CHUNG INSTITUTE OF INTEGRATIVE MEDICINE

M. Kyu Chung, M.D. Andrew Oswari, M.D. Kevin Ng, M.D. Tracy Brobyn, M.D.

Dear Prospective Patient:

Your first visit is extremely important in setting the direction of your care. The information that you provide in the enclosed forms plays a large part in setting that direction.

Enclosed is a packet for new patients. We need you to complete this before your office visit. Completion of the forms in this packet will help us to thoroughly evaluate your health problem and to avoid delays and long wait times when you arrive for your first visit. The form titled Initial Patient Questionnaire must be filled out then either emailed, faxed or sent to our office before your appointment in time for us to prepare another document which will facilitate your care. Fill out the questionnaire to the best of your memory. You are free to contact our office for help while you fill out the questionnaire at home.

After receiving your returned questionnaire, a staff member will contact you via telephone if she has any questions after reading your returned forms. Remember you are free to contact us for help while you fill out the questionnaire at home.

Here is a check list of items you should prepare prior to coming to the office:

_____ 1. Read and sign the **General Informed Consent for Evaluation and Treatment, Financial Agreement, HIPPA Notice for Privacy Practices, Advance Beneficiary Notice (only for Medicare patients), and Audio/Visual Recording Consent Form.**

_____ 2. Complete the **Patient Registration Form, Initial Patient Questionnaire, and the Health Survey.**

_____ 3. Bring copies of the **written reports** of labs, X-rays, MRI's, CT scans, specialists' consultations reports. You do not need to bring copies of the actual X-ray or scans.

_____ 4. If you take medications, non-prescription supplements, herbs, vitamins, homeopathic remedies, and/or creams, please place a single dose of each item into a small half size **zip-lock bag**, labeled with a magic marker. Bring these items in and we can evaluate them for compatibility to your body.

_____ 5. Read pages pertinent to you at our website: www.chunginstitute.com . In particular, we recommend patients to read "**autonomic response testing**" at:

http://www.chunginstitute.com/Chung_Institute_of_Integrative_Medicine/Autonomic_Response_Testing.html

Thank you for helping us to give you the best possible care.

Our email address is: info@chunginstitute.com

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General Informed Consent for Evaluation and Treatment, Autonomic Response Testing, Acupuncture and Scar Injection

I,_____the recipient, understand that:

The Chung Institute of Integrative Medicine is a medical center that considers the practice of medicine both a science and an art. Also, I understand that all things related to the human body cannot be explained by current conventional knowledge in science.

By coming to the Chung Institute, I, as a patient, realize that the Institute will use techniques that are unique, and alternative compared to the methods commonly utilized by regular conventional physicians. **In fact, there will be numerous instances where the methods employed by the Chung Institute will be largely unrecognized by "mainstream" conventional physicians**. These methods include many diagnostic and treatment techniques, however most of our patients will receive at a minimum, a combination of autonomic response testing, scar injection and acupuncture which will be addressed below in this, our main consent form.

These methods may include the following alternative techniques (this list below is not all inclusive):

- **Alternative diagnostic Techniques**

  Autonomic Response Testing (ART), Manual Diagnostic Techniques, Special Laboratories (e.g.ZRT Labs, Doctor's Data or Ingenex Labs), and other diagnostic techniques unique to this center.

- **Alternative Treatments**

  Acupuncture (even our acupuncture technique is unique compared to other conventional acupuncture) and **scar and tooth Injection Therapy, herbal Therapy, homeopathy, low potency laser therapy and Color Therapies.** I understand that many homeopathic, herbal and supplements are not FDA approved. Lack of FDA approval most often means that evaluation according to FDA specifications has not occurred. The absence of FDA approval does not necessarily mean that a product or service has been shown to be harmful or ineffective. Often, complementary/alternative products and services do not undergo the evaluations to obtain FDA approval due to the cost of the evaluation process.

- **Alternative Recommendations**

  I understand that I may be recommended exercises and/or dietary changes. I may be occasionally referred to other alternative practitioners.

The majority of our patients will receive at a minimum a combination of autonomic response testing, scar injection and acupuncture which will be addressed below and is therefore included in this, our main consent.

Autonomic Response Testing

Autonomic Response Testing (ART) is a form of applied kinesiology (also known as muscle testing) developed by German physician, Dietrich Klinghardt. ART is a diagnostic technique which measures a patient's nervous system's response when that patient is brought into close contact with a substance within the patient's body. The patient's response is predictive as to whether that substance is beneficial, harmful, or neutral to the patient's body. The nervous system's response leads to energetic conduction that is picked up by an outside neutral person (or surrogate) through receptors in the skin when they are touching the patient. This translates into either a strengthening or weakening of the surrogate's strength. There are no risks when undergoing testing with ART since there is no requirement for harvesting of any blood or bodily fluids. It is considered alternative and therefore not approved by the US Food and Drug Administration, the American Medical Association, or any other regulatory agency in the United States as a diagnostic procedure.

Acupuncture

Acupuncture is a therapeutic treatment modality which originated in China nearly 4000 years ago. Acupuncture uses very fine needles (roughly the width of a human hair) which are inserted into key points in the skin throughout the body to stimulate the flow of Qi. Qi is a type of energy believed to travel throughout the body. It is felt to be essential in achieving pain relief, healing and processing of all bodily functions. Acupuncture enhances the flow of Qi and restores it to deficient areas. Many studies have been done showing the benefits of acupuncture however it remains an unconventional technique in the United States not taught in traditional medical institutions.

Acupuncture is a safe procedure, however there are still rare but possible risks. These include bleeding, infection, nerve damage and depending on the location of the needle, puncturing of a lung or vital organ. These complications are rare amongst acupuncturists throughout North America.

Scar and Tooth Injections

Scars and, on occasion, teeth, can be the cause of blockage to energy flow within the body. Like acupuncture, re-establishing energetic flow is used to reduce pain and promote healing in areas of the body that are injured or diseased. It is often necessary to re-initiate the flow of blocked energy through injection of the scar or tooth with a local anesthetic. Scar injection is performed using 0.5% procaine where the solution is injected just under the skin along the length of the scar using approximately ¼ of a teaspoon of procaine for every inch of scar injected. Teeth are also injected with 0.5% procaine just under the gum at the level of the root. Approximately 1/10th of a teaspoon of procaine is used per tooth. Three minutes after the tooth is injected with procaine, less than 1/10th of a teaspoon of ozone gas is injected just under the gum at the same site as the procaine injection.Occasionally it may

be necessary to inject a scar inside the mouth if the tonsils have been removed or if the tonsils are found to be a source of energy blockage when tested. When this is the case, the physician will inject the tonsil/tonsillectomy scar with approximately 1/10th of a tsp of 0.5% procaine. Scar and tooth injections are components of a larger discipline of procedures known as Neural Therapy, whereby local anesthetics are used to restore nervous system function and reduce pain.

The more common **risks** associated with scar and tooth injection are fainting, bleeding, allergic reaction or swelling at the site of injection. There are other more serious **risks** which are extremely unlikely, however need to be listed including internal bleeding, infection, numbness, increased pain or pain which is unchanged following treatment. Scar injections that are done over devices or implants have an added risk of possible perforation of the implant or mechanical disruption of the device. When ozone is used in the treatment of a tooth, very small amounts are used. Nevertheless, there is a small risk of a bubble of ozone gas being passed into a blood vessel which could travel to the rest of the body and cause damage. In addition, ozone should not be used on anyone on ACE inhibitors or people with overactive thyroid glands.

At the Chung Institute of Integrative Medicine, we have given over 40,000 injections and over 200,000 acupuncture needles per year for over 15 years with no known significant resultant permanent injury. We estimate that we have given over 600,000 injections and over 2 million acupuncture needle placements. We estimate that the possibilities are less than 1 in 600,000 that any given injection and less than 1 in 2 million that any given acupuncture needle will cause significant or permanent harm.

Anyone who experiences feelings of faintness or of lightheadedness should not arise without asking for our assistance. A person who arises without our assistance risks falling and injuring themselves.

Side Effects:

There is a risk of temporary increase in symptoms (sometimes referred to as a "healing crisis"), which can occur and is not rare. These usually subside within a few days and uncommonly can last a few weeks.

I understand that if I receive either an acupuncture needle or hypodermic needle injection, I can experience temporary lightheadedness, soreness, muscle cramps, fatigue, and weakness. The vast majority of these types of symptoms resolve in a few days to a week. Rarely, it can last several weeks or months.

Allergic Reactions:

Any therapy involving injecting any substances into the body or ingesting any substance by mouth can have the potential to result in a mild, moderate, severe, or even **life-threatening allergic reaction**. Severe reactions can lead to injury of internal organs. This can occur with conventional or unconventional substances. *Again, in our combined 30 years of practice experience, we have not seen any permanent injury to an organ such as the kidney, liver, heart, or any other organ.* I understand that this risk is extremely small but know that the **potential risk still exists**.

Research and Teaching:

I understand that data collected from treating me may also be used for the purpose of teaching or research and all reasonable efforts will be used to hide my identity. If I happen to verbally consent to having a video taken, I am giving permission to use that video for teaching purposes understanding that my face may not be hidden. I have the full option to refuse the taking of the video if I feel that I do not want the video shown for that purpose. My refusal will not affect in any way the choices of therapies offered to me at this center.

I understand that I do not have to undergo the alternative therapy and diagnosis offered by the Chung Institute. I can choose to be treated with traditional remedies such as drugs (pain medications, anti-inflammatory medications, antibiotics, drugs that suppress the immune system, or drugs that affect the neurologic system), steroid injections, surgeries designed to relieve pain or orthopedic injury, physical therapy, or osteopathic/chiropractic manipulation. These treatment options are available by providers outside of this practice. I am also free to choose no treatment for my condition and/or use self-help remedies such as exercise. I understand that there is no guarantee that my condition will improve with acupuncture or scar injection treatment or that the autonomic response testing evaluation will always be accurate.

I understand that the diagnostic and treatment methods received here are based on the experience, training and study of the physicians here and that they are usually not endorsed by the AMA, FDA, or mainstream medicine in general.
I have received a clear, comprehensive explanation of the risks inherent in acupuncture and scar/tooth injection therapy. I am confident I have the information necessary to understand the risks and benefits of the above described procedures. I understand that I am entitled to receive a copy of this consent form when it is completed.

I HAVE READ AND UNDERSTAND THE ABOVE. I HEREBY ELECT TO UNDERGO EVALUATION AND TREATMENT AT THE CHUNG INSTITUTE.

Signed:_____ Date: _____

_____
Print name

I have counseled the above patient regarding the risks and benefits of the above described therapy. I have explained to the patient what the alternatives are to this treatment and have answered all of their questions to their complete satisfaction.

Signature of physician:_____ Date: _____

_____
Print name

OFFICE POLICIES

- **Billing Policy**

I understand that many of the diagnostic and treatment procedures performed at the Chung Institute of Integrative Medicine are not covered by my insurance, and I will be expected to pay the full amount at the time of service. I understand that these procedures include but are not limited to the list under the "**Alternative Treatments.**"

I also understand that some types of injection therapies may be covered by my insurance. In those instances that these services are covered, the Chung Institute of Integrative Medicine will bill my insurance directly. I may contact the office at 856-222-4766 with any questions.

- **Fees**

🕓 ***Standard***
Initial Consultation and Treatment: ***$600***
I understand that this fee includes the medical history and physical evaluation and the first acupuncture treatment. If other additional procedures are performed, I understand that the charge will be extra.

Follow-Up Treatment: ***$150***
I understand that this fee **only** covers the evaluation component as well as any acupuncture that is performed. Injection therapies, supplements, and additional autonomic response testing will result in additional charges. If more than 2 problems are addressed or the follow-up problem requires additional time and testing's, I understand that there may be an additional $50-$150 charge.

Some procedures are occasionally covered by insurance. In those instances that these services are covered, the Chung Institute of Integrative Medicine will bill my insurance directly. I may contact the office at 856-222-4766 with any questions.

🕓 ***Chronic Lyme Disease***
Initial Consultation and Treatment: ***$600***
Follow-Up Treatment: ***$200***

I understand that due to the complexity of patients with chronic Lyme disease, the evaluation and treatment almost always takes much longer than a Standard visit which results in higher costs.

- **Expected Average Number of Treatment Sessions Needed**

I understand that **the number of treatments needed is highly variable**.
Generally, problems that did not involve a major trauma and have been present less than 3 months require no more than 6 treatments. Problems that have been severe and chronic usually require a minimum of 6 treatments to obtain 50% improvement and 12 treatments to obtain 80% improvement. I understand that these are averages, and I may need more or less treatments than average.

Appointment Cancellation and "No Show" Policy

I understand that the Chung Institute of Integrative Medicine ***requires*** me to cancel an appointment **at least 24 hours prior** for Tuesday – Friday appointments or the **Friday before 12:00PM** for Monday appointments. During the holidays, I may have to give the Chung Institute of Integrative Medicine **more than 24 hour notice** for cancellation. I also understand that the Chung Institute of Integrative Medicine does not have weekend hours. However, for any emergency cancellations, I may call to leave messages.

I understand that if I either ***fail to show***, or ***cancel less than 24 hours before the appointment, or cancel after 12:00PM on Friday for Monday's appointments,*** I will be charged a ***cancellation fee.***

For the ***first*** appointment, a ***cancellation fee of $150*** will be charged to the card or the check I provided when the appointment was made. I understand that I will not be able to make any future appointments until the first "No Show" payment of $150 is fully made.

The cancellation fee for ***follow-up*** appointments will be charged **$50** payable before the next appointment. I understand that I will not be able to make any future appointments until the follow-up "No Show" payment of $50 is fully made.

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Financial Agreement

- I understand that acupuncture may not be a covered service under my insurance contract and if not, I will be financially responsible for acupuncture treatments.

- I understand that even if my insurance company covers acupuncture, the Chung Institute may not participate with my insurance carrier and/or the acupuncture network associated with my insurance carrier, and I therefore may be financially responsible for payment for acupuncture treatments performed by the Chung Institute.

- I also have been informed that my insurance will be billed separately for the injections I may be receiving as they are a separate service and not a part of acupuncture.

- I have been informed that the injections I receive may not be a covered service and/or the provider of services may be out of network with my insurance carrier. In that circumstance, I will be financially responsible for payment of these services.

- I have been informed that autonomic response testing is not a covered service; therefore, I will be financially responsible for payment of these services.

Signed_____ Date_____

110 Marter Avenue
Suite 507
Moorestown, NJ 08057

PHONE (856) 222-4766
FAX (856) 222-1137
E-MAIL info@chunginstitute.com

HIPPA NOTICE FOR PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and provide individuals with this Notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any questions, please speak with our HIPPA Compliance Officer in person or by phone at our main number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

By signing this form, you are also allowing our office to:

1. Confirm appointments at your home by phone or answering machine.
2. Disclose medical information requested by other treating physicians.
3. Leave messages or discuss medical information with your pharmacist.
4. Disclose medical information to your lab/insurance company.
5. Request medical records when necessary, from physicians or health care facilities.
6. Anonymously use your charts for medical research

I hereby give permission to disclose health information (i.e. test results) about me to the following people: (please print name on the line provided)

Spouse_____

Son/Daughter_____

Mother/Father_____

Other _____

Can we leave Medical Results on your Answering Machine? Yes No

I have the right to withdraw or revise my permission at any time, in writing.

Print Patient's Name_____

Signature_____**Date**_____

Patient's Name: Medicare#(HICN):

IF YOU DO NOT HAVE MEDICARE, YOU DO NOT HAVE TO FILL THIS OUT

Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.
We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.
Right now, in your case, Medicare probably will not pay for

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $_____), in case you have to pay for them yourself or through other insurance.

Please Choose **One** Option. Check **One** Box. **Sign & Date** Your Choice

□ Option 1. YES. **I want to receive these items or services.**
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

□ Option 2. NO. **I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____
Date Signature of patient or person acting on patient's behalf

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

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Patient Registration Form

First Name: _____ Home number: _____

Last Name:_____ Cell: _____

Address:_____ Email: _____

City/State:_____ Email: _____

Zip: _____

Birthdate:_____

Soc. Sec #:_____ Sex: _____

Spouse's Name: _____ Primary Physician: _____

Spouse Birthdate: _____ Referring Physician:_____

Spouse SS#_____

Employment Information Address:_____

Occupation:_____ City/State/Zip: _____

Employer: _____

For Patients Under 18 Years of Age

Parent/Guardian Name: _____ Occupation:_____

Relation to Patient: _____ Employer:_____

Address: _____ Email:_____

City/State _____

Zip: _____ Cell:_____

Insurance Information

Ins Co: _____ **Address:** _____

Subscriber Name: _____ _____

Subscriber SS#:_____**Relation to Patient:** _____

Policy #:_____**Subscriber DOB** _____

110 Marter Avenue
Suite 507
Moorestown, NJ 08057

PHONE (856) 222-4766
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E-MAIL Info@chunginstitute.com

Initial Patient Questionnaire

Name:_____Date of Birth: _____

Date:_____

Occupation (if retired what was your prior occupation):

_____

Who referred you to our office? _____

What is the main problem that brings you to our office? (If more than one list in priority)

1. _____
2. _____
3. _____
4. _____

5. Now tell us the story of your problem beginning with approximately when it began and subsequent events that occurred in chronological order. Describe all your problems in as much detail as possible, (how often; how long do they last; how severe are they; what characteristics do they have: aching, burning, shooting, throbbing, heaviness, frightening, incapacitating, and so on):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What makes your condition worse? Sitting, standing, walking, running, other:

_____

_____

_____

What makes the problem better: lying down, heat, medications, other?

_____

_____

_____

How does your problem limit you: with work, exercise, recreation, social life, climbing stairs, getting dressed, getting into and out of car, and sitting standing, bathing?

_____

_____

_____

_____

_____

_____

_____

List the doctors/practitioners you have seen for your current problems (include type of specialty):

_____

_____

_____

_____

What tests have you had so far, (MRI, xray, ultrasound etc)? and if possible, please indicate results:

_____

_____

_____

_____

_____

_____

_____

What treatments have you had for this problem? Indicate whether they helped or didn't help: medications, surgery, physical therapy, alternative therapies (for example acupuncture,

chiropractic). Be sure to give the names of the medications and alternative therapies if you know them.

What treatments are you currently still receiving?

Medications: what medications are you currently taking?

What supplements, (vitamins, herbs, etc.) are you taking?

What medication have you tried that has not worked (include side-effects or problems)?

List any chronic medical conditions: such as hypertension, diabetes, asthma, cholesterol, heart disease, reflux, other:

List **allergies** including type (i.e. medication/food/insects/seasonal) and description of reaction:

_____

_____

_____

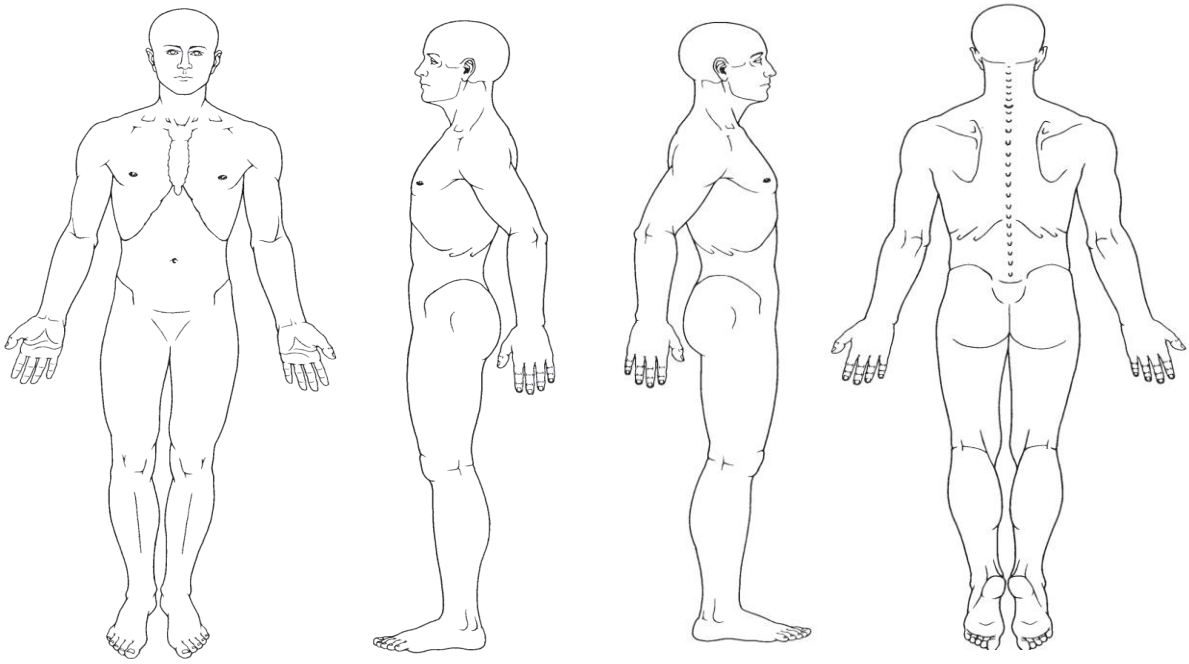
Do you smoke or use tobacco?_____How many cigarettes/packs per day? _____

Alcohol intake?_____How much or How many drinks per week? _____

For those patients who are coming to us for a painful condition please answer the following:

Please draw in the area in the figure below.

Use "X's" to indicate painful areas, "O's" for numbness or tingling:



Rate your over-all daily pain level on a scale of 0 to 10: _____

What are some things that you can't do that you hope the treatments will help you perform? (Walking, standing, exercise, lifting, sports, other):

_____

_____

_____

_____

List previous surgeries and traumas. Include **even very minor surgeries**:

_____

_____

_____

Please list where there are scars on your body including tiny or very superficial scars, vaccination scars, pimple scars, minor cuts, burns, tattoos, laser hair removal and body piercings.

_____

_____

_____

_____

_____

List **any dental procedures** have had such as, teeth extractions, root canals, number and type of fillings (especially metal):

_____

_____

_____

List any health problems in your family.

Mother:_____ Father:_____

Brothers/Sisters:_____

Children:_____

Grandparents:_____

Aunts, Uncles, others:_____

_____