What to Expect During Your Acupuncture Treatment

1. Your visit will involve a brief assessment of your condition and includes treatment.

2. Choose one or two health concerns to address (pain, anxiety, etc.). Some conditions are complex and require an in-depth intake assessment prior to treatment. For complex conditions (long-term, chronic illness, chronic digestive disorders, infertility, etc.) an office visit is necessary in order to properly diagnose you.

3. Acupuncture treatments vary depending on the individual or the condition. Acupuncture needles are typically retained for about 15-30 minutes.

4. Acupuncture is not a painful experience; however there will be some sensation and possibly minor discomfort. Normal sensations are heaviness, warmth, tingling, cramping, aching, the sensation of “something” moving through the body (channels), pinching and some points will have no sensation at all. Some of the sensations may be strange or uncomfortable, while others pleasant. Most people find themselves falling asleep during their acupuncture treatment. Some patients experience an emotional release (crying or feeling angry), especially those with pent up emotions. These releases are considered positive results.

What to expect after your acupuncture treatment

1. After your acupuncture treatment is complete some find their relief to be immediate, for others it may be delayed for a few hours or even become noticeable after a few days. Relief may last for a few hours on the first visit and then last longer with each successive treatment, or relief may last from the first treatment until your next visit. Individual responses to acupuncture vary. One should keep in mind that for any therapy, a single visit will not be enough to produce significant results.

Acupuncture Side Effects

1. Side effects to acupuncture are rare, but may include the following: feeling lightheaded, dizziness, sleepiness, euphoria (“acu-buzz”), extreme relaxation, improved sleep, a feeling of being at peace, nausea, digestive changes, tenderness or bruising around insertion point, residual muscle aches or soreness around insertion points. Most side effects should only last a short time and should be reported to your practitioner at your next visit. Being comfortable and relaxing during treatment will help reduce potential negative side effects. Staying hydrated after your treatment is important. Any side effects should be reported at so we can further reduce the opportunity for them to occur.

Flare-Ups

1. On rare occasions, the original symptoms may briefly get worse, or “flare-up,” after a treatment. A flare-up typically occurs later on the day of your treatment or the following few days. After a flare-up, your symptoms should begin to improve. “Flare-ups” occur as the body attempts to reestablish balance. Blood, Qi and neural impulses create sudden changes in the body and sometimes brief “flare-ups” can happen. This should be considered a normal part of the process and should not deter you from your path of healing.

2. In some conditions, the body must fully expel a pathogen in order for healing to occur. For example, if you have a cold or flu, acupuncture will not get rid of the condition, but it can often reduce symptoms while accelerating the cold/flu cycle so your body recovers faster. If you are fatigued and beginning to get a cold or the flu, acupuncture can often help your body fight it off.

3. In cases of chronic pain, the original pain may improve and then unmask less obvious pain in the surrounding areas or sometime opposite sides/areas of the body which have been compensating for the current condition.

4. If you have concerns following your treatment, please call us at 407-738-7412.

How To Prepare For Your First Treatment

Wear loose, comfortable clothing that roll above the knees and elbows, have a light snack at least one hour before your appointment and expect to lay quietly on a treatment table for up to one hour.
Acupuncture Intake Form

Personal Information

Patient Name: ___________________________ Age: ______ Birth Date: ___/___/____ Gender: M/F

Marital Status: ___Single   ___Married   ___Divorced   ___Widowed   Height: _______ Weight: ______

Address: ___________________________ City: ___________ State: ______ Zip: ______

Telephone: ___________________________ Is it okay to leave a detailed message at this number? Y/N

May we use email to communicate with you?  Y/N Email Address: ___________________________

Occupation: ___________________________ Employer: ___________________________

How did you hear about us? ___________________________

Who is your primary health care provider/MD? ___________________________

Insurance Information:

Primary Insurance Company: ___________________________

Name of Policy Holder: ___________________________ Policy ID No. ___________________________

Group No.:_________ SSN:_____________ Phone Number:_____________________

Secondary Insurance Company: ___________________________

Name of Policy Holder: ___________________________ Policy ID No. ___________________________

Group No.:_________ SSN:_____________ Phone Number:_____________________

Emergency Contact Information

Name: ___________________________ Relationship: ___________ Phone: ___________________________
Main Concern

Please identify your main health concern(s)

___________________________________________________________________________________

How long have you had this problem(s)

___________________________________________________________________________________

Have you been given a diagnosis for this problem(s)?

___________________________________________________________________________________

What other treatments have you tried and what were the outcomes?

___________________________________________________________________________________

___________________________________________________________________________________

Please list any Western Diagnosis (Diabetes, Hypertension, etc.)

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Please list ALL medications and dosage including herbs, supplements, vitamins you are taking and the reason each:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Allergies (Medications, herbs, foods, seasonal, etc.)

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________
1. History of heart problems, chest pain or stroke?  
2. Increased blood pressure?  
3. Any chronic illness or condition?  
4. Do you ever get dizzy, lose your balance or lose consciousness?  
5. Difficulty with physical exercise?  
6. Advice from physician not to exercise?  
7. Recent surgery (last 12 months)?  
8. Pregnancy (now or within last 3 months)?  
9. History of breathing or lung problems?  
10. Swollen, stiff, or painful joints?  
11. Foot problems?  
12. Back problems?  
13. Any significant vision or hearing problems?  
14. Diabetes or thyroid condition?  
15. Cigarette smoking habit?  
16. Do you ever drink alcoholic beverages?  
17. Do you use recreational drugs?  
18. Increased blood cholesterol?  
19. History of heart problems in immediate family?

Please explain any yes answers below. (If necessary use the back of this page)

**FAMILY HISTORY**

**Father**  
Current age if living: _____  
Father’s general health is: excellent ___ good ___ fair ___ poor ___  
Reason for fair/poor health is? ____________________________

**Mother**  
Current age if living: _____  
Mother’s general health is: excellent ___ good ___ fair ___ poor ___  
Reason for fair/poor health is? ____________________________

**Siblings**  
Number of brothers _________ Number of sisters _________ Age range _________  
Any health problems? Please explain. ____________________________

Have any of your BLOOD relatives had: yes no  
1. Heart disease? ___ ___  
2. Stroke? ___ ___  
3. High blood pressure? ___ ___  
4. Elevated cholesterol? ___ ___  
5. Diabetes? ___ ___  
6. Obesity? ___ ___  
7. Leukemia or cancer? ___ ___  

If yes explain: ____________________________
Exercise and Physical Activity

For the following questions, please mark which best applies to you.

Are you currently involved in a regular fitness program?  yes  no

Are you involved in physical activities of daily living?  yes  no (walking, gardening, etc.)
If yes, what type and how often?

Are you involved in cardiovascular exercise or a group fitness program?  yes  no
If yes, what type and how often?

Are you involved in a strength training/weight lifting program?  yes  no
If yes, what type and how often?

Are you involved in any sports?  yes  no
If so, what sports and how often?

For the following questions, mark which best applies to you.

Do you consider yourself:  
  ___ sedentary  
  ___ lightly active (sporadic workouts, lawn work, little aerobic work)  
  ___ moderately active (work out 1-2 days/week for at least 15-30 minutes)  
  ___ highly active (work out three or more days/week at least 30-45 minutes)

Do you believe that you are physically fit?
  ___ no  ___ average  ___ outstanding  
  ___ less than average  ___ above average  ___ don’t know

Indicate the main reason you exercise or why you want to begin an exercise program.
  ___ it is good for my health  ___ helps to relieve stress  
  ___ my doctor told me to  ___ I am trying to lose weight  
  ___ it makes me feel good  ___ other __________________

What activities would/do you prefer in a regular exercise program?
  ___ walking and/or running  ___ racquetball or squash  
  ___ swimming  ___ tennis  
  ___ stationary cycling  ___ basketball  
  ___ stretching  ___ rowing  
  ___ strength/resistance training  ___ group fitness classes  
  ___ none  ___ other __________________
General
- Poor Appetite
- Changes in Appetite
- Food Cravings (salty/sweet/other)
- Weight Loss/Gain
- Weakness
- Fatigue
- Sudden Energy Drops
- Hearing Loss
- Ear Infections

Skin & Hair
- Rashes
- Itching
- Dry Skin
- History of Eczema/Psoriasis/Shingles/Other

Head, Eyes, Ears, Nose, and Throat
- Headaches/Frontal/Temples/Behind
- Eyes/Vertex/Occipital/Throbbing/Stabbing/Dull/Band around Head/Other
- Head Injury
- Dizziness
- Vision Changes
- Blurry Vision
- Night Blindness
- Dry Eyes
- Red Eyes

- Puffiness/Edema
- Sudden onset/Gradual
- Strong Thirst
- Preferred Temperature of drinks
- Thirsty w/no desire to drink
- Desire to drink but only in small sips
- Tinnitus/Ringing in Ears (Low/High pitched/sudden onset/gradual)
- Bruise Easily/Bleed Easily

- Night Sweats
- Spontaneous Sweating (all over/head/other)
- Easy to Sweat
- Hot Flashes
- Heat Sensation in Hands/Feet/Chest/Face/Head
- Low Libido/Sex Drive
- Insomnia/sleep problems

- Hair Loss
- Change in Hair Texture
- Brittle Hair
- Dry Hair

- Brittle Nails
- Nail Fungus
- Other Nail Problems

- Itchy Eyes
- Floaters
- Cataracts
- Other Eye Problem
- Sinus Problems
- Allergies
- Nose Bleeds
- Poor Sense of Smell
- Snoring
- Facial Pain/Trigeminal Neuralgia/Bell’

- TMJ Pain
- Poor Sense of Taste
- Mouth Pain
- Mouth Sores
- Recurrent Sore Throat
- Sensation of something stuck in throat
- Thyroid Problems
Cardiovascular
- High blood Pressure/Hypertension
- Low Blood Pressure
- Irregular Heartbeat
- Arrhythmia
- Palpitations
- Pace-Maker
- History of Blood Clots
- Chest Pain
- Heaviness in Chest
- Swelling of Hands/Feet
- Phlebitis
- Fainting/Lightheadedness
- Cold Hands/Feet
- Shortness of Breath

Respiratory
- Cough
- Bronchitis
- Difficulty Breathing
- Phlegm
- Sleep Apnea
- Coughing Up Blood
- Pneumonia
- Asthma
- Use Inhaler/Nebulizer
- Painful Breathing
- Easily Winded
- Shortness of Breath
- On oxygen
- Other Breathing Problem

Urology
- Painful Urination
- Urgency to Urinate
- Unable to Hold Urine
- Incontinence
- Change in Urine Flow
- Frequent Urination
- Blood in Urine
- Cloudy Urine
- Kidney Stones
- Urinary Tract Infections
- Frequent Night Urination
- Pain in Groin Area
- STDs
- Prostate Problems
- Inability/Difficulty to Achieve/Maintain Erection

Gastro-Intestinal
- Nausea
- Vomiting
- Number of BM/Day
- Constipation (Hard to Pass/Goat Pellets)
- Diarrhea
- Alternate Constipation/Diarrhea
- Loose Stools
- Sticky Stools (use a lot of paper or sticks to toilet)
- Mucus in Stools
- Undigested Food in Stools
- Pain after Bowel Movement
- Diarrhea when upset
- Urgent need for Bowel Movement early in the morning
- Foul Smelling Stools
- Bad Breath
- Ulcers
- Hernia
- Abdominal Pain
- Chronic Laxative Use
- Intestinal Gas
- Indigestion
- Rectal Pain/Burning
- Belching
- Blood in Stools
- Hemorrhoids (Bleeding/Prolapse/Pain)
- Burning/Itching Anus
- Diagnosed w/Colon Polyps, etc.
## Neuro-Psychological
- Seizures
- Areas of Numbness
- Tingling/Pins & Needles
- Concussion
- Twitches (Eye/Fingers/Toes/Other)
- Lack of Coordination
- Depression
- Grief/Sadness
- Anger
- Irritability
- Loss of Balance
- Stress
- Poor Memory
- Anxiety
- Tremors
- Poor Concentration/lack of focus
- Mood swings
- Phobias
- Over thinking/worrying
- Parkinson’s/Alzheimer’s/other

## Gynecology
- Age of Menses
- Irregular Periods
- Clots
- Painful Periods
- PMS
- Date of Last Menses
- Breast Lumps
- Menopausal
- # of Pregnancies
- # of Births
- Miscarriages/Abortions
- Spotting
- Yeast Infections
- Vaginal Discharge
- Odor
- Fertility Problems
- PCOS/Fibroids/PID/HPV
- Endometriosis
- Uterine Fibroids
- STD
- Other

## Musculo-Skeletal
- Injury
- Arthritis
- Sciatica
- Muscle Weakness
- Muscle Cramping
- Muscle Spasms
- Scoliosis
- Joint Pain
- Low Back Pain
- Hand/Finger Pain
- Hand Weakness
- Wrist/Elbow Pain
- Foot/Ankle Pain
- Carpal Tunnel Diagnosis
- Buttock Pain
- Coccyx (tai bone) Pain
- Pain worse w/Damp/Cold/Heat
- Pain with movement
- Pain Better w/movement
- Unexplained Pains
- Pain/Bloating on Sides/Ribs
PAYING AT THE TIME OF SERVICE POLICY

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our usual and customary rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit, after which time you’ll only be responsible for a standard office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visits, which will be modified. Any of these procedures used during your treatment will be reduced to $0.00, and you will be responsible for the office visit fee only.

The fee for the New Patient office visit (code 99203) is $185.00
The fee for each office visit after the initial visit (code 99213) is $150.00

NO SHOW/ CANCELLATION POLICY

I understand and agree that if I fail to cancel an appointment with at least 24 hours’ notice, I will be charged a $25 fee for that visit. The full $25 late cancellation fee must be received prior to my next scheduled appointment. Failure to properly cancel my appointment three times will result in my dismissal from the practice for non-compliance.

I understand and agree that if I fail to cancel an appointment with at least 24 hours’ notice, I will be charged a $35 fee for that visit. The full $35 late cancellation fee must be received prior to my next scheduled appointment. Failure to properly cancel my appointment three times will result in my dismissal from the practice for non-compliance.

I, __________________________, have read the above policies and understand my rights and agree to abide by said policies.

______________________________  __________________________  ________
Printed Name  Signature  Date
Financial Responsibility / Assignment of Benefits

I hereby authorize Jeannette “Jett” Kerns acupuncture physician, Yolanda Rice and/or Jennifer Ordinas-Torres and/or any other licensed provider at East Lake Acupuncture & Wellness, LLC (hereinafter “Provider) to furnish Acupuncture, Massage, Acupoint Injection Therapy as long as said method of treatment falls within said provider’s scope of practice. Moxibustion, Gua Sha, Cupping Therapy and/or various other therapeutic treatments and any other therapies within the practioner’s scope of practice.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say I owe, and that the Provider must bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the acupuncture treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pay all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider.

I, understand that Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I hereby request that my insurance carrier make payment directly to the treating physician or to East Lake Acupuncture & Wellness, LLC, for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker’s Compensation benefits and those benefits and are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

____________________________________  ______________________________________
Patient/Guardian                      Date
Fainting during acupuncture

Acupuncture is a safe treatment; however, I a small number of patients experience light-headedness and some faint. This is generally caused by nervousness, though dehydration and sudden changes in blood sugar can play a role. To help prevent fainting, you should drink plenty of water and eat a light snack (not a heavy meal) prior to each treatment.

Fainting Causes

Fainting (syncope) is a sudden loss of consciousness from a lack of blood flow to the brain. Fainting victims usually wake up quickly after collapsing because once a person goes from vertical to horizontal, blood starts flowing back into the brain and they begin to wake up. It can be quick or it can take a while; everybody's different.

Most fainting is triggered by the vagus nerve, which connects the digestive system to the brain, and its job is to manage blood flow to the gut. Unfortunately, the vagus nerve can get a little too excited and pull too much blood from the brain, resulting in fainting.

Symptoms of fainting

Before fainting, a victim can exhibit or feel all or some of these signs and symptoms, depending on the cause of the fainting:

- Dizziness or feeling light-headed
- Confusion
- Nausea
- Sudden trouble hearing
- Tunnel vision or blurred vision
- Sweating
- Flushed or pale color
- Feeling hot
- Weakness
- Trembling or shaking
- Eye shaking (nystagmus)
- Headache
- Shortness of breath

Common symptoms that can occur after fainting

- Sweating stops
- Color begins to return
- Rapid pulse or “racing heart”
- Loss of bowel or bladder control

Common triggers fainting during acupuncture

Psychological Triggers

Anxiety or nervousness and stress can stimulate the vagus nerve in some people and lead to a loss of consciousness. In regards to acupuncture, those who faint are most often first-timers, experiencing some anxiety over the needles.

Dehydration

Too little water in the bloodstream lowers blood pressure, stimulating the vagus nerve. Dehydration coupled with nervousness over acupuncture creates a double-whammy. Toss in failing to eat a light snack prior to treatment and the odds of fainting or at least becoming light-headed are greatly increased.

Fainting facts and general information

There are other causes of fainting, including, but not limited to, heart conditions; however, nervousness and dehydration are the most common in regards to acupuncture. All by itself, fainting is not life-threatening; however, sudden cardiac arrest looks a lot like fainting and requires immediate treatment.

If you feel suddenly flushed, hot, nauseated or break out in a cold sweat, don't try to stand up. Lie down until it passes. If it doesn't pass in a few minutes or you begin to experience chest pain or shortness of breath it is our policy to call 911.

Whenever someone passes out in our office and/or fails to become fully alert (recite day, month, year and name of president) within a few moments of fainting or feeling light-headed, it is our policy to call 911. Your safety is our primary concern.

I, ___________________________ (please print), have read the above information on fainting and understand that eating a light snack and drinking plenty of water prior to acupuncture is important and failing to do so may cause light-headedness and in some cases, fainting.

_________________________  ____________________________
Signature                     Date
Consent to Treat Form

I hereby request and consent to the provision of acupuncture, herbs, supplements, medical, laboratory and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Jeannette Kerns, Jennifer Ordinas and/or other licensed/certified acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for/at East Lake Acupuncture & Wellness, LLC, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, bleeding, Gua-Sha, vitamin injections, liptropic injections, homeopathic injections, bio-puncture, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell and/or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and Gua-Sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses disposable sterile needles and maintains a clean and safe environment. Some potential risks of injections of any type are bruising, tenderness, allergic reaction, numbness, muscle soreness or nerve damage. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE [X] (Date) (Indicate relationship if signing for patient)

OFFICE SIGNATURE (Date)

Copy of this document available upon request
How ELAW Uses and Safeguards your Health Information
We use your health information to pay for your health services and to operate the Medicaid program. We may also use your health information to tell you about treatment alternatives or other health related benefits and services.

The following are some examples of how we may use your health information:

- Your doctor may send medical release form requesting copies of your records. We will transmit your records only with a written, HIPAA complaint consent form signed by you.
- We may send copies of progress note, lab results or other documents contained in your file to your insurance company to facilitate payment of services.
- We may send appointment reminders for services.

ELAW may also use and disclose your health information as permitted by law, such as:

- To entities outside the agency only if the information is used to verify income, eligibility and the amount of public assistance payment.
- In responding to public emergencies, access to your health information may be granted to persons or agency representatives who are subject to standards of confidentiality comparable to those of ELAW. Such other agencies may include the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control (CDC).
- To law enforcement, correctional facilities, medical examiners, funeral directors, and organ donor program personnel where disclosure would determine eligibility for benefits, amount of medical assistance payment or otherwise assists the agency in the administration of the Medicaid program.
- To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the agency by law.
- For health oversight activities and/or administration of your insurance program, such as inspections, investigations and audits.
- As otherwise required by law.

Other uses or disclosures of your protected health information require your or your personal representative’s written authorization. At any time, you may revoke such authorization in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

Your Health Information Rights
You have the following rights with respect to your protected health information:

To see or obtain a copy of your health information that is maintained by ELAW. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law. We may charge a copying fee.

To request that we amend health information we maintain that you believe is incorrect or incomplete.

To request a list of where we have sent your health information since October 02, 2012. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations or other disclosures permitted by law.

To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you.

To request that we limit the use and disclosure of your health information. We are not required to agree to your request.

Contact Information
If you have any questions, wish to make a request regarding your health information, or would like another paper copy of this notice, please contact the ELAW at the telephone number listed below. We may ask you to make the request in writing.

Filing a HIPAA Complaint
If you believe your privacy rights have been violated by ELAW or one of its employees, you may file a complaint with ELAW and/or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

Future Changes to the Notice of Privacy Practices
ELAW reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain. If we make a material revision to this notice, we will send a revised copy of the notice to recipient households within sixty (60) days of the revision.

Community Acupuncture Privacy Policy Notice:
Community acupuncture is conducted in a communal setting. You will be surrounded by other people quietly receiving treatment at the same time. Your intake interview will be conducted in a semi-private setting and we make our best efforts to avoid being overheard, but due to the type of environment community acupuncture requires, it is possible others may overhear. If you are concerned about this, you may want to consider foregoing the community acupuncture setting and booking a private appointment.