy of your records.*

Name \_\_\_\_\_

Name you prefer to be called \_\_\_\_\_

Occupation \_\_\_\_\_

Relationship status \_\_\_\_\_ Do you have children? \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

Other healthcare providers you use on a regular basis and reason:

_____	Phone _____
_____	Phone _____
_____	Phone _____

Please describe how you would like acupuncture to help you:

\_\_\_\_\_  
\_\_\_\_\_

Please list any particular questions or concerns you have regarding acupuncture treatment: \_\_\_\_\_

Please check the box if YOU have been diagnosed with the following. Please circle the box if a blood relative has been diagnosed with them.

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholism/Drug Addictions | <input type="checkbox"/> High Blood Pressure     |
| <input type="checkbox"/> Asthma/Lung Disease        | <input type="checkbox"/> Hepatitis/Liver Disease |
| <input type="checkbox"/> Bleeding Disorders         | <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Mental Illness          |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Epilepsy/Seizures          | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Other _____             |

Please list any hospitalizations/surgeries and approximate date: \_\_\_\_\_

Please describe any major illnesses, accidents or physical/emotional traumas? \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list all over-the counter drugs, vitamins, herbs or supplements you are currently taking: \_\_\_\_\_

Please list any allergies you have (medications, foods or environmental): \_\_\_\_\_

Please describe your usual physical activity/exercise: \_\_\_\_\_

Please give an example of your meals on a typical day:

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>

How many servings per day do you have of the following?

Coffee: \_\_\_\_\_

Caffeinated Tea: \_\_\_\_\_

Soft Drinks (diet/regular): \_\_\_\_\_

Sweets: \_\_\_\_\_

Fast/fried food: \_\_\_\_\_ day/week

Cigarettes: \_\_\_\_\_

Other tobacco: \_\_\_\_\_

Beer/wine: \_\_\_\_\_ day/week

Liquor: \_\_\_\_\_ day/week

Recreational drugs (please specify): \_\_\_\_\_

\_\_\_\_\_ day/week

Do you have a spiritual practice or orientation? If so, please describe briefly:

\_\_\_\_\_  
\_\_\_\_\_

Please check any statements that are generally true for you:

- |   |   |
|---|---|
| <input type="checkbox"/> I feel well rested when I awaken.    | <input type="checkbox"/> I frequently feel fearful or cautious.                                 |
| <input type="checkbox"/> I often feel irritable or angry.     | <input type="checkbox"/> I have scary dreams or thoughts.                                       |
| <input type="checkbox"/> Little things often annoy me.        | <input type="checkbox"/> I relax easily.  |
| <input type="checkbox"/> It's difficult to make decisions.    | <input type="checkbox"/> I have panic attacks.  |
| <input type="checkbox"/> I enjoy myself.                      | <input type="checkbox"/> I feel depressed often.  |
| <input type="checkbox"/> I feel lonely.                       | <input type="checkbox"/> I cry frequently.  |
| <input type="checkbox"/> I have good relationships.           | <input type="checkbox"/> I feel anxious a lot.  |
| <input type="checkbox"/> I feel well supported by others.     | <input type="checkbox"/> I have a good balance between work, family, leisure and personal time. |
| <input type="checkbox"/> I feel like I have enough.           | <input type="checkbox"/> I'm having trouble at work or with my family/partner.                  |
| <input type="checkbox"/> It's hard to concentrate.            | <input type="checkbox"/> I have sought counseling or psychiatric help.                          |
| <input type="checkbox"/> I worry a lot.                       |   |
| <input type="checkbox"/> I have experienced significant loss. |   |
| <input type="checkbox"/> I have a satisfying spiritual life.  |   |
| <input type="checkbox"/> I feel respected.                    |   |

Please **check** any of the following symptoms/statements you have experienced in the past year. Please **circle** any you are currently experiencing, or would particularly like to discuss.

***General***

- Fatigue
- Fevers
- Night sweats
- Changes in mood

***Musculoskeletal***

- Neck pain
- Jaw pain (TMJ)
- Arm/shoulder/wrist pain
- Back pain
- Hip pain
- Leg/ankle/foot pain
- Joint stiffness
- Joint swelling
- Muscle spasm/stiffness
- Tendon/ligament problems

***Skin***

- Dry skin
- Acne/pimples
- Eczema
- Rashes/hives
- Itching
- Easy bruising
- New or changing moles

***Head/Eyes/Ears/Nose/Throat***

- Dizzy spells/fainting/vertigo
- Seizures/convulsions
- Shaking/trembling
- Frequent headaches
- Severe headaches
- Difficulty with vision
- Red/itchy eyes
- Dry eyes
- Floaters
- Difficulty hearing
- Ringing in ears
- Nosebleeds
- Sinus infections
- Nasal congestion/runny nose
- Mouth/lip sores
- Bad taste in mouth
- Difficulty with teeth
- Sore throat
- Hoarseness
- Allergies
- Frequent colds
- Swollen glands

**Cardiovascular**

- Irregular heartbeat/palpitations
- Heart murmur
- Chest pain or tightness
- Pressure in chest
- High blood pressure
- Low blood pressure
- Varicose veins
- Swelling of feet/ankles
- Numbness
- Cold hands/feet

**Respiratory**

- Shortness of breath
- Wheezing
- Dry cough
- Wet cough with phlegm
- Coughing of blood
- Asthma

**Gastro-Intestinal**

- Difficult swallowing
- Nausea
- Vomiting
- Belching/gas
- Indigestion
- Bloating after eating
- Ulcers
- Abdominal pain
- Constipation
- Diarrhea
- Black or bloody stool
- Hemorrhoids
- Heartburn/acid regurgitation
- Change in appetite
- Gained/lost 10 pounds or more in last 6 months
- Anorexia/bulimia

**Genito-Urinary**

- Urinate more than 5x per day
- Urinate more than 2x at night
- Pain or burning with urination
- Leaking of urine/incontinence

- Blood in urine
- Bladder/Kidney infection
- Frequent urinary tract infections
- Sexually active
- Use contraception
- Sexually transmitted diseases
- Sexual difficulties
- Satisfied with sex life

**For Women:**

\_\_\_\_\_ Age at first menstrual period  
 \_\_\_\_\_ Date of last menstrual period  
 \_\_\_\_\_ Date and result of last pap smear

- Menstruating
- Irregular menstrual cycle
- Cramping with menstruation
- Heavy bleeding
- Bleeding between menstruation
- Clots
- Vaginal discharge
- Frequent yeast infections
- Breast lumps
- Discharge from nipples
- Soreness or bloating
- Mood changes related to menstruation
- Endometriosis
- Ovarian cysts
- Infertility
- Uterine prolapse
- Vaginal dryness
- Hot flashes

\_\_\_\_\_ Number of pregnancies  
 \_\_\_\_\_ Number of living children

**For men:**

- Discharge from penis
- Lumps or swelling on testicles
- Prostate trouble
- Infertility
- Erectile dysfunction
- \_\_\_\_\_ Number of living children

## PHYSICIAN CARE FORM

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

I have been diagnosed with the following condition(s) (*check all that apply & provide name and phone number of physician*):

- Hypertension (high blood pressure) \_\_\_\_\_
- Cardiac condition \_\_\_\_\_
- Acute, severe abdominal pain \_\_\_\_\_
- Undiagnosed neurological changes \_\_\_\_\_
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months \_\_\_\_\_
- Suspected bone fracture or dislocation \_\_\_\_\_
- Suspected systemic infection \_\_\_\_\_
- Serious hemorrhagic (bleeding) disorder \_\_\_\_\_
- Acute respiratory distress without a previous history \_\_\_\_\_
- Pregnancy \_\_\_\_\_
- Cancer \_\_\_\_\_
- Other: \_\_\_\_\_

I am currently under the care of a physician for (*check all that apply*):

- Hypertension (high blood pressure)
- Cardiac condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions.

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Phone: \_\_\_\_\_