Chang Acupuncture & Associates, Inc.

Patient Information Sheet

CONFIDENTIAL

7969 Engineer Road, Suite 209 ☯ San Diego, CA 92111 ☯ Phone: (858) 495-0771 ☯ Fax: (858) 495-0772 ☯ www.sdhealthylife.com

Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	Full Name			Preferred Name/Nickname
Gender M F	Date of Birth	Age	Marital Status Single Married Separated Divorced	
Address		City	State	Zip
Daytime Phone # (home, work, cell – circle one) ( )		Alternate Phone # (home, work, cell – circle one) ( )		
Emergency Contact & Relationship		Phone Numbers of Emergency Contact Primary ( ) Alternate ( )		
Circle Health Insurance Coverage None PPO POS HMO Workers' Comp Auto Injury with MedPay Military Other _____				
Would you like to receive an appointment confirmation via email? Y N Would you like to receive a monthly email acupuncture newsletter? Y N Would you like to be updated on clinic events via email? Y N Please be assured that your email address will only be used by our office for the above intended purposes and will not be sold to other companies or individuals. Email: _____				
Primary Care Doctor		Specialty		
Other Doctors You See		Specialty		
Other Doctors You See		Specialty		
How did you hear about us?				
Cancellation Policy – I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _____				

Major Complaint(s), in order of importance to you:

	Severe	Moderate	Slight	
1.	☐	☐	☐	_____
2.	☐	☐	☐	_____
3.	☐	☐	☐	_____

Patient _____ Date_____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under appropriate person's column. "P" should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
Arthritis											
Asthma-Hay Fever											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Diabetes											
Disc Problems											
Emotion Problems											
Emphysema											
Epilepsy											
Headaches											
Heart Trouble											
High Blood Pressure											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Nervousness											
Neuritis											
Obesity											
Pinched Nerves											
Scoliosis											
Sinus Trouble											
Stomach Trouble											
Other:											

If any of the above family members are deceased, please list their age at death and cause.

_____

_____

List any surgeries you have had and year it was performed.

_____

_____

TRAVEL: Have you ever traveled or lived outside the U.S.? ☐ Yes ☐ No

Any health problems when abroad? ☐ Yes ☐ No If yes, what?_____

FEMALES:

Form of birth control_____	Pregnant ☐ Yes ☐ No	☐ Clotting	☐ Hot flashes
Last period_____	Last PAP test_____	☐ Heavy bleeding	☐ Vaginal dryness
Age started menstrual cycle_____	Age stopped_____	☐ Vaginal discharge	☐ Other:_____
☐ Menstrual pain	☐ Water retention	No. Pregnancies_____	_____
☐ Low backache	☐ Mood changes	No. Vaginal Deliveries____	No. Miscarriages_____
☐ Irregular	☐ Painful breast	No. Caesareans_____	No. Abortions_____

Patient _____ Date_____

MEDICAL CONDITIONS - Please list conditions & surgeries you have or have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (✓) if your work exposes you to the following.
Year	Condition/Surgery		Occupation:
			☐ Stress
			☐ Heavy Typing/Computer Use
			☐ Hazardous Substances
			☐ Heavy Lifting
			☐ Other

MEDICATIONS - Please list all prescription medication you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription name	Purpose	How long	Dose	How often	Last Dose

SYMPTOMS - *For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if N/A.*

LIVER/GALLBLADDER
___ Irritability
___ Depression
___ Headaches/migraines
___ Visual problems
___ Red eyes
___ Dry/itchy eyes
___ Spots in front of eyes
___ Blurred vision
___ Feeling of lump in throat
___ Clenching of teeth at night
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Cold hands/feet
___ Soft/brittle nails
___ Craving/avoiding sour foods

KIDNEY/URINARY BLADDER
___ Urinary problems
___ Frequent urination
___ Incontinence
___ Weakness/pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Craving/avoiding salty food

HEART/SMALL INTESTINE
___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia
___ Easily startled
___ Restlessness/agitation
___ Anxiety
___ Breathlessness
___ Vivid dreams
___ Dreams are bothersome
___ Lack of joy in life
___ Laughing for no reason
___ Craving/avoiding bitter foods

LUNG/LARGE INTESTINE
___ Dry cough
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes
___ Itchy skin
___ Grief, sadness
___ Shortness of breath
___ Allergies
___ Low resistance to colds or flu
___ Low physical stamina
___ Mild fever comes and goes
___ Craving/avoiding spicy foods

SPLEEN/STOMACH
___ Heaviness anywhere in body
___ Fatigue
___ Hard to get up in the morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Nausea
___ Vomiting
___ Gas/belching
___ Bloating
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion/heartburn
___ Over-thinking
___ Tendency to become obsessive
___ Craving/avoiding sweets

Healthy Living Questionnaire

Patient Name: _____ **Date:** _____

Age:_____ **Gender:** ❑ **Male** ❑ **Female**

Current Weight: _____

Do you consider yourself:
❑ **underweight** ❑ **overweight** ❑ **just right**

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes ❑ **No** ❑

Recent changes in your ability to:
❑ **see** ❑ **hear** ❑ **taste**
❑ **smell** ❑ **feel hot/cold sensations**

1. Check the Following Statements That Apply:
- ❑ Occasionally or frequently skip meals
- ❑ Suffer from fatigue
- ❑ Currently overweight
- ❑ Crave sweets or carbohydrates
- ❑ Crave stimulants, such as caffeine or soft drinks
- ❑ Suffer from chronic pain
- ❑ Suffer from headaches

2a. Activity Level – Check Your Current Level of Work or Lifestyle:
- ❑ **Level 1 – Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- ❑ **Level 2 – Light Work:** Light housework, labor, childcare, mechanic, some sitting, etc.
- ❑ **Level 3 – Moderate Work:** Heavy gardening, housework, labor, no sitting, etc.
- ❑ **Level 4 – Heavy Work:** Heavy manual labor, construction, digging, etc.

2b. Exercise Level – Check Your Current Level of Exercise:
- ❑ **None**
- ❑ **Level A – Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- ❑ **Level B – Moderate Exercise:** 2-3 times per week, moderate pace, some weights, etc.
- ❑ **Level C – Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

3. Balance Eating – Check Which Apply:
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt Restriction
- ❑ Fat Restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction
- ❑ Specific food restrictions of:
  - ❑ dairy ❑ wheat ❑ eggs
  - ❑ soy ❑ corn ❑ all gluten
- ❑ Other_____

Servings per day:
Fruits (citrus, melons, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed)_____
Beans, peas, legumes _____
Dairy, eggs_____
Meat, poultry, fish_____

4. Eating Frequency – Check Which Apply:
- ❑ Skip breakfast or other meals_____
- ❑ Three meals/day
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze-small frequent meals (how many/day) _____
- ❑ Generally eat on the run

5. Exercise Frequency and Schedule – Check Which Apply:
- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 min or more duration per workout
- ❑ 30-45 min or more duration per workout
- ❑ Less than 30 min
- ❑ Use of personal trainer
- ❑ Member of fitness club
- ❑ Own exercise equipment
- ❑ Walk: days/week _____
- ❑ Run, jog, jump rope, other aerobic: days/week_____
- ❑ Weight lift: days/week_____
- ❑ Stretch: days/week_____
- ❑ Yoga: days/week_____
- ❑ Other_____ days/week_____

Healthy Living Questionnaire~Page 2

6. Stimulant Use Habits – Check Which Apply:

❑ Tobacco:
- Cigarettes: #/day_____
- Cigars: #/day_____
- Pipe: #/day_____

❑ Alcohol:
- Wine: # glasses/day or week_____
- Liquor: # ounces/day or week_____
- Beer: # glasses/day or week_____

❑ Caffeine:
- Coffee: # of 6 oz cups/day _____
- Tea: # of 6 oz cups/day _____
- Soda w/caffeine: # of cans/day _____
- Soda w/o caffeine: # of cans/day _____
- Other sources_____

❑ Water:
- # glasses/day _____

7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents: Y ❑ N ❑

Do you suffer from insomnia/sleep disorders? Y ❑ N ❑

Do you often abruptly awake from sleep? Y ❑ N ❑

Do you suffer from depression/mood swings? Y ❑ N ❑

8. Supplement Use Habits – Check Which Apply:

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ GLA (Evening primrose)
❑ Calcium, source_____
❑ Magnesium
❑ Zinc
❑ Minerals, describe_____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (lutein, resveritol, etc.)
❑ Herbs – teas
❑ Herbs – extracts
❑ Chinese herbs
❑ Ayurvedic herbs
❑ Homeopathy
❑ Bach flowers
❑ Superfoods (bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
❑ Other_____

9. Energy – Vitality

I'd like to:

❑ Have more energy
❑ Have longer endurance
❑ Have more motivation
❑ Sleep better
❑ Be less tired after lunch
❑ Feel more vital
❑ Regain vitality and vigor of my younger years
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not use so many over the counter drugs
❑ Stop using laxatives
❑ Be free of pain

10. Longevity – Life Enrichment

I'd like to:

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Monitor biomarkers of aging
❑ Have less facial wrinkles
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to a creating wellness lifestyle

11. Body Composition – Fat/Muscle

I'd like to:

❑ Be stronger
❑ Be thinner
❑ Be more muscular
❑ Burn more body fat
❑ Be more flexible
❑ Lose weight

12. Stress Reduction – Mental/Emotional

I'd like to:

❑ Be happier
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Be more focused
❑ Think more clearly
❑ Improve my memory
❑ Learn how to reduce stress
❑ Learn how to meditate

COMMENTS

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments 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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist 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 office medical and administrative staff may review my medical 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, this 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's Name _____

Patient's Signature_____ Date Signed _____

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____

Print Name of Patient Representative _____

Signature of Patient Representative _____

Relationship or Authority of Patient _____

Name of Acupuncturist Julie T. Chang, L.Ac., Eric Hollander, L.Ac.

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Financial Policy

Thank you for choosing Chang Acupuncture & Associates for your health care needs. We are committed to your improved health by providing appropriate, high quality, comprehensive family health care. While our intention is to assist you, it is your responsibility to ensure that all services rendered by Chang Acupuncture & Associates on your behalf are paid in full. In order to understand our Financial Policy, we have listed below our financial requirements.

Patients Without Insurance Coverage

Payment at the time of service is required. Cash, check, Visa, and MasterCard are accepted as payment options.

Patients With Insurance Coverage

Many health insurance plans now cover acupuncture treatment. At your request, we can verify acupuncture coverage for you. Eric Hollander, L.Ac. is currently an in-network provider for American Specialty Health (ASH) only. For all other insurance plans, we are out-of-network providers regardless of what their representatives or websites & literature may say. You will be expected to pay at the time services are rendered. Cash, check, Visa, and MasterCard are accepted as payment options. You will be given an invoice to submit to your insurance company. They will reimburse you directly according to their fee structure. If you are covered by ASH and are being treated by Eric Hollander, your responsibility is the deductible, copay, and any portion of fees not covered by the insurance payment.

Workers' Compensation Claims

Treatment will be provided with a workers' compensation claim approval. If your employer or their insurance carrier denies your claim, you will be held financially responsible for all charges incurred for services rendered on your behalf. Any quotes given regarding treatment are cash rates – insurance may be billed differently.

Auto Injury Claims

Treatment will be billed to the MedPay portion of your auto insurance policy. If your insurance carrier denies your claim due to exhausted benefits or any other reason, you will be held financially responsible for all charges incurred for services rendered on your behalf. No liens will be accepted. Any quotes given regarding treatment are cash rates – insurance may be billed differently.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any and all charges incurred from service provided.

Print Name _____ Date _____

Signature _____

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Appointment Policy

Welcome to our office of Chang Acupuncture & Associates! We are delighted to have you as a new patient and look forward to providing you with the highest quality care. In order to optimize our relationship, please take a minute to carefully read our appointment policy.

Many patients are surprised to find that we are usually on time. This is because your treatment time has been reserved for you. Most medical offices do not reserve time for each individual, but instead appoint several patients at, or near, the same time. That type of scheduling provides the Doctor a steady flow of patients for treatment, but does not respect the patient's time.

Our time and expertise are what you essentially pay for. Occasionally there is a problem with patients who are not used to keeping on schedule themselves. Patients who are late may not be seen that day. If you expect to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice for cancelled or rescheduled appointments (Sunday excluded) is required or your standard treatment fee may be assessed. This allows us time to schedule another patient and the time is not lost.

This policy of charging for failed appointments has been very well accepted. Since we sell time it is only logical to charge those who reserve our time and then waste it. We have found that most patients respect our time as much as we respect theirs.

Any questions I have concerning my appointments have been answered. I have read this statement and fully understand it.

Print Name _____ Date _____

Signature _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a written copy of the **Notice of Privacy Practices**.

_____ _____

Signature of Patient or Representative Date

If a personal representative signs this authorization on behalf of the patient, complete the following:

_____ _____

Personal Representative's Name Relationship to Patient

TO BE COMPLETED BY ACUPUNCTURIST IF ACKNOWLEDGEMENT CANNOT BE OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

☐ Patient (or authorized agent) refused to sign after being requested to do so.

☐ Other: (please describe)

_____ _____

Date Signature of Acupuncturist

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;

- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office:

Julie Chang, L.Ac.
7969 Engineer Road, Suite 209
San Diego, CA 92111
(858) 495-0771