

Policy Statement For Scheduling Appointments

When you schedule an appointment, that time is reserved for you. If you arrive late, we will work through to the end of your scheduled session. If I am late, you will receive the full amount of time for which you scheduled.

If you need to cancel or reschedule your appointment, I need at least 24 hours notice. If less than 24 hours notice is given, you will be charged for the session. Please sign below to acknowledge that you have read and agree to the above policy. Thank you.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Soaring Crane Massage & Acupuncture  
Eric J. Spivack, LMP/Dipl. Ac.  
206.726.1785  
2119 17<sup>th</sup> Avenue South  
Seattle, WA 98144

PATIENT INTAKE FORM

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Partner/Spouse \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_ Employer \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_ - \_\_\_ - \_\_\_ Occupation \_\_\_\_\_

Referred By: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Group # \_\_\_\_\_

ACCIDENTS, INJURIES, OR SURGERIES (Please Describe)

More Than 5 Years Ago.: \_\_\_\_\_

Less Than 5 Years Ago: \_\_\_\_\_

Who is Your Primary Care Physician? \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Are You Receiving Chiropractic Care? No \_\_\_\_ Yes \_\_\_\_ If Yes, Dr.'s Name \_\_\_\_\_

Are You Receiving Any Other Kind of Medical Treatment? No \_\_\_\_ Yes \_\_\_\_ If Yes, Please Explain:

Please List Any Pharmaceutical and Herbal Medicines You are Currently Taking:

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE LAST 3 MONTHS.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Rashes          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Sciatica        |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Stiff Joints    |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Skin Allergies  |
| <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Herpes Virus        | <input type="checkbox"/> Excess Stress   |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Swollen Feet    |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Tendinitis      |
| <input type="checkbox"/> Constipation         | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Tingling        |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Muscle Spasms       | <input type="checkbox"/> Tumors          |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Digestive Problems   | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Whiplash        |
| <input type="checkbox"/> Disc Problems        | <input type="checkbox"/> Psoriasis           |  |

Please Check if You Are Currently Experiencing Any of the Following Conditions:

- |   |                                      |                                       |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Flu or Cold | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Fever              | <input type="checkbox"/> Infection   | <input type="checkbox"/> Pregnancy    |

HISTORY OF PRESENT ILLNESS

Location of Problem: \_\_\_\_\_

When Did You First Notice This Problem? \_\_\_\_\_

Is the Problem Constant or Variable? \_\_\_\_\_ If Variable, When and Where Does it Happen? \_\_\_\_\_

What Does it Feel Like? (Dull, Sharp, Achy, Burning, Throbbing, Numb, Etc.) \_\_\_\_\_

Are There Any Other Related Symptoms? (Headache, Insomnia, Nausea, Etc.)  
\_\_\_\_\_

Please Rate Your Pain/Discomfort? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Does This Condition Interfere With Your Normal Function? \_\_\_ No \_\_\_ If Yes, Please Explain.  
\_\_\_\_\_

List The Areas of Tension In Your Body and Any Related Symptoms: \_\_\_\_\_

Please Rate Your Energy Level? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Please Describe Your Appetite:  
\_\_\_\_\_

How Many Glasses of Water Do You Drink Daily? \_\_\_\_\_

How Many Hours of Sleep Do You Average Each Night? \_\_\_\_\_ Please Describe Any Sleep Difficulties: \_\_\_\_\_

Check Those Which You Consume: \_\_\_Alcohol \_\_\_Caffeine \_\_\_Cigarettes \_\_\_Recreational Drugs

Physical Activity: \_\_\_Light \_\_\_Moderate \_\_\_Heavy

How Often Do You Exercise? \_\_\_\_\_ What Type? \_\_\_\_\_

PLEASE READ AND SIGN

I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical purposes. I authorize Eric J. Spivack, LMP/Dipl.Ac. Inc. (DBA Soaring Crane Massage & Acupuncture) to obtain any information from my primary health care providers concerning my health. I clearly understand that massage therapy and acupuncture treatments are my personal financial responsibility, and I agree to pay for these services at the time of treatment, unless other arrangements have been made. I understand that I will be charged for any appointment broken with less than 24 hours notice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Informed Consent for Acupuncture and Oriental Medicine

**Nature of Treatment:** Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), infra-red (heat lamps), therapeutic exercises and dietary counseling based on the fundamentals of Chinese medicine.

**Purpose of Treatment:** The purpose of the treatment is to resolve your complaint, i.e. the reason that you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Based on these theories, diagnosis and treatment are used to promote health and treat organic or functional disorders.

**Benefit of Treatment:** Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health Organization lists 40 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. As with any form of health care, there is no guarantee regarding the outcome of any course of treatment.

**Risks of Treatment:** Acupuncture and Oriental medicine have been shown to be relatively safe. However, there are some uncommon, but potential risks. These potential risks may include, but are not limited to:

- discomfort during and after the insertion of a needle
- "needle sickness" (dizziness, fainting, nausea)
- localized, minor bruising or swelling
- minor burns with the use of moxa
- temporary aggravation of symptoms that existed prior to treatment
- a broken needle (rare with the use of disposable needles-see below)
- infection (rare with the use of disposable needles-see below)

**Special Situations:** Some acupuncture points are contraindicated during pregnancy. Please notify your practitioner if you are or might be pregnant. Additionally, you need to inform your practitioner if you have severe bleeding disorders, or if you are wearing a pacemaker or other electronic medical device.

**Use of Disposable Needles:** To reduce the possibility of infection from acupuncture, all needles used at this office are pre-sterilized, one-time-use needles made of surgical stainless steel. After each treatment, they are disposed of as medical waste. Needles are never reused.

**Unforeseen Risks:** Of course, your practitioner is unable to anticipate or explain all risks and complications that may occur during or after a treatment. Your practitioner will exercise judgment based upon his determination of your best interests.

**Requirement of Washington State Law:** Washington State Law does not permit acupuncturists to treat certain disorders without the consultation of a physician, i.e. a medical doctor. These conditions are:

- a) Cardiac conditions including uncontrolled hypertension
- b) Acute abdominal symptoms
- c) Acute undiagnosed neurological changes
- d) Unexplained weight loss/gain in excess of 15% of body weight within a 3-month period.
- e) Suspected bone fracture or dislocation
- f) Suspected systemic infection

- g) Any serious undiagnosed hemorrhagic disorder
- h) Acute respiratory distress (without previous history or diagnosis)

**The Consent Part**

I \_\_\_\_\_, request and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that I am free to withdraw my consent, and that I may stop treatment or any procedure at any time. I understand that my signature on this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask. I hereby release Eric J. Spivack, LMP/Dipl.Ac., Inc. (DBA Soaring Crane Massage & Acupuncture) from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Patient's Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

## **Notice of Privacy Practices**

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

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

### **MY PLEDGE REGARDING YOUR MEDICAL INFORMATION**

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situation, the law requires me to disclose your health information without either a written or verbal consent.

### **USE AND DISCLOSURE WITH CONSENT INFORMATION**

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I are required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

### **USE AND DISCLOSURE WITHOUT CONSENT**

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any

other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.

- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a health-care provider (examples are lawyer, healthcare research firm, etc). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

This notice is effective as of March 17th, 2003, and I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about my privacy practices: For more information on HIPPA or to file a complaint:

Privacy Officer  
Soaring Crane Massage & Acupuncture  
2119 17<sup>th</sup> Avenue South  
Seattle, WA 98144  
(206) 726-1785

The US Dept of Health & Human Services  
Office of Civil Rights  
200 Independence Ave. SW  
Washington DC 20201  
877-696-6775 (toll free)

This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.

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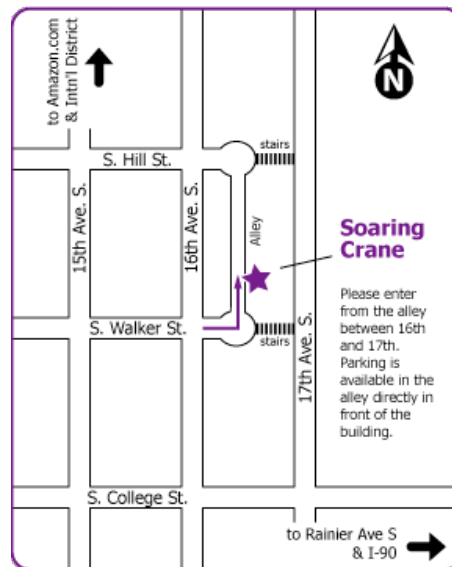
Signature of Patient or Legal Representative

Date

Please follow these directions carefully, as it is easy to get lost while finding this very special tucked away office. Please do not use google or mapquest, since they will put you in a different place!

**Soaring Crane** is located on North Beacon Hill in a classic 1909 private residence at 2119 17th Avenue South, Seattle, WA 98144. Access to the office is from a residential alley located between 16th Avenue South and 17th Avenue South.

**Essential Information about This Location:** Although the address is on 17th Avenue South, the house is accessible ONLY through the alley between 16th & 17th Avenues South and S. Walker and S. Hill Streets. The house is painted dark plum and is the 2nd house on the right from the S. Walker cul-de-sac, just after the log cabin. Go through the cedar gate and follow the garden path along the right side of the house. Go up the back stairs and follow the signs to the office entrance.



**Bus Service:** Metro Buses #36 and #60 serve the neighborhood and come within 2 blocks of my office.

**Light Rail:** The Sound Transit Beacon Hill Light Rail Station is located exactly 2 1/2 blocks south of my office. When you exit the elevators, turn right (heading north) and walk along 16th Avenue South for 2 1/2 blocks. Refer to the map above.

**Parking:** There is space for four vehicles in the alley directly in front of the office. Ample street parking is also available in the cul-de-sac of S. Walker.

**Driving Directions from I-5 traveling NORTH-bound:**

- You are Northbound on I-5.
- Take the W SEATTLE BRIDGE/COLUMBIAN WAY- EXIT 163
- Merge onto COLUMBIAN WAY S.
- Turn LEFT at the first light at S SPOKANE ST.
- Turn LEFT at the first light onto 15TH AVE S.
- Go through the business district & turn RIGHT onto S WALKER ST, which is one street after the traffic light at S. COLLEGE.
- Turn LEFT into the alley just before the cul-de-sac ends.
- See the **Essential Information** section above for remainder of directions

#### **Directions from I-5 traveling SOUTH-bound:**

- You are Southbound on I-5.
- Merge onto I-90 E & get into the right lane.
- Take the first exit - RAINIER AVE. S. & turn RIGHT onto RAINIER AVE. S.
- Go one block & turn RIGHT at the light onto S MASSACHUSETTS ST.
- Turn LEFT onto 17TH AVE S.
- At the first traffic light, turn RIGHT onto S. COLLEGE.
- Go 1 block & turn RIGHT onto 16TH AVE. S.
- Go 1 block & turn RIGHT onto S. WALKER ST.
- Turn LEFT into the alley just before the cul-de-sac ends.
- See the **Essential Information** section above for remainder of directions

#### **Directions from I-90 traveling WEST-bound:**

- You are Westbound on I-90.
- Take the RAINIER AVE S - EXIT 3-A.
- Go under the bridge & turn RIGHT at the 2nd light onto S MASSACHUSETTS ST.
- Turn LEFT onto 17TH AVE S.
- At the first traffic light, turn RIGHT onto S. COLLEGE.
- Go 1 block & turn RIGHT onto 16TH AVE. S.
- Go 1 block & turn RIGHT onto S. WALKER ST.
- Turn LEFT into the alley just before the cul-de-sac ends.
- See the **Essential Information** section above for remainder of directions

#### **Directions from HWY 99 (Aurora Ave.) traveling SOUTH-bound:**

- You are Southbound on HWY 99.
- Take the 1st Ave. South exit (Safeco & Qwest fields).
- Stay on 1st Ave for about 1/2 mile and take a LEFT onto S. HOLGATE.
- Go over the railroad tracks and continue up the hill as you drive over I-5.
- At the stop sign, turn LEFT onto 14th AVE. S.
- Go 2 blocks & turn RIGHT onto S. WALKER ST.
- Stay on S. WALKER for 2 blocks until it ends at a cul-de-sac.
- Turn LEFT into the alley just before the cul-de-sac ends.
- See the **Essential Information** section above for remainder of directions.

The Cedar Gate

