



Acupuncture & Nutrition Clinic

Karen Siegel Propis MPH, MS, R.D., L.D., LAc

9660 Hillcroft, Suite 202, Houston, Texas 77096

Welcome to our office!

Our entire team would like to thank you for selecting us to care for your acupuncture and/or nutritional needs.

We strive to provide each person with the highest quality care in a gentle, efficient, and pleasant manner. It is our goal to help you enjoy the benefits of good health for the rest of your life.

To make the first appointment as comfortable as possible for you, we ask that you fill out the enclosed patient information sheets at your convenience. Please fill them out prior to your appointment and bring them with you to your first visit.

If you have any questions, please do not hesitate to call. We are looking forward to meeting you on your initial visit. The date and time of your appointment is filled in for you on the enclosed questionnaire.

Thank you and we look forward to seeing you soon.

Sincerely,

A handwritten signature in black ink that reads "Karen Siegel". The signature is written in a cursive, flowing style.

Karen Siegel, MPH, MS, RD, LD, LAc



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Patient Information:

Name: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

Date of birth: _____ Social Security: _____ Driver's Lic.No.: _____

Marital status: Married / Single / Divorced / Other

Height: _____ Weight: _____ Children's ages: _____

Home Phone No. _____ Email: _____

Cell No. _____ Other/Fax: _____

Work No. _____

Employer's Name: _____ Address: _____

Occupation _____

***** ***** *****

Referring doctor/therapist's name: _____

Address: _____ City/State _____ Zip: _____

Phone No. _____

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

I authorize Karen Siegel, MPH, RD, LD, LAc. To
Dietitian / Acupuncturist

- . Discuss my treatment progress
- . To obtain medical records and/or progress notes
- . To release medical records and/or progress notes

With/To/From the following individuals:

. Primary Therapist	. Physician	. Other _____
Name: _____	_____	_____
Address: _____	_____	_____
_____	_____	_____
Phone: _____	_____	_____

I understand that my records and treatment are confidential and will not be disclosed without my consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Date: _____ Client Signature: _____
Address: _____
Parent/Guardian Signature _____
Dietitian/Acupuncturist Signature _____

I hereby revoke my consent:

Date: _____ Signature: _____

I hereby acknowledge I have been asked to sign the above exchange of confidential information and elect to revise permission.

Date: _____ Client Signature: _____
Parent/Guardian Signature: _____
Dietitian/Acupuncturist Signature: _____

NUTRITION ASSESSMENT

Please provide the following information on professionals with whom you are in treatment

Therapist	Physician	Psychiatrist
Name: _____	_____	_____
Address: _____ _____	_____	_____
Phone: _____	_____	_____

Have you ever worked with a nutritionist? Yes ___ No ___ If yes, who: _____

List any medications you are currently taking:

List food and/or vitamin/mineral supplements you are taking:

The following are questions relating to your eating and exercise patterns and your weight history. Please complete them to the best of your ability.

1. Describe what hunger feels like to you: _____

2. Describe what fullness feels like to you: _____

3. How do you know when to quit eating: _____

4. Do you usually eat when you get hungry? Yes _ No _ Describe: _____

5. Do you often eat when you are not hungry? Yes _ No_ Describe: _____

6. Can you tell the difference between physical hunger and “emotional hunger”? Yes _ No _

7. What was your highest weight? _____ Age _____ What was your lowest? _____ Age _____

8. How often do you weigh yourself? _____

9. What is your desired weight? _____ Last time you weighed this? _____ For how long? _____

10. What do you believe is a reasonable weight for recovery? _____

11. “Set Point” is a weight where the body tends to stabilize and eating patterns become easier to normalize. What do you think your “set point” weight is? _____ Last time you weighed this? _____ For how long? _____

WOMEN ONLY

12. Are you on birth control pills? Yes ___ No ___

13. Approximate date of last menstrual period? _____

14. What is your average weight fluctuation during your cycle? _____

15. How old were you when you first started your menstrual cycle? _____

16. As you lose weight, do your cycles become irregular or cease? Yes ___ No ___

17. Do you have problems with:

a) constipation? Yes ___ No ___ Describe _____

b) diarrhea? Yes ___ No ___ Describe _____

c) nausea? Yes ___ No ___ Describe _____

d) "bloating"? Yes ___ No ___ Describe _____

18. Circle any of the following that describes your eating patterns:

a) Eat 3 meals a day.

b) Eat a 'normal' amount of food.

c) Eat 3 meals with snacks.

d) Restrict intake of food.

e) Binge without purging.

f) Binge followed by vomiting.

g) Binge followed by restricting food intake

h) Binge followed by laxatives

i) Binge followed by diuretics

j) Binge followed by exercise

k) Vomit without binging

l) Restrict food intake without binging

m) Use laxatives without binging

n) Use diuretics without binging

o) Exercise excessively without binging

19. Are you currently engaged in a regular exercise program? Yes _ No _

Please describe: _____

20. Describe past history with exercise: _____

21. Do you consider yourself a compulsive exerciser? Yes _ No _

22. List any nutrition/eating patten/exercise goals you hope to achieve as a result of nutritional counseling:

[PATIENT'S COPY]

Acupuncture and Nutrition Clinic

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At the Acupuncture and Nutrition Clinic we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the Acupuncture and Nutrition Clinic, a record of your visit is made. Typically, this record contains your name, contact information, symptoms, examination, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the Acupuncture and Nutrition Clinic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been

taken.

Our Responsibilities

The Acupuncture and Nutrition Clinic is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization

If have questions and would like additional information, you may contact the Acupuncture and Nutrition Clinic office at 713-721-7755. If you believe your privacy rights have been violated, you can file a complaint with this clinic, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either this Clinic or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this document

I, *(please print)* _____, have a received
a copy of this office's Notice of Privacy Practices

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

EXAMPLE TO FOLLOW IN LISTING FOOD EATEN (See Instructions below)

<u>Time</u>	<u>Food</u>	<u>Amount</u>	<u>How prepared</u>
7 am	Corn Flakes	1 cup	
	2% Milk	1 cup	
	Orange Juice	½ cup	
12 pm	Chicken	6 ounces	Fried
	Mashed Potatoes	½ cup	with margarine & 2% milk
	Coleslaw	½ cup	1 tsp. salad dressing
	Coke	12 oz	
4 pm	Oreos	10	
6:30	2% Milk	1 cup	
	Chocolate Cupcake	1	with vanilla icing
7:30	Sirloin Steak	10 oz	Grilled
	Baked Potato	1 large	
	Margarine	1 tsp	
	Sour Cream	1 tbsp	
	Tossed Salad	1 bowl	
	1000 Island Dressing	1 tbsp	
	Fruit Salad	1 cup	
	White wine	8 oz	
10:30	Wheat Thins	20	
	Peanut Butter	2 tbsp	
	2% Milk	1 cup	

In the space below, please write down everything you have had to eat and drink over the past 2 days. Include the time of day, the food eaten, the quantity of food consumed and how the food was prepared. See the example above.

<u>Time</u>	<u>Food</u>	<u>Amount</u>	<u>How prepared</u>
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