Daniel J. Hudson, Lic Ac.

303 777 7891
yaoclinic.com
1305 S WASHINGTON ST, DENVER, CO 80210

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PLEASE PRINT LEGIBLY

GENERAL INFORMATION

Name: ______________________ Birthday: ____________ Social Security #: ______________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Occupation: ______________________ Cell ✆: ______________ Home ✆: ______________

E-mail: ______________________ Who referred you? ______________________

Emergency Contact: ______________________ Emergency ✆: ____________ Relationship: ______________

Do we have permission to leave detailed messages regarding your health on voicemail? ☐ YES ☐ NO

FAMILY HISTORY if any blood relative has suffered any of the following – please indicate which relative

☐ Tuberculosis _________	☐ Epilepsy _____________	☐ Arthritis _____________	☐ Hypertension___________
☐ Stroke ______________	☐ Diabetes _____________	☐ Gout ________________	☐ Alcoholism ____________
☐ Migraine ____________	☐ Cancer ______________	☐ Kidney Disease________	☐ Heart Attack ___________
☐ Mental Illness ________	☐ Allergy_______________	☐ Glaucoma ____________	☐ Asthma _______________

PRIOR SURGERY OR ILLNESS

Date:	Illness or operation:	Date:	Illness or operation:
____________	______________________________	____________	______________________________
____________	______________________________	____________	______________________________
____________	______________________________	____________	______________________________

MEDICATIONS

____
____
____

DRUG ALLERGIES

____
____
____

MEDICAL HISTORY

Chief Complaint(s): ____
____

Cause or how it started: ____

Is your condition due to an accident or an illness? ______________________________

Have you ever had this condition before? ☐ YES ☐ NO

Have you received treatment for this condition before? ☐ YES ☐ NO

If you received treatment, when, by whom, and what was the diagnosis? ______________________

What were the results of the treatment? ______________________________

What makes your condition better? ______________________________
____

What makes your condition worse? ______________________________
____

Additional Comments: ____
____
____

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MEDICAL HISTORY CONTINUED

Please read carefully the symptoms below. Check any and all that apply: ○ = past ☐ = present

Eye, Ear, Nose, and Throat
○ ☐ Decreased Hearing
○ ☐ Ringing in Ear
○ ☐ Ear Infections - Frequent
○ ☐ Dizzy Spells
○ ☐ Sensitive to Light
○ ☐ Eye Twitch
○ ☐ Eye Dryness
○ ☐ Failing Vision
○ ☐ Double or Blurred Vision
○ ☐ Eye Pain
○ ☐ Eye Infections - Frequent
○ ☐ Nose Bleeds - Recurrent
○ ☐ Sinus Trouble
○ ☐ Sore Throats - Frequent
○ ☐ Dry Mouth
○ ☐ Lump in Throat
○ ☐ Mouth/ Tongue Sores
○ ☐ Teeth Problems
○ ☐ Grind Teeth
○ ☐ Hayfever / Allergies
○ ☐ Hoarseness - Prolonged

Respiratory
○ ☐ Pneumonia / Pleurisy
○ ☐ Bronchitis / Chronic Cough
○ ☐ Asthma / Wheezing
○ ☐ Shortness of Breath:
On Exertion ☐ Lying Flat ☐
○ ☐ Difficulty Inhaling
○ ☐ Sigh Often
○ ☐ Cough
○ ☐ Cough with Phlegm
○ ☐ Cough with Blood

Circulatory
○ ☐ Heart Problems
○ ☐ Chest Pain
○ ☐ Convulsions / Seizures
○ ☐ Stroke
○ ☐ High Blood Pressure
○ ☐ Low Blood Pressure
○ ☐ Slow Heart Beat Rate
○ ☐ Irregular Heart Beat
○ ☐ Heart Murmur
○ ☐ Palpitations
○ ☐ Irregular Pulse
○ ☐ Ankle Swelling
○ ☐ Facial Swelling
○ ☐ Hand Swelling
○ ☐ Fainting Spells
○ ☐ Numbness/ Tingling
○ ☐ Leg Pain when Walking
○ ☐ Varicose Veins / Phlebitis

Digestion
○ ☐ Recent Loss of Appetite
○ ☐ Bitter Taste in Mouth
○ ☐ Nausea / Vomiting
○ ☐ Foul Breath
○ ☐ Constant Hunger
○ ☐ Difficulty Swallowing
○ ☐ Indigestion or Heartburn
○ ☐ Persistent Nausea / Vomiting
○ ☐ Peptic Ulcers
○ ☐ Abdominal Pain - Chronic
○ ☐ Hemorrhoids
○ ☐ Gall Bladder Trouble
○ ☐ Jaundice / Hepatitis
○ ☐ Hernia

Stool
○ ☐ Change in Bowel Habits
○ ☐ Diarrhea ○ ☐ Constipation
○ ☐ Colon Problems
○ ☐ Diverticulosis
○ ☐ Bloody or Tarry Stools
○ ☐ Burning Anus
○ ☐ Pain / Cramping
○ ☐ Undigested Food in Stool
○ ☐ Intestinal Worms

Urination
○ ☐ Urine Infections - Frequent
○ ☐ Burning
○ ☐ Cloudy
○ ☐ Urgent
○ ☐ Strong Smell
○ ☐ Painful Urination
○ ☐ Blood in Urine
○ ☐ Overnight Urination
○ ☐ Incontinence
○ ☐ Decrease in force of Urination
○ ☐ Kidney Stones
○ ☐ Venereal Disease
○ ☐ Urethral Discharge

General Symptoms
○ ☐ Chronic Fatigue
○ ☐ Weight Loss
○ ☐ Anemia
○ ☐ Bruise Easily
○ ☐ Cancer
○ ☐ Diabetes
○ ☐ Thyroid Disease
○ ☐ Tremor / Hands Shaking
○ ☐ Muscle Weakness
○ ☐ Headaches - Frequent
○ ☐ Dizziness
○ ☐ Vertigo

General Symptoms Continued
○ ☐ Sleeping - Difficulty
○ ☐ Night Sweats
○ ☐ Perspire without Exertion
○ ☐ Cold Hands / Feet
○ ☐ Warm Palms / Soles
○ ☐ Hot Flashes
○ ☐ Alternate Chills and Fever

Pain
○ ☐ Arthritis / Rheumatism
○ ☐ Back Pain - Recurrent
○ ☐ Sciatica
○ ☐ Neck Pain
○ ☐ Hand/ Wrists
○ ☐ Hip
○ ☐ Knee
○ ☐ Foot/ Ankle
○ ☐ Muscle Cramp
○ ☐ Bone Fracture / Joint Injury
○ ☐ Gout
○ ☐ Foot Pain
○ ☐ Cold Numb Feet

Skin
○ ☐ Rashes
○ ☐ Hives
○ ☐ Psoriasis / Eczema
○ ☐ Dry Skin
○ ☐ Oily Skin
○ ☐ Itching
○ ☐ Boils
○ ☐ Moles / Warts

Psychological
○ ☐ Nervousness
○ ☐ Depression
○ ☐ Memory Loss
○ ☐ Excessive Moodiness
○ ☐ Phobias
○ ☐ Mental Illness

Disease
○ ☐ Chicken Pox
○ ☐ Polio
○ ☐ Measles / German Measles
○ ☐ Rheumatic
○ ☐ Scarlet Fever
○ ☐ Mumps
○ ☐ Tuberculosis
○ ☐ Hepatitis
○ ☐ Venereal Disease
○ ☐ Herpes
○ ☐ HIV-Positive
○ ☐ AIDS
○ ☐ Other ________________

Habits
○ ☐ Alcohol _________ oz. / week
○ ☐ Smoking ________ cig. / day
○ ☐ Coffee / Tea _____ cups / day
○ ☐ Soft Drinks ______ cans / day
○ ☐ Recreational Drugs ________

Male - History
○ ☐ Reduced Sex Drive
○ ☐ Seminal Emission
○ ☐ Impotence
○ ☐ Discharge
○ ☐ Genital Pain
○ ☐ Prostate Problems
○ ☐ Pain/Burning during Urination
○ ☐ Dribbling Urine

Female - History
No. of Pregnancies ____________
No. of Live Births ____________
No. of Miscarriages____________
Birth Control Method____________
B.C. Pill Name ____________
○ ☐ Reduced Sex Drive
○ ☐ Irregular PAP Test
○ ☐ Facial or Excessive Body Hair

Menses
___ Age of Onset __ Days of Flow
☐ Age stopped
☐ Irregular
☐ Painful
☐ Heavy Flow
☐ Scanty Flow
☐ Dark Color
☐ Light Color
☐ Clotting
☐ Water Retention
☐ Abdominal Bloating
☐ Painful / Tender Breasts
☐ Emotional Changes
☐ Spotting between Periods
☐ Lump in Throat
☐ Constipation
☐ Diarrhea
☐ Chest Tightness
☐ Hormonal Problems
☐ Backache
☐ Sigh Often
☐ Vaginal Discharge
☐ Flushing / Menopause
☐ Other __________________

Allergies__________________
____
____

Other important information ____
____
____

I certify that above information is true and accurate to the best of my knowledge.

Patient Signature ________________________________ *Date* ____________________

(Parent or Guardian if a minor)

The above signed has read the disclosed form.

PATIENT FORMS

Metabolic Assessment

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PLEASE PRINT LEGIBLY

PART I

Name: ____ Age: ______ Sex: _____ Date: ___________________________

Please list the 5 major health concerns in your order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

PART II

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.*

CATEGORY I	0	1	2	3
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard, dry, or small stool	☐	☐	☐	☐
Coated tongue of "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Use laxatives frequently	☐	☐	☐	☐

CATEGORY II	0	1	2	3
Excessive belching, burping, or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

CATEGORY III	0	1	2	3
Stomach pain, burning, or aching 1- 4 hours after eating	☐	☐	☐	☐
Use antacids	☐	☐	☐	☐
Feel hungry an hour or two after eating	☐	☐	☐	☐.
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	☐	☐	☐	☐

CATEGORY IV	0	1	2	3
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side	☐	☐	☐	☐
Under rib cage	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling,	☐	☐	☐	☐
Mucous-like, greasy, or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

CATEGORY V	0	1	2	3
Greasy or high-fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and or bloating several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates from clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed	YES	☐	NO	☐

CATEGORY VI	0	1	2	3
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, or have tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory/forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

CATEGORY VII	0	1	2	3
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal or larger than hip	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

CATEGORY VIII	0	1	2	3
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

** Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only.*

PATIENT FORMS

Metabolic Assessment

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CATEGORY IX	0	1	2	3
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amounts of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 or more hours of sleep	☐	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

CATEGORY X	0	1	2	3
Tired, sluggish	☐	☐	☐	☐
Feel cold – hands, feet, all over	☐	☐	☐	☐
Require excessive amounts of sleep to function	☐	☐	☐	☐
Increase in weight gain even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression, lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face, or genitals or excessive falling hair	☐	☐	☐	☐
Dryness of skin and/or scalp	☐	☐	☐	☐
Mental sluggishness	☐	☐	☐	☐

CATEGORY XI	0	1	2	3
Heart palpitations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervous and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

CATEGORY XII	0	1	2	3
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders or lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

CATEGORY XIII	0	1	2	3
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
"Splitting" type headaches	☐	☐	☐	☐

CATEGORY XIV (MALES ONLY)	0	1	2	3
Urination difficulty or dribbling	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐

CATEGORY XIV (MALES ONLY)	0	1	2	3
Feeling of incomplete bowel evacuation	☐	☐	☐	☐
Leg nervousness at night	☐	☐	☐	☐

CATEGORY XV (MALES ONLY)	0	1	2	3
Decrease in libido	☐	☐	☐	☐
Decrease in spontaneous morning erections	☐	☐	☐	☐
Decrease in fullness of erections	☐	☐	☐	☐
Difficulty in maintaining morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decrease in physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increase in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional than in the past	☐	☐	☐	☐

CATEGORY XVI (MENSTURATING FEMALES ONLY)	0	1	2	3
Are you menopausal	☐	☐	☐	☐
Alternating menstrual cycle lengths	☐	☐	☐	☐
Extended menstrual cycle, greater than 32 days	☐	☐	☐	☐
Shortened menses, less than every 24 days	☐	☐	☐	☐
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne breakouts	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

CATEGORY XVII (MENOPAUSAL FEMALES ONLY)	0	1	2	3
How many years have you been menopausal?	☐	☐	☐	☐
Since menopause, do you ever have uterine bleeding?	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breasts	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal pain, dryness or itching	☐	☐	☐	☐

PART III

How many alcoholic beverages do you consume per week? _________ How many caffeinated beverages do you consume per day? __________

How many times do you eat out per week? ____________ How many times a week do you eat raw nuts or seeds? ________________________

How many times a week do you eat fish? ____________ How many times a week do you workout? ______________________________________

List the three worst foods you eat during the average week: ______________________, ________________________, _________________

List the three healthiest foods you eat during the average week: ______________________, ______________________, _______________

Do you smoke?________ If yes, how many times a day: ____

Rate your stress levels on a scale of 1-10 during the average week: ____

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions: ____

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Professional Disclosure, informed consent, Summaries of State and Federal Regulations

SUMMARY OF THE STATE OF COLORADO REGULATIONS

This disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies (DORA). Daniel J. Hudson complies with all rules and regulations specified by the Colorado Department of Health. He follows clean needle technique, using sterilized disposable needles, and follows state guidelines for sanitation and sterilization within the treatment room. Patients may seek a second opinion from any another health care professional or may terminate treatment at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the division of registrations in the department of regulatory agencies. Acupuncture is regulated by the Department of Regulatory Agencies. Any Complaints should be directed to: Department of Regulatory Agencies, Office of Acupuncturists Registration at 1560 Broadway, Suite 680, Denver, CO 80202, (303) 894-2464. Patients are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy.

INFORMED CONSENT TO TREATMENT

Daniel Hudson's training includes the recommendation and application of adjunctive therapies and herbs as defined by oriental medicine concepts, including Herbal medicine (internal and external use), electro-stimulation, cupping, auriculotherapy (ear acupuncture), moxibustion, acupressure, gua sha, bleeding techniques, as well as dietary, nutrition and lifestyle recommendations. I understand that I may be recommended or administered any of the above therapies.

SUMMARY OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT

The U.S. Dept of Health & Human Services had developed the Health Insurance Portability & Accountability Act (HIPPA). A policy that requires all health care providers to make reasonable efforts to protect your personal health information from being released to unauthorized persons. As your Oriental Medicine provider, I only share your health information with your referring physician, your insurance carrier, our billing dept or company and ANY other individuals or entities **specified by you**. All efforts are made by YAO Health Professionals and each of these entities to protect your health information. If you feel your personal health information has been released to any unauthorized person, please notify us in writing (YAO Health Professionals, 1305 S. Washington St, Denver, CO 80210) and we will take the necessary steps to resolve the problem. For more information about HIPAA , contact the U.S. Department of Health and Human Services Office of Civil rights, 200 Independence Ave, S.W., Washington, D.C., 20201, 202-619-0257, Toll free 877-696-6775.

ACKNOWLEDGEMENT

By signing below, I acknowledge having read the above written notices, having received a copy of the Privacy Notice and having been provided an opportunity to receive/review the complete copy of the Notice of Privacy Practices for YAO Health Professionals. I give my permission and consent to treatment.

I certify that above information is true and accurate to the best of my knowledge.

Patient Signature ____ *Date* ______________________________

Disclosure: Daniel J. Hudson, Lic Ac.

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EDUCATION

2010 – 2011	Golden Gate School of Feng Shui, San Francisco, CA
2009 – Active	Doctorate Fellow, 5 Branches Institute, San Jose, CA
2007 – 2011	Auricular Diagnosis and Treatment, Colorado
1999 – Active	Lotus Institute of Integrative Medicine, Continued Education: - Herbal Complements to Cancer treatment, Prescription Drugs and Herbal Alternatives, Recognition and Prevention Herb Drug Interactions, Herbal Alternatives for Pain Management, New Balance Method, Treating Gynecological Disorders, Science of Herbal Combinations.
2001 – 2005	Dynamis School for Advanced Homeopathy, Colorado
1999 – 2000	NAET, Allergy Elimination through Acupuncture Advanced BioSET, Allergy Elimination
2004 – Active	Dr. Datis Kharrazian, Continued Education: - Functional Endocrinology and Functional Blood Chemistry Analysis
1997	Colorado School of Acupuncture and Oriental Medicine, Colorado
1995	Colorado School of Traditional Chinese Medicine, Colorado (1960 hrs)
1994	Body Therapy Institute of Massage Therapy, Santa Barbara, California

PROFESSIONAL CERTIFICATION, LICENSURE, REGISTRATION

1998 – Current	National Certification Commission for Acupuncture and Oriental Medicine
1998 – Current	CO Dept of Regulatory Agencies, Registered Acupuncturist (No. 465)
1999	NAET Certification and Advanced BioSET
1996	Council of Colleges of Acup & Oriental Medicine, Clean Needle Certification

PROFESSIONAL AND CLINICAL EXPERIENCE

1998 – Current	Private Practice, Denver, Colorado
2008 – Current	Colorado School of Traditional Chinese Medicine, Clinic Supervisor
1999 – 2002	Wild Oats Wellness Center, Resident Acupuncturist, Colorado
1998 & 2005	Dr. Yu Yun, Clinical Assistant, California and Spain
1998 – 1999	Mile High Council of Alcoholism & Drug Abuse, Resident Acupuncturist
1996 – 1998	Van Troung Acupuncture Clinic, Clinical Assistant, Colorado
1995 – 1996	Yan Jing Pharmacy Herbal Pharmacist, Colorado

PROFESSIONAL ORGANIZATIONS

1999 - Current	Acupuncture Association of Colorado
2004 - Current	California State Acupuncture Association

FEES

New Patient Visit $305
1.5-2.5 hour appointment

Regular Patient Visit $140
1.5 hour appointment

Longtime Returning Patient.................... $190
1.5 hour appointment

Consultation Visit (i.e. Consultations, Lab Review and Nutritional & Herbal Review, by case time) $54
15 minute appointment

Late cancellation or No-show of appointment .... full cost of scheduled visit

Prescribed items .... Additional

Out of town patient management follows the same fee schedule.

INTIAL VISIT

Our first office appointment is scheduled for 2 hours in length. Please complete the forms we send you **before** the visit so that we can spend our time addressing your current concerns, history, risk factors and perform an acupuncture treatment.

CANCELLATION POLICY

If you need to cancel an appointment, please give at least 24 hour notice, as it is a great inconvenience to both the office and other patients whom we could have seen at an earlier time.
You will be charged the arranged appointment time if less than a 24 hour notice is provided.

PAYMENT

The patient is responsible for payment at the time of service. We accept checks, cash and credit cards. If we are to send botanical items, vitamins or minerals to you between visits, we will use a charge card for that purpose. We do not process insurance. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I certify that above information is true and accurate to the best of my knowledge.

Patient Signature ________________________________ *Date* ______________________

 (Please sign both sides)

Notice of YAO Health Professional's Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Use and Disclosure of Health Information

YAO Health Professional's Health Plan ("The Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Plan has established a policy to guard against unnecessary disclosure of your health information.

Generally, we may not use or disclose your Health Information without your permission. Further, once your permission has been obtained, we must use or disclose your health information in accordance with specific terms of that permission.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. Health care operations includes such activities as: a) Quality assessment and improvement activities. b) Activities designed to improve health or reduce health care costs. c) Clinical guideline and protocol development, case management and care coordination. d) Contacting health care providers and participants with information about treatment alternatives and other related functions. e) Health care professional competence or qualifications review and performance evaluation. f) Accreditation, certification, licensing or credentialing activities. g) Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits. h) Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. i) Business planning and development including cost management and planning related analyses and formulary development. j) Business management and general administrative activities of the Health Plan, including customer service and resolution of internal grievances.

For example, the Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives. The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

To Individuals Involved in Your Care or Payment for Your Care. The Health Plan may release medical information about you to a friend or family member who is involved in your medical care. The Health Plan may also give information to someone who helps pay for your care. In addition, the Health Plan may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Appointment Reminders. The Health Plan may use your health information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

For Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, an internal research project may involve comparing the health and recovery of all patients who received one form of chinese medicine and/or acupuncture to those who received other treatments for the same condition.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or

safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

Authorization to Use or Disclose Health Information. Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize the Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights With Respect to Your Health Information.

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR HEALTH INFORMATION THAT THE HEALTH PLAN MAINTAINS:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. However, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please make your request in writing to the Privacy Officer, Ewa Long.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer (see contact information). The Health Plan will attempt to honor your reasonable requests for confidential communications

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer (see contact information). If you request a copy of your health information, the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to the Privacy Officer (see contact information). The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Privacy Officer (see contact information). The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The fee is set as base fee of $30.00 for the first 10 (ten) pages, $1.00 for pages 11-60, $.50 for pages 61-400. The base fee must be paid at eh time of the request and the balance due at the time of pick up or receipt.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Officer, Ewa Long (see contact information).

Revisions to This Notice. We reserve the right to revise or amend This Notice at any time. Any revised Notice will be effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of any revised Notice in this clinic at 1305 S. Washington St, Denver, CO 80210. Any revise Notice will contain the effective date on the FIRST PAGE, in the top right-hand corner. In addition, each itme you visit the clinic we will make a copy of the current Notice that is in effect, available to you.

Duties of the Health Plan. The Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

Complaints You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to the Health Plan's Privacy Officer. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person / Privacy Officer
You may write to the Privacy Officer that the Health Plan has dedicated as its contact person for all issues regarding your privacy rights. Contact: Ewa Long at YAO Health Professionals, 1305 S. Washington St., Denver, CO 80210.

Effective Date
This Notice is effective April 14, 2003.