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. Completing the forms in this packet will help us evaluate your health problem, schedule your first visit and make the most of your time.

The forms in the new patient packet must be completed either online, emailed, faxed or sent to our office before your appointment is scheduled. You are free to contact our office for help while you fill out the questionnaire at home.

After receiving your registration form and questionnaire, a staff member will contact you to schedule your first visit. You may also receive a call from a staff member to review your paperwork.
Here is a check list of items you should prepare prior to coming to the office:

1. Bring copies of the **written reports** of labs, X-rays, MRI's, CT scans and specialists' consultations **if possible**. Please do not bring copies of the actual X-ray or scans.

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

3. 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

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

I, ____the recipient, understand that:
The Chung Institute, as an integrative medicine group of practitioners, frequently use techniques which are largely unrecognized by “mainstream” conventional physicians. These include many diagnostic and treatment techniques which are discussed below.

Autonomic Response Testing

Automatic Response Testing (ART) is an innovative form of applied kinesiology developed by Dietrich Klinghardt,MD. The testing method is completely noninvasive. We have found this method to be useful in diagnosing our patients’ problems and in helping guide our treatments. It has allowed us to diagnose and treat patients who failed to improve with conventional means. This method is not acknowledged by mainstream physicians as a valid form of diagnosis. Like all medical tests it is not 100% accurate. By signing this consent, you are acknowledging that ART can be used to help in the management of your condition, knowing that it is an imperfect test, and that ART should not be a substitute for conventional tests (such as mammograms, MRI's, blood work etc.) that are recommended by mainstream doctors.
It is not CLIA certified. 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

Many studies have been done showing the benefits of acupuncture. 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 very rare.

Scar and Tooth Injections

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. Scar injection is performed using 0.5% lidocaine where the solution is injected just under the skin along the length of the scar using approximately ¼ of a teaspoon of lidocaine for every inch of scar injected. Teeth are also injected with 0.5% lidocaine just under the gum at the level of the root. Approximately 1/10th of a teaspoon of lidocaine is used per tooth. Three minutes after the tooth is injected with lidocaine, less than 1/10th of a teaspoon of ozone gas is injected just under the gum at the same site as the lidocaine injection.
The most 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 ozone gas being passed into a blood vessel which could travel to the rest of the body and cause damage.

Other Injection therapies

We will often recommend other alternative injection therapies including but not limited to prolotherapy, prolozone therapy, bee venom therapy, neural therapy, autosanguinous therapies. You will be asked for consent for these procedures at the time of the service. When you consent to these procedures, you understand that any and all injection therapies have a very rare possible risk of infections, damaged internal organs, punctured lung, nerve damage, severe allergic reaction, and even worsening of your condition and that when you give consent at the time of service you knowingly accept these risks. You have the option to refuse any procedure at the time of service even if you sign this consent form.

Herxheimer Response

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

Allergic Reactions

Any therapy involving injecting any substances of any kind 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 to internal organs. This can occur with conventional or unconventional substances. The risk is very small.

I understand the Chung Institute provides an alternative to standard of care. I am free to choose standard of care, no treatment and/or self-help remedies such as exercise and any combination of the above in managing my health. I understand that there is no guarantee that my condition will improve with any treatments I receive at Chung Institute and that the autonomic response testing evaluation should be supported by other diagnostic tests.

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 their questions to their complete satisfaction.

Physician signature:(to be completed in office) Date

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Patient Registration Form

First Name: ________________________

Last Name: ________________________

Address: ________________________

City/State: ________________________

Zip: ________________________

Home number: ________________________

Cell: ________________________

Birthdate: ________________________

Email: ________________________

Soc. Sec #: ________________________

Sex: ____________

Spouse's Name: ________________________

Spouse Birthdate: ________________________

Spouse SS# ________________________

Primary Physician: ________________________

Referring Physician: ________________________

Employment Information

Occupation: ________________________

Employer: ________________________

Address: ________________________

City/State/Zip: ________________________

For Patients Under 18 Years of Age

Parent/Guardian Name: ________________________ Relation to Patient: ____________

Address: ________________________ City/State ____________ Zip: ____________

Insurance Information

Ins.Co ________________________ Policy #: ________________________

Subscriber Name: ________________________ Subscriber DOB ________________________

Subscriber SS#: ________________________ Relation to Patient: ________________________

Occupation: ________________________ Employer: ________________________

Email: ________________________ Cell: ________________________

Patient History Information

Name:____________________________________Date of Birth: ________________

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 order):

Now tell us the story of your problem beginning with approximately when it began and subsequent events that occurred in chronological order. Describe in as much detail as possible. (Ex.: 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?

What practitioners have you seen for this problem? Indicate if they helped, didn't help and if you are still seeing any of them: surgery, physical therapy, alternative practitioners (for example acupuncture, chiropractic).

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

What alternative therapies have you tried? Please note which you are currently using, if any:

Medications: include prescription and non-prescription, dose and length of time you have taken____

Supplements: (vitamins, herbs, etc.) include dose, and length of time you have taken____

____

What medication, if any, have you tried that has not worked (including side-effects or problems)?

____

____

Do you have chronic medical conditions: (mark box if yes)

Hypertension	High cholesterol	Heart disease	Stroke
Diabetes	Kidney disease	Thyroid disease	Arthritis
Gallbladder disease	Irritable bowel disease		Celiac disease
Multiple Sclerosis	Alzheimer's	Parkinsons	Allergies
ADD/ADHD	Autism	Depression	Fibromyalgia
Headache	Migraine	Seizure disorder	Cancer

Do you have a family history of chronic medical conditions: (mark box if yes)

Hypertension	High cholesterol	Heart disease	Stroke
Diabetes	Kidney disease	Thyroid disease	Arthritis
Celiac disease	Cancer	Allergies	Headache
Multiple Sclerosis	Alzheimer's	Parkinsons	Migraine
ADD/ADHD	Autism	Depression	Seizure disorder

Do you have significant chronic symptoms: (mark box if yes)

Weight Change　Abdominal Pain　Bloating　Change in Appetite

Change in bowel habits　Nausea　Difficulty swallowing

Indigestion　Difficulty Urinating　Urine leaks

Frequent urination　Sexual difficulty　Fatigue　Weakness

Joint Pain　Joint swelling　Back pain　Sensitivity to Light

Sensitivity to heat or cold　Fevers　Chills　Rash

Itching　Scars　Mouth/gum sores or pain　Dizzy Spells

Blurred Vision　Ringing in Ears　Sinus problems

Difficulty falling asleep　Difficulty staying asleep　Irritability　Anxiety

Please list any surgeries or traumas:

____

____

If you have any physical scars (accidents, acne, injury or surgical scars) please list them:

____

____

Please list dental work. Include root canals, metal fillings, extractions etc.:

____

____

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? ______________
Nicotine use? ____________ Quantity___________________

Alcohol use? _____ Quantity ____________Marijuana use? ___________ Quantity_________________

If there is anything else, you'd like to share about your medical condition(s):

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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

I understand that this fee includes medical history or update, physical evaluation and acupuncture treatment. 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, I understand that there may be an additional 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.

Expected Average Number of Treatment Session 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 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.

Financial Agreement

- I understand that the majority of the treatments rendered are not covered by insurance plans.
- Specifically, I understand that acupuncture, prolotherapy, other injection therapies, autonomic response testing as well as many other alternative therapies are not covered. I will be financially responsible for these treatments.
- In those instances that my insurance covers for acupuncture and some of the injection therapies, my insurance will be billed directly. If they reject these claims, I understand I will be financially responsible.
- 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________________________

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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