Juliet Kim Acupuncture, PLLC
110 Bedford Ave, Bellmore, NY 11710
Juliet Kim, L.Ac, MSTOM, Dipl. OM

PERSONAL INJURY QUESTIONNAIRE

Name_____Phone ( ) _____Work ( ) _____

Cell #_____Address _____

City_____State_____Zip Code_____

Age_____Birthday_____Sex_____S.S. #_____

Employer's Name_____Address_____

Your Ins. Co._____Policy #_____Agent Name _____

Name on Policy (if other than self)_____Policy # _____

Responsible Party's Name _____

Address_____City_____State_____Zip Code_____

ATTORNEY:

Name_____Phone ( ) _____

Address_____City_____State_____Zip Code _____

Were there any witnesses? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT:

1. Date of accident_____time of day_____

2. Were you: ( ) Driver ( ) Front seat passenger ( ) Right back seat ( ) Left back seat

3. Type of vehicle: ( ) Car ( ) Van ( ) Pick-up truck ( ) Station Wagon ( ) Large Truck ( ) Bus

4. Number of people in your vehicle: _____ Were you wearing a seat belt? _____

5. What direction was you headed? ( ) North ( ) East ( ) South ( ) West

Name of Street: _____

6. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

Name of Street: _____

7. Where was your vehicle struck? ( ) Rear ended ( ) Left front ( ) Right front ( ) Head on ( ) Left rear ( ) Right rear

8. What was the direction of your head at time of accident? ( ) Facing forward ( ) Turned to right ( ) Turned to left

9. During the accident did your body strike the inside of the vehicle? ( ) Yes ( ) No

If yes please describe_____

_____

10. Approximate speed of your car _____mph. Other car _____mph.

11. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

12. Were police notified? ( ) yes ( ) No

13. In your own words, please describe accident: _____

_____

14. Did you see the accident coming? ( ) Yes ( ) No

15. Did you brace for the impact? ( ) Yes ( ) No

16. Did your air bags deploy? ( ) Yes ( ) No

17. Damage to vehicle? ( ) Mild ( ) Moderate ( ) Totaled

18. Damage to other parties vehicle? ( ) Mild ( ) Moderate ( ) Totaled

19. Visibility at time of accident? ( ) Poor ( ) Fair ( ) Good

20. Road conditions? ( ) Icy ( ) Wet ( ) Sandy ( ) Clean & dry

21. Did you have any physical complaints BEFORE the ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

22. Please describe how you felt:

(a) During the accident: _____

_____

(b) Immediately after the accident: _____

_____

(c) Later that day: _____

_____

(d) The next day: _____

_____

23. What are your PRESENT complaints and symptoms? _____

_____

_____

24. Do you have any previous illnesses which relates to this case? ( ) Yes ( ) No If yes, please describe: _____

_____

_____

25. Do you have any congenital (from birth) factors which relates to this problem? ( ) Yes ( ) No If yes, please describe:

_____

_____

26. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and

type(s) of accidents, as well as injuries received: _____

_____

27. Where were you taken after? ( ) Hospital E.R. ( ) Home ( ) Work ( ) Private Doctor

28. How did you get there? ( ) Drove self ( ) Ambulance ( ) Police officer ( ) someone else

29. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctors name and

Address: _____

_____

30. What type of treatment did you receive? _____

_____

_____

31. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

32. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___Headache	___Irritability	___Numbness in Toes	___Face Flushed	___Feet Cold
___Neck Pain	___Chest Pain	___Short of Breath	___Buzzing in Ears	___Hands Cold
___Neck Stiff	___Dizziness	___Stomach Upset	___Loss of Balance	___Fatigue
___Depression	___Constipation	___Sleeping Problems	___Head Heavy	___Fainting
___Back Pain	___Lights bother eyes	___Pins & Needles In Arms	___Loss of Smell	___Cold Sweats
___Nervousness	___Loss of Memory	___Pins & Needles In Legs	___Loss of Taste	___Fever
___Tension	___Ears Ring	___Numbness in Fingers	___Diarrhea	

Other: _____

33. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete these questions.

(a) Last day worked: _____

(b) Type of employment: _____

(c) Present salary: _____

(d) Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation

you are receiving: _____

_____

34. Other pertinent information: _____

_____

_____

Patient Signature:_____ Date:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
FROM: _____ THROUGH: _____	_____ (DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE ☐	INDEPENDENT CONTRACTOR ☐	OTHER (SPECIFY) ☐

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME _____ SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? YES ☐ NO ☐

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? YES ☐ NO ☐

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

Patient records release and doctor's lien

To: Attorney/Insurance Carrier
_____
_____
_____

From: Juliet Kim Acupuncture, PLLC
8 Liberty Ave
Hicksville, NY 11801

Patient Name: _____

Release of records: I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____ (date of accident or injury).

Lien on settlement: I hereby give Lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing my doctor for service rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

Assignment of benefits: I further assign my claim or right to compensation for treatment expenses incurred with the doctor/clinic named above arising from a tort or liability claim in connection with this accident or injury.

Irrevocable lien: I understand that this Lien shall be irrevocable either by myself or any other agent that represents me; that in the event another attorney is substituted in this matter, the new attorney shall honor this Lien as inherent to the settlement and enforceable upon the case as if it was executed by him or her.

Responsibility for payment: I understand that I am directly and fully responsible to said doctor/clinic for acupuncture bills submitted by her for service rendered me, and this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

A photocopy or facsimile of this executed instrument shall be considered as valid as the original.

Patient
signature:_____Date:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above Lien, and does agree to honor the same to protect adequately the above named doctor/clinic as per SCR 20:1.15(b). In additional consideration to the above, for executing this Lien, the doctor/clinic will provide the attorney with billing summaries and availability to discuss patient's care on a reasonable basis. The attorney may further protect his or her lien interest for compensation by having a priority status over this lien.

Auth.
Signature:_____Date:_____

NOTICE: Please sign, date, and return the original to our office as soon as possible.

This form (or a suitable "Letter of Protection" from the attorney) must be executed by both the patient and the patient's attorney before this clinic will consider awaiting settlement for payment of services rendered in this case.

Juliet Kim Acupuncture, PLLC
110 Bedford Ave, Bellmore, NY 11710
Juliet Kim, L.Ac, MSTOM, Dipl. OM

INFORMED CONSENT AND PRIVACY POLICY

I (or the patient named below, for whom I am legally responsible) hereby request and consent to the performance of Traditional Chinese Medicine treatments including acupuncture and other procedures on me by Juliet Kim, L.Ac, MSTOM, Dipl. OM, associated with Juliet Kim Acupuncture, PLLC. I understand that Traditional Chinese Medicine treatments may include, but are not limited to, acupuncture, electrical stimulation, moxabustion, cupping, Tui-na, Gua Sha, Chinese herbal medicine, and lifestyle/nutritional counseling.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, pain, numbness at the needle site, dizziness or fainting. I understand that I should be well-hydrated and have eaten something before a treatment to minimize the risk of dizziness or fainting. I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burns or scarring. 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 when practiced by professional practitioners of Oriental Medicine, although some may be toxic in large doses. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that some herbs are inappropriate during pregnancy and along with other herbs or prescription medication. **I will notify the acupuncturist that is caring for me if I am or suspect that I am pregnant**. I will also notify the acupuncturist what drugs (medicinal or recreational) and supplements I take and if there is any change in them.

I do not expect Juliet Kim Acupuncture PLLC and their affiliates to be able to anticipate and explain all possible risks and complications of all modalities, and I wish to rely on Juliet Kim Acupuncture PLLC and their affiliates to exercise judgment during the course of my visits which she thinks, based upon the facts then known is best in my interest. I also understand that results are not guaranteed.

I understand Juliet Kim Acupuncture PLLC's clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent, in full compliance of HIPAA regulations. I also understand Juliet Kim Acupuncture PLLC will from time to time send me information via mail or e-mail including but not limited to receipts, newsletters and office announcements, but that my name and contact information will never be released to any other business or organization. I understand that I may receive a print copy of this INFORMED CONSENT AND PRIVACY POLICY upon request.

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 benefits and risks of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of my treatments for my present condition and for any future condition(s) during my visits to Juliet Kim Acupuncture PLLC. I also understand NY state Law required my acupuncturist to advise me of the importance of consulting a licensed physician regarding my condition.

Patient:_____

(or patient representative) Print Signature Date

Relation to patient if not self:_____

Office Signature:_____ Date:_____

HIPPA

Notice Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

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

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

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

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Juliet Kim Acupuncture, PLLC maintain my records confidentially in accordance with the law. I agree to inform Juliet Kim Acupuncture, PLLC if I need any special arrangements pertaining to this issue.

Signature:	**Date:**
Print Name:	