

ACUPUNCTURE CENTER  
for Reproductive Health

254 US Highway Rt. 202/206 □ Pluckemin, NJ 07978 □ (908)719-1362 □ www.acrh.net

**Consent for Purposes of Treatment, Payment  
and Health Care Operation**

I consent to the use or disclosure of my identifiable health information by Acupuncture Center for Reproductive Health (hereafter noted as ACRH) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at ACRH may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. ACRH is not required to agree to the restrictions that I may request. However, if ACRH agrees to a restriction that I request, the restriction is binding upon ACRH.

I have the right to revoke this consent, in writing, at any time except to the extent that ACRH has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review ACRH's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ACRH. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and ACRH with respect to my identifiable health information.

ACRH reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

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Acupuncture Center for Reproductive Health  
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a certified acupuncturist at the Acupuncture Center for Reproductive Health (ACRH). I understand that acupuncturists practicing in the state of New Jersey are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. All patients must have a physician's diagnosis prior to treatment.

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 may result. I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy and heat lamp are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, vomiting, headache, diarrhea, rashes, hives, tingling of the tongue and the possible aggravation of symptoms existing prior to herbal treatment. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the ACRH as soon as possible.*

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

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

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

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.

Signature: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_

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Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work/cell phone \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_  
Marital status \_\_\_\_\_ Number & ages of children \_\_\_\_\_  
Occupation \_\_\_\_\_  
Email \_\_\_\_\_  
Personal physician \_\_\_\_\_  
Date of last physical examination \_\_\_\_\_  
In emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Referred by \_\_\_\_\_  
Have you ever had **acupuncture** before? Y  N   
How did you hear about our clinic? \_\_\_\_\_

MAJOR COMPLAINT (Reason for Visit)

\_\_\_\_\_

How long have you had this complaint? \_\_\_\_\_

Have you ever received treatment for this condition? If yes, when? By whom?  
\_\_\_\_\_

What was the diagnosis? What were the results of the treatment?  
\_\_\_\_\_

Has the condition gotten:  Better  Worse  About the same

What makes it better?  
\_\_\_\_\_

What makes it worse?  
\_\_\_\_\_

Describe what caused it or how it started:  
\_\_\_\_\_

FAMILY MEDICAL HISTORY:

- Cancer  Diabetes  High or Low Blood Pressure  Heart Trouble  TB  Allergies  Kidney Disease  
 Epilepsy  Asthma  Liver Disease  Ulcers  Sinus Problems  Eye Disease  Arthritis  Alcoholism  
 Spinal Problems  Mental Disorders  Drug Addiction  Other  
\_\_\_\_\_

PERSONAL MEDICAL HISTORY

(Include date) Major Surgeries - Illnesses - Diseases - Accidents  
\_\_\_\_\_

CONTAGIOUS DISEASES

(Circle if you have or ever had one of the following):  
 HIV +  AIDS  Hepatitis  Venereal Disease  Herpes  Other \_\_\_\_\_

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ALLERGIES

(Drugs, chemicals, food, animals, seasonal, etc.)

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MEDICATIONS PRESENTLY TAKING:

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EXERCISE:

Never  Little  Moderate  Heavy  Type of exercise \_\_\_\_\_

NEUROPSYCHOLOGICAL:

Happy  Easily irritable  Difficulty expressing anger  Angry  Cry easily  Poor memory  Tics  
 Tremors  Depression  Easily effected by stress  Restless  Anxious  Other \_\_\_\_\_

DIET (Typical Foods):

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APPETITE:

Up and down  Poor  Good  Hungry a lot  Loss of taste  Hunger with no desire to eat  
Do you normally crave  Sweets  Sour food  Salty food  Bitter food  Spicy food

WEIGHT:

Normal  Underweight  Overweight  Recent gain  Recent loss

ENERGY:

Up and down  Low  Normal  Excess  Low after eating  Heavy feeling in 4 limbs  
 Tired in the afternoon  Other \_\_\_\_\_

BODY TEMPERATURE:

Feel Warm/Hot often  Flushed face  Feel warmer late afternoon and night  Sweat easily  Night sweats  
 Feel cold often  Warm palms  Warm soles  Alternate chills and fever  Profuse perspiration  Never  
sweats  Hate the cold  Hate when it is windy  Hate the heat  Cold hands and feet  Cold limbs  Normal  
 Sweat on chest  Other \_\_\_\_\_

DIGESTION:

Indigestion  Bloating  Heartburn  Nausea  Vomiting  Full feeling or distention  Belching/hiccuping  
 Abdominal pain or cramps  Gas  Difficulty digesting fatty or oily foods  Bitter taste in mouth upon waking  
 Sticky/wet feeling in mouth  Normal  Other \_\_\_\_\_

BOWELS:

Loose stool  Diarrhea- foul smelling  Diarrhea- no smell  Diarrhea upon waking  Hemorrhoids  Dry, hard  
stool  Constipation  Undigested food in stool  Pain or cramps  Mucous in stool  Blood in stool  Use  
laxatives  Normal  Other \_\_\_\_\_

URINATION (three to four times per day is normal):

Frequent  Burning  Bladder infections  Urgency  Nighttime  Incontinence  Cloudy  Copious  Scanty  
 Dark yellow color  Dribbling  Pale/clear color  Kidney stones or infections  Normal  Other \_\_\_\_\_

THIRST:

Lack of thirst  Crave cold drinks  Thirsty but no desire to drink  Prefer hot drinks  Thirsty but likes to sip  
fluid  Excessive  Normal  Other \_\_\_\_\_

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SLEEP:

- Difficulty falling asleep Lots of dreams Tired when get up in morning Nightmares Sleep too much  
Waking during the night Restless Wake very early Normal Other \_\_\_\_\_

HEADACHES - DIZZINESS:

- Headaches Migraines Vertigo Dizziness Motion sickness Poor balance Faint easily Muzzy head  
Poor memory Where are the headaches located? \_\_\_\_\_  
Does it happen at a particular time (before period, when stressed etc) \_\_\_\_\_

SKIN:

- Dry Hives Itching Oily Cystic Acne Red acne Bruise easily Rashes Damp Greasy  
Edema/swelling Areas of numbness Cuts heal slowly Normal Other \_\_\_\_\_

HAIR:

- Dry Oily Dandruff Falling out Early grey Normal Other \_\_\_\_\_

NAILS:

- Soft Spots Grow slowly Ridges and lines Purple Normal  
Weak/Break easily Pale Other \_\_\_\_\_

EYES:

- Blurry Eyelids swollen Red Dry Itch Poor night vision Twitch Pain Color blindness  
Tear easily Floaters Dark circles under Normal Other \_\_\_\_\_

EARS:

- Poor hearing Ringing (high pitch) Ringing (low pitch) Discharges Ear aches Normal  
Other \_\_\_\_\_

NOSE:

- Stuffy nose Hay Fever Sneeze a lot Environmental sensitivity Clear runny mucous Yellow mucous  
Bleeding Loss of smell Blow nose a lot Sinusitis Rhinitis Normal Other \_\_\_\_\_

MOUTH & THROAT:

- Dry Gum problems Frequent colds Difficulty swallowing TMJ Feel lump in throat Chapped lips  
Mouth/tongue sores Normal Other \_\_\_\_\_

RESPIRATORY:

- Shortness of breath Difficulty inhaling Difficulty exhaling Sighing Chest pain Dry cough  
Asthma Difficulty breathing Cough with phlegm Weak Voice Sneezing Cough with blood  
Tightness in chest Wheezing Normal Other \_\_\_\_\_

CARDIOVASCULAR - CIRCULATION

- Diagnosed heart problems Palpitations Low blood pressure High blood pressure Bleed easily Facial swelling  
High cholesterol Varicose veins Ankle/leg swelling Chest pain Bruise easily Hand swelling  
Irregular heart beat Numbness in extremities Normal Other \_\_\_\_\_

PAIN:

- Low back Shoulder Muscle weakness Sciatica Hands or wrists Muscle cramps Rib pain  
Upper back Hips Muscle twitching or spasm Mid back Knees Worse with Damp weather  
Neck Foot or ankle Nerve Spine Arthritis Flank area Other \_\_\_\_\_

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS?

\_\_\_\_\_

\_\_\_\_\_

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\*\*\*\*\* FOR WOMEN ONLY \*\*\*\*\*

Are you or might you be pregnant? YES NO MAYBE  
Are you experiencing low sex drive? YES NO  
Do you have regular pap tests? YES NO  
Do you have facial hair or excess body hair? YES NO  
Do you have vaginal dryness? YES NO  
Do you have any nipple discharge? YES NO

MENSTRUAL CYCLE:

(Please check all that apply and explain as applicable)

Age started \_\_\_\_\_ Days of flow \_\_\_\_\_

Cycle Details:

Always early (21 days or less) Always late (more than 35 days) Irregular Normal (approx. 28 days)  
Spotting between periods Spotting before period Bleeding stops and starts

Menstrual blood color:

Dark color Light red/pink Purple Bright red Brown/black

Pelvic pain/cramps:

None  During menses  Before menses  After menses  At ovulation  During intercourse  
 With bowel movements  With urination  Felt in external genital area

Pelvic pain/cramps are:

Mild  Moderate  **Severe**  Stabbing  Dull/achy Feel better with heat Improve with rest  
Improve with exercise  Better after passing clot Relieved by pressure Worsened by pressure  
Genital/uterine pain that is worse with cold or better with heat.

Blood flow is:

Heavy flow Scanty flow Thick blood Thin watery blood Large clots (quarter size)  
Small clots (pea size) Dark colored clots Bright red clots

Premenstrual symptoms - mark with B (before), D (during) or A (after) period:

\_\_\_ Water retention \_\_\_ Abdominal bloating \_\_\_ **Painful or tender breasts** \_\_\_ **Breast lumps** \_\_\_ Nausea  
\_\_\_ Emotional changes \_\_\_ Lump in throat feeling \_\_\_ Constipation \_\_\_ Diarrhea \_\_\_ Insomnia  
\_\_\_ Tightness in chest \_\_\_ Backache Other \_\_\_\_\_

VAGINAL DISCHARGES:

Yellow Thick Bad odor White Greenish Clear   
Other \_\_\_\_\_

FERTILE CERVICAL MUCUS

Lasts 1-3 days Scanty Absent

MENOPAUSE PROBLEMS?

Age menarche started \_\_\_\_\_

Explain symptoms: \_\_\_\_\_  
\_\_\_\_\_

PREGNANCIES:

Total number \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of children \_\_\_\_\_ Number of abortions \_\_\_\_\_

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

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

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GYNECOLOGICAL HISTORY AND OPERATIONS

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WHAT METHOD OF BIRTH CONTROL DO YOU NOW USE?

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WHAT METHOD OF BIRTH CONTROL HAVE YOU USED IN THE PAST?

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\*\*\*\*\* FOR MEN ONLY \*\*\*\*\*

URO-GENITAL:

(Please check and explain as applicable)

- Low sperm count Nocturnal emissions Premature ejaculation Prostate problems Sperm motility problems  
Low sex drive Unusually high sex drive Erectile dysfunction

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## 1. IDENTIFYING INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
 Significant Other Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
 Primary Care MD \_\_\_\_\_  
 Physician Diagnosis \_\_\_\_\_  
 Primary GYN or RE \_\_\_\_\_  
 How long have you been attempting conception? \_\_\_\_\_ Marital Status \_\_\_\_\_

## 2. RACE (You)

- Caucasian     Hispanic  
 Asian         African American  
 Other ( \_\_\_\_\_ )

## Significant Other

- Caucasian     Hispanic  
 Asian         African American  
 Other ( \_\_\_\_\_ )

## E THNICITY

- Ashkenazi Jew     Southeastern Asian  
 Greek/Italian     Ashkenazi Jew         Southeastern Asian  
 Greek/Italian

## 3. PREGNANCY HISTORY

Times pregnant \_\_\_\_ Term births \_\_\_\_ Premature births \_\_\_\_ Miscarriages \_\_\_\_ Elective abortion \_\_\_\_  
 Adopted children \_\_\_\_ Ectopic \_\_\_\_

Date	Months to conceive	Infertility Treatment	Complications
1.			
2.			
3.			

## 4. CONTRACEPTIVE USE

Type	Duration of use	Reason discontinued
1.		
2.		
3.		

## 5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation/Reason for Hospitalization	Physician
1.			
2.			
3.			

## 6. MEDICATIONS *List all prescriptions used during the past year*

Dates used	Dose and Frequency	Reason
1.		
2.		
3.		

## 7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		
3.		

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**8. MENSTRUAL/HORMONAL**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of last two menstrual periods \_\_\_\_/\_\_\_\_/\_\_\_\_ and \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have a hormonal disorder, please specify type and treatment: \_\_\_\_\_

Do you have or have you had? (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hot flushes         | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Breast discharge    | <input type="checkbox"/> Increased acne          | <input type="checkbox"/> Increased facial/ body hair |
| <input type="checkbox"/> Visual disturbance  | <input type="checkbox"/> Weight increase >10 lbs | <input type="checkbox"/> Thyroid disorder            |
| <input type="checkbox"/> Poor sense of smell | <input type="checkbox"/> Weight loss > 10 lbs    | <input type="checkbox"/> Autoimmune disease          |
| <input type="checkbox"/> Chronic headache    | <input type="checkbox"/> Special dietary habits  | <input type="checkbox"/> Extraordinary stress        |
| <input type="checkbox"/> Head trauma         | <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Psychiatric treatment       |

Please explain a "Yes" answer: \_\_\_\_\_

**9. GYNECOLOGIC / INFECTION**

Do you have or have you had?

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Gonorrhea                                | <input type="checkbox"/> Ovarian cysts         |
| <input type="checkbox"/> Chlamydia        | <input type="checkbox"/> Colitis/ enteritis | <input type="checkbox"/> Syphilis                                 | <input type="checkbox"/> Toxoplasmosis         |
| <input type="checkbox"/> Endometriosis    | <input type="checkbox"/> Uterine fibroids   | <input type="checkbox"/> Mycoplasma                               | <input type="checkbox"/> Cytomegalovirus (CMV) |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Trichomonas        | <input type="checkbox"/> Ureaplasma                               | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Cervicitis       | <input type="checkbox"/> Vaginitis          | <input type="checkbox"/> Genital warts                            | <input type="checkbox"/> Abnormal uterus shape |
| <input type="checkbox"/> Genital herpes   | <input type="checkbox"/> Abnormal Pap       | <input type="checkbox"/> Cryo (freezing) or surgery of the cervix |  |
| <input type="checkbox"/> HIV +            | <input type="checkbox"/> AIDS               | <input type="checkbox"/> Hepatitis                                | <input type="checkbox"/> Other _____           |

**10. OTHER HISTORY**

Your occupation: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_

Cigarettes:  Yes  No How many packs per day? \_\_\_\_\_

Alcohol:  Yes  No How many drinks per week? \_\_\_\_\_

Illicit drugs:  Yes  No Type and amount: \_\_\_\_\_

Caffeine  Yes  No Drinks per day: \_\_\_\_\_

Electric blanket use:  Yes  No

Toxic exposure:  Yes  No

Hot tub or sauna use:  Yes  No

Radiation exposure:  Yes  No

**15. MALE HISTORY:**

Medications \_\_\_\_\_

Reproductive surgery: \_\_\_\_\_

Illnesses: \_\_\_\_\_

STDs: \_\_\_\_\_

Mumps  Yes  No

Testicular trauma  Yes  No

Smoker  Yes  No How many packs per day? \_\_\_\_\_

Impotence  Yes  No

Alcohol  Yes  No How many drinks per week? \_\_\_\_\_

Allergies: \_\_\_\_\_

Ejaculatory Disorder: \_\_\_\_\_

Seen urologist for infertility?  Yes  No

If yes: Physician name and location \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Fathered a child/pregnancy with another woman?  Yes  No If yes, when? \_\_\_\_\_ years ago

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**16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).**

Have you been treated for infertility previously?     Yes     No

If yes, who was your physician? \_\_\_\_\_

What cause of infertility was diagnosed? \_\_\_\_\_

What drugs have you taken for infertility? Please check all that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi      | <input type="checkbox"/> Antibiotics         |
| <input type="checkbox"/> Gonal F            | <input type="checkbox"/> Progesterone     | <input type="checkbox"/> Baby aspirin        |
| <input type="checkbox"/> Follistim          | <input type="checkbox"/> Lupron           | <input type="checkbox"/> Heparin             |
| <input type="checkbox"/> Repronex           | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids            |
| <input type="checkbox"/> Pergonal           | <input type="checkbox"/> Antagon          | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex           | <input type="checkbox"/> Parlodel         | <input type="checkbox"/> Other _____         |

Which of the following tests have you or your partner had performed? Please fill in latest results:

FSH \_\_\_\_\_

LH \_\_\_\_\_

Prolactin \_\_\_\_\_

Estradiol \_\_\_\_\_

DHEA-S \_\_\_\_\_

Testosterone \_\_\_\_\_

Progesterone \_\_\_\_\_

Hysterosalpingogram \_\_\_\_\_

Sonohystogram \_\_\_\_\_

Ultrasound \_\_\_\_\_

Laparoscopy, Hysteroscopy \_\_\_\_\_

Thyroid tests \_\_\_\_\_

Semen analysis \_\_\_\_\_

Antisperm antibodies \_\_\_\_\_

Varicocele repair \_\_\_\_\_

OTHER: \_\_\_\_\_

Have you ever undergone Artificial Insemination (IUI)     Yes     No

Have you ever undergone In Vitro Fertilization (IVF)?     Yes     No

If yes, how many?     1     2     3     4 or more

Did any lead to pregnancy?     yes     no     Live birth     miscarriage

Sperm was from:     partner     donor sperm

Eggs were from:     self     donor egg

How many eggs were retrieved with each cycle? \_\_\_\_\_

How many embryos survived up to the day of transfer? \_\_\_\_\_

Have you ever been on Clomid?     Yes     No

If yes, how many cycles?     1     2     3     4 or more

Outcome \_\_\_\_\_

Fertility Shots (natural cycle)     Yes     No

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## Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at our office include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that we gather and use:***

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 908-719-1362.

Yours truly,

Candace Jania, Dipl.Ac., C.A.  
1 Robertson Drive, Suite 21  
Bedminster, NJ 07921  
908-719-1362