PATIENT'S PERSONAL HISTORY

CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name			Marital Status
Sex M F	Patient's Date of Birth	E-mail	
Telephone (Home) ( ) Primary ☐		Telephone (Mobile) ( ) Primary ☐	
Address			
City		State	Zip

Employer			
Employer	Occupation		
Telephone (Bus.) ( )			
Address	City	State	Zip

Insurance Company	Insured's Date of Birth

If you would like us to courtesy-bill your insurance company electronically on your behalf, please give your insurance card to the receptionist to make a copy.

Emergency Contact	Relationship
Primary Phone ( )	Secondary Phone ( )

How were you referred to our office?:

Have you ever had acupuncture?: ☐ Yes ☐ No | If yes, condition treated

Have you ever been diagnosed with any of the following?: Hepatitis: ☐ Yes ☐ No HIV Virus: ☐ Yes ☐ No AIDS: ☐ Yes ☐ No

If you are currently under another physician's care for any medical conditions, please give your doctor's name and the medical condition:

Doctor	Medical Condition
Doctor	Medical Condition

If you are currently taking any prescription medications, please list each of them:

Medications

List Any Substances You Are Allergic To:

List any conditions you would like us to focus on:

CONSENT FOR ACUPUNCTURE

I, the undersigned, realize that acupuncture may be considered an investigative procedure in the United States of America.
I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Patient's Signature ____________________ Date ____________________

© 2003 Acupuncture Fertility Center, Inc.

PATIENT PROFILE

CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name:	Date:

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms, thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience, use two checks for those which occur often, and three checks for symptoms that are a major concern.

WATER ELEMENT

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Lower back ache
- ☐ Neck pain
- ☐ Sinus congestion
- ☐ Edema
- ☐ Emotional instability
- ☐ Aversion to cold
- ☐ Hair thinning or loss
- ☐ Premature aging
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Prespire very easily
- ☐ Weakness of legs / knees
- ☐ Asthmatic cough
- ☐ Rapid weight change
- ☐ Loose teeth
- ☐ Reduced sexual energy
- ☐ Thyroid problems
- ☐ Diabetes

WOOD ELEMENT

- ☐ Headaches
- ☐ Migraines
- ☐ Ringing in the ears
- ☐ Eczema
- ☐ Herpes simplex
- ☐ Warts
- ☐ Nervousness
- ☐ Convulsion, spasms
- ☐ Irritability
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Vomiting
- ☐ Gallstones
- ☐ Indecisive
- ☐ Fullness below ribs
- ☐ Shoulder pain/tension
- ☐ Neck pain/tension
- ☐ Insomnia 11PM - 3 AM

FIRE ELEMENT

- ☐ Dry Scalp
- ☐ Skin eruptions, rashes
- ☐ Cysts, tumors
- ☐ Ear infections
- ☐ Sore throat, tonsilitis
- ☐ Lymphatic swelling
- ☐ Hot palms and soles
- ☐ Heart palpitations
- ☐ Aversion to heat
- ☐ Bitter taste in mouth
- ☐ Gum problems
- ☐ Nose bleed
- ☐ Facial redness
- ☐ Itching / burning skin
- ☐ Hot hands
- ☐ Hot feet
- ☐ Thirst
- ☐ Vivid dreaming
- ☐ Dark urine
- ☐ Flatulence
- ☐ Food allergy
- ☐ Stomach ache
- ☐ Stomach ulcer
- ☐ Diarrhea
- ☐ Anemia
- ☐ Halitosis
- ☐ Sores in mouth
- ☐ Heartburn
- ☐ Strong appetite
- ☐ Weak appetite
- ☐ Nausea
- ☐ Abdominal bloating
- ☐ Low body weight

METAL ELEMENT

- ☐ Bronchitis
- ☐ Asthma
- ☐ Shallow breathing
- ☐ Cough
- ☐ Sinus congestion
- ☐ Nasal infections

OTHER

- ☐ Fatigue
- ☐ Athralgia
- ☐ Sciatica
- ☐ Nerve pain
- ☐ Cold hands
- ☐ Cold feet
- ☐ Tendonitis
- ☐ Bursitis

PAIN (describe below)

____

____

____

OTHER COMMENTS

____

____

____

WOMEN'S FERTILITY HISTORY

 CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name:	Date:

Age when menses began: ______

Have your cycles changed since they began? ☐ Yes ☐ No

If yes, how? ______

Are your periods painful? ☐ Yes ☐ No

If yes, how many days does the pain last? ______

How many days do you normally bleed? ______

How heavy is the bleeding?

	1	2	3	4	5	6	7	8	9	10	11	12
Heavy												
Normal												
Light												

Day

What color is the blood? ☐ Light Red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Do you have premenstrual tension? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycle spaced irregularly? ☐ Yes ☐ No

Date last mentrual cycle began ______

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

	Number	Years
How many pregnancies have you had?		
How many children do you have?		
How many abortions have you had?		
How many miscarriages have you had?		
How many times has a D&C been performed?		

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with chlamydia? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Do you have any sores on your genitalia? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No

If yes, how were you treated for it? ______

Date of last pap smear ______

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever been diagnosed with adhesions? ☐ Yes ☐ No

Have you ever been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you ever taken oral contracepives? ☐ Yes ☐ No
When? ______ How long? ______

Have you ever taken DepoProvera? ☐ Yes ☐ No
When? ______ How long? ______

other than contraceptives? ☐ Yes ☐ No

Medication	Reason	How Long

© 2003 Acupuncture Fertility Center, Inc.

WOMEN'S FERTILITY HISTORY

 CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name:	Date:

How long have you been trying to conceive? ____________

Have you had a diagnosis relating to fertility? ☐ Yes ☐ No

If yes, what was it? ____________

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when? ____________
Where? ____________
By whom? ____________
What types? ____________

Have you taken medication to help you ovulate? ☐ Yes ☐ No

If yes, what? ____________
When? ____________
How long? ____________

Have your fallopian tubes been medically evaluated? ☐ Yes ☐ No

If yes, what were the results? ____________

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone lab tests perfomed? ☐ Yes ☐ No

If yes, what were the results? ____________

____

____

Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No

Are you currently taking steroids? ☐ Yes ☐ No

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No

If yes, how long have you been together? ____________

Has he had a fertility workup? ☐ Yes ☐ No

If yes, what were the results? ____________

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Do you douche regularly? ☐ Yes ☐ No

If yes, with what? ____________

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% under your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you drink coffee, tea or sodas? ☐ Yes ☐ No

If yes, how much? ____________

Do you smoke? ☐ Yes ☐ No

Do you have excessive facial hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Have you noticed discharge from your nipples? ☐ Yes ☐ No

Notes: ____________

____

© 2003 Acupuncture Fertility Center, Inc.

MEN'S FERTILITY HISTORY

CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name:	Date:

How long have you and your partner been trying to conceive? ____________________

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have an undescended testes? ☐ Yes ☐ No

Have you ever been diagnosed with a varicocele? ☐ Yes ☐ No

Have you had any urologic surgeries? ☐ Yes ☐ No

Have you had a vasectomy reversed? ☐ Yes ☐ No

Have you experienced difficulty maintaining erection? ☐ Yes ☐ No

Have you experienced difficulty ejaculating? ☐ Yes ☐ No

Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you experienced any penile discharge? ☐ Yes ☐ No

Do you regularly experience nocturnal emission? ☐ Yes ☐ No

Have you had a fertility workup? ☐ Yes ☐ No

If yes, what was your sperm count? ☐ Below normal ☐ Normal Number ____________________

What was the sperm motility? ☐ Below normal ☐ Normal Notes ____________________

What was the sperm morphology? ☐ Below normal ☐ Normal Notes ____________________

Please list any prescription medications you are currently taking: ____________________

Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

Notes: ____________________

© 2003 Acupuncture Fertility Center, Inc.

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. __________
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. __________
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. __________
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell __________
- I understand that travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the past 14 days, I have NOT traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. __________
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. __________
- I have been offered a copy of this consent form. __________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	__________	Parent / Guardian Signature	__________	Witness Signature	__________
Name	__________	Name	__________	Name:	__________
Date	__________	Date	__________	Date:	__________

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 the acupuncturist indicated 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 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, 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 be 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.

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.

ACUPUNCTURIST NAME: Jeneanne Paden, L.Ac.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

FEES, INSURANCE AND PAYMENT AGREEMENT

8950 Villa La Jolla Dr, Ste C126 ◆ La Jolla, CA 92037 ◆ Ph: (858) 546-1530

Name:	Date:

The fees charged at Acupuncture Fertility Center, Inc. and Galena AcuSpa are comparable to those charged by other specialists with similar qualifications in this geographic area.

The fees for office services are payable at the time of the visit, except in cases explained below. For your convenience we accept cash, personal checks, Mastercard, Visa, Discover and American Express.

All of our providers are considered "out-of-network" providers. If you carry health insurance covering any service that we offer, we can provide you with the necessary paperwork for you to receive reimbursement, or we can courtesy bill your carrier electronically on your behalf. Amounts billed by our office that are not reimbursed by your insurance company are the responsibility of the patient or their legal gaurdian.

If you choose to have acupuncture at your doctor's office during your IVF transfer, you will be solely responsible for these fees, and an insurance claim will not be submitted by our office.

If you are part of an industrial accident, on your first visit you must provide us with the proper paperwork signed by your employer, supervisor or medical referral with authorization from your Workers Compensation Carrier. We cannot treat you until we have proper authorization. Office visits will be billed directly to your Workers Compensation Carrier.

In cases where payment becomes overdue, we reserve the right to apply a finance charge at an interest rate of 1.5% per month for every month the account remains overdue.

If you agree to the above terms, please sign in the space provided below.

____

Patient's Signature

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Acupuncture Fertility Center, Inc. dba Galena AcuSpa dba Acupuncture Fertility Center Notice of Privacy Practices. I further acknowledge that a paper copy of the current notice will be on file at all locations and will be available to me at my request during office hours, and that a current copy of the notice is available to me at www.acufertility.com.

Name of Patient:_______________________________________ Date:______________________

Patient Signature:______________________________________ Phone:_____________________

If patient is a minor, parent or legal guardian must sign below:

Parent or Legal Guardian of Minor Patient:____

Acupuncture Fertility Center, Inc. dba Galena AcuSpa
Acupuncture Fertility Center, Inc. dba Acupuncture Fertility Center

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.
IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK OUR STAFF.

Acupuncture Fertility Center, Inc. understands that your medical information and your health is personal and should be confidentially maintained. We are committed to protecting medical information about you. We are also committed to providing you with the best possible care. In order to serve you properly, we create a record of the care and services that we provide to you. This notice applies to all records that we generate to serve you. The following policy will be followed by everyone of our employees to ensure your information is confidentially maintained. This notice will explain the ways we use information about you in order to make sure that you receive all the care you need.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect on 08/01/2003, 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 changes are permitted by applicable law. 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, healthcare operations and payment. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose medical information in the form of a patient status report to your worker's compensation carrier or insurance company representative so that they may monitor how you are progressing.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare 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.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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 medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

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

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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed you health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six (6) years, but not before April 14, 2003. 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.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by reasonable alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. 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.

Contact: Jeneanne Paden, L.Ac.
c/o Acupuncture Fertility Center
8950 Villa La Jolla Dr, Ste C126
La Jolla, CA 92037
(858) 546-1530
E-mail:jvpaden@acufertility.com