UPTOWN acupuncture
wellness begins here

Adam Miramon, M.O.M., Dipl.Ac., L.Ac.
Uptown Acupuncture
4545 42nd Street, NW, Suite 301
Washington, DC 20016
202.630.2435
www.uptownacupuncturedc.com

PATIENT REGISTRATION (Please Print)

PATIENT INFORMATION

Last Name: First: Middle:		Birth Date: / /	Age:	Sex: ☐M ☐F ☐T
Street Address:		Marital Status (choose one) Single		
City:	State:	Zip:	Cell Phone:	
Email Address:	Social Security Number:		Home Phone: (if not cell #)	
Employer:	Occupation:		Work Phone: (if not cell #)	

Referred to us by (please check one box):

☐ Doctor/Provider: _____ ☐ Insurance Plan ☐ Family ☐ Friend

☐ Close to Home/Work ☐ Yelp/Other Advertising ☐ Other: _____

INSURANCE

Primary Insurance (Please provide your insurance card and driver's license)

☐ BCBS ☐ Aetna ☐ Cigna ☐ Medicare ☐ Other

Member ID or Policy #	Group or Enrollment #	Subscriber's Name (if not you) & Birth Date	Co-payment: $
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
Person responsible for bill (if not you):	Address:	Main Phone #:	

Secondary Insurance (if applicable)

Member ID or Policy #	Group or Enrollment #:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

IN CASE OF EMERGENCY

IS YOUR EMERGENCY CONTACT A PATIENT AT THIS PRACTICE? ☐ YES ☐ NO

Name of Local Friend or Relative:	Relationship to Patient:	Cell Phone:	Home Phone:	Work Phone:

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Adam Miramon, L.Ac., and Uptown Acupuncture. I understand that I am financially responsible for any balance. I further agree to pay all collection costs and attorney fees that may be incurred to enforce collection of any amounts outstanding. I also authorize Adam Miramon, L.Ac. and Uptown Acupuncture or their billing company to release any information required to complete and process my insurance claims. I have read and agree to UPTOWN ACUPUNCTURE'S OFFICE POLICIES.

Patient Signature: _____ ***Date:*** _____

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2016 OFFICE POLICIES

Fees and Payment: Fees and co-payments for services are required at the time of service unless other arrangements have been made in writing. We accept cash, check, or credit card. Opened herbs, nutritional supplements, and natural remedies cannot be returned since they cannot be resold.

Insurance Claims: If your insurance company rejects your claim for any reason, you will be responsible for payment. This includes all charges. You may still be able to obtain reimbursement from your insurance company, but you will be responsible for the payment. If you have any questions regarding your coverage, please see your benefits manager.

Secondary Insurance: This office does not submit claims to secondary insurance. You should call your secondary insurance carrier and set up "automatic crossover" so that your primary insurance company sends your claim directly to your secondary insurance company. Once automatic crossover is set up, your secondary insurance company should make payment directly to this office. Otherwise, you are responsible for the balance.

Medicare Eligible Clients: This office does not participate in Medicare. If you are Medicare eligible, you or your legal representative are responsible in full for payment of fees. Medicare payment limits do not apply to services we provide nor will they pay for treatment we conduct. Medigap plans will not and other supplemental plans may elect not to make payments for services Medicare will not pay for. As patient, you may not submit a bill from us for reimbursement from Medicare although you are free to receive other Medicare-covered services from clinicians who are covered by the program.

Appointment Cancellation: Our office has a 24-hour cancellation policy. In an effort to provide you with professional and personalized holistic health care, we reserve your appointment time exclusively for you. If you miss your appointment and do not cancel with at least 24 hours notice prior to your appointment time, you will be charged a $60.00 late cancellation fee.

Returned Check Fee and Collection Efforts: A fee of $40.00 will be charged for returned checks. If your account is turned over to a collections agency, you will be responsible for any fees imposed by the collections agency to collect your account. Unless otherwise agreed upon in writing, any charges billed for after time of service are due in full 30 days from the time of service.

Medical Records: There is a $25.00 processing fee plus $0.50 per page. There will also be a charge for postage if you choose to have the records mailed.

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NOTICE OF PRIVACY PRACTICES

According to HIPAA effective April 2003, the following guidelines are policy at Uptown Acupuncture and fall within the purview of the law.

Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment:** Information obtained by your practitioner will be entered in your record and used to plan the course of treatment.
- **Payment:** Your record will be used to receive payment for services rendered by the practitioner at Uptown Acupuncture. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis and/or practitioners impressions, and procedures performed.
- **Quality Monitoring:** Uptown Acupuncture will use your health information to assess the care you received and compare your treatment outcomes to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and Drug Administration (FDA):** This office is required by law to disclose heath information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation:** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health**: This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.
- **Law Enforcement:** (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a member of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct or violations of clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.
- **Domestic Violence:** Uptown Acupuncture will disclose your health information in cases of domestic violence.

It is the practice of Uptown Acupuncture to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Uptown Acupuncture will request your authorization only when disclosure of personal health information is necessary to parties other than those referenced here.

- **Communications with Family:** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
- **Marketing:** Uptown Acupuncture may send information to you about health-related issues that you may find useful. Only your name and address will be used.

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ACUPUNCTURE INFORMED CONSENT TO TREAT

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 Adam D. Miramon, L.Ac., M.Ac., Dipl.Ac. 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 Uptown Acupuncture or Adam D. Miramon, including those working at 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, electrical stimulation, Tui-Na (Chinese massage), Chinese 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 and in writing. The herbs may have an unpleasant smell 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 clinic uses sterile disposable needles and maintains a clean and safe environment.

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 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 notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 Name: _____ DOB: _____

Signature: _____ Date: _____