Allexi Chiropractic and Acupuncture

813 Fox Lane Ste D, Waterford, WI 53185

CONFIDENTIAL PATIENT INFORMATION

First Name: ____________________ Last Name: ______________________ Middle Initial: ____

Preferred Name: __________________ Address: _______________________________________

City: ______________________________ State: ___________ Zip: _________________________

Birthdate: _____-_____-_________ Age: ______ Children? Ages/Names ______________________

Gender: □ Male □ Female Status: □ Single □ Married/Partner □ Divorced □ Widowed

Home Phone: ( ) ____________________ Cell Phone: ( ) ________________________

Employer: _______________________________ Work Phone: ( ) ________________________

Referred by: □ Our Website □ Phonebook □ Internet □ NAET Website

□ A Current Patient: _________________________ □ Referral: ___________________

NOTICE OF PRIVACY PRACTICES (FEDERAL HIPAA PRIVACY ACT)

Effective Date for this Notice: October 2011

This notice describes how your protected health information may be used and disclosed, your rights as a patient, our legal duties with respect to your information, and how you can access additional information.

We may use or disclose your health information for the following purposes:

- **Treatment:** to all providers and staff within our clinic that are involved with your care; to other health care providers consulting with your care; and for contacting you about appointments, treatment options, and clinic-related information.
- **Billing and Collection:** to your insurance carrier and/or financially-responsible party to obtain payment for your medical services.
- **Health Care Operations:** for quality control; for office administration, development, and record-keeping; and for training providers and staff within our clinic.

Your rights with respect to your health information allow you to:

- Inspect and obtain a copy of your health record
- Amend your health record and/or request a restriction on certain uses and disclosures of your information
- Receive confidential communications by alternative means or locations
- Obtain a paper copy of notice upon request
- File a complaint regarding our privacy notice or practices

We are required by law to:

- Maintain the privacy of your protected health information
- Provide you with a notice of our privacy practices, including any future revisions
- Abide by the terms of this notice

Contact for additional information:

If you have any questions, concerns, or complaints about our privacy policies, your privacy rights, and/or your protected health information, please contact:

Allexi Chiropractic and Acupuncture LLC
813 Fox Lane Ste D, Waterford, WI 53185
Phone: (262) 323-2925

Patient (*or Authorized Rep.*) Signature: ___________________________________ Date: ______________

Authorized representative's relationship to patient: __________________________

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DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT

Dr. Jasmine S. Allexi, D.C., L.Ac. Graduated with a Doctorate in Chiropractic and a Certificate in Acupuncture from Northwestern Health Sciences University in 1995. Dr. Allexi graduated from Midwest College of Oriental Medicine in 2003 with a Masters in Acupuncture. Dr. Allexi has a Diplomate in Acupuncture from the National Certification Commission for Acupuncture and Oriental Medicine. Dr. Allexi is licensed to practice both chiropractic and acupuncture under separate licenses in the state of Wisconsin.

Under Dr. Allexi's chiropractic license, she is able to perform examinations, chiropractic adjustments, electrical stimulation, therapies, x-rays and request lab work for patients. Chiropractic focuses primarily on the musculoskeletal and nervous system. Dr. Allexi is able to advise patients on nutrition and nutritional supplementation through her nutritional counseling certificate. Under Dr. Allexi's acupuncture license, she is able to perform examinations, insert needles, apply electric current to needles, apply non-needle stimulation of meridians, use cupping, gua sha, heat, infra-red, therapies, and herbal medicine and supplementation to move and balance energy in the body. Acupuncture focuses on regulating and balancing energy which flows through meridians throughout the body. Dr. Allexi uses only sterile, disposable needles in her acupuncture treatments.

Acupuncture may cause minor bruising, minor bleeding, minor reddening of skin, some pain at the site of needle insertion, and, rarely, allergic responses to herbal medicine. Fire cupping can cause bruising and in rare cases blistering. Acupuncture and Chinese medicine provide an energetic assessment of the body and organ systems and in no way purports to be an allopathic or Western medicine evaluation, diagnosis, or treatment.

I understand that Dr. Allexi is both a chiropractor and an acupuncturist. I understand that these are separate and completely different professions employing different healing modalities. I understand that no guarantee has been made as to the use and effects of acupuncture and herbal medicine on my health. I have read the above information for myself (or my dependents) and I hereby authorize Dr. Allexi to perform treatment on me. I understand that in any practice of medicine there may be risks or complications associated with treatment. I do not expect Dr. Allexi to be able to anticipate and explain all risks possible with acupuncture treatment, but I have been given the opportunity to ask questions and discuss my concerns. Therefore, I wish to rely on the judgment of Dr. Allexi during the course of my treatment and care, based on the facts then known.

AUTHORIZATIONS

Please initial by each statement and sign below to indicate your acceptance of stated terms:

______ 1. I certify that I am the patient (or authorized representative of the patient) and all information I furnish is current, valid, and complete.

______ 2. I understand that my payment is due at the time of service.

______ 3. I understand that Dr. Jasmine Allexi does not bill insurance companies for acupuncture services or herbal medicine. At my request, she will supply me with a receipt that I may choose to submit for possible reimbursement. **I accept financial responsibility for all fees and any non-covered or under-covered services by my insurance company. I will verify all benefits with my insurance company.**

I, ________________________________, have read both the **DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT** and **AUTHORIZATIONS**. I accept the terms of each.

Print Your Name

Patient (*or Authorized Rep.*) Signature: ________________________________ Date: ______________

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Witness Signature and Date