EM Practitioner Intake Form

Patient: ______________________ Date: ___________ Practitioner Name: ______________

Main Complaint: ____

Secondary Complaint: ____

Tertiary Complaint: ____

Visual and Auditory Observations:____

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Observations: ____

Treatments: ____

Clear Histio: ____

Pathogens/Gu/Chong Treated With EM *Full Life Cycle Stage Treatment or the EM Pathogens Treatment:*

Practitioner Signature:___________________________

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EM Treatment Follow Up Form

Patient:____________________________ Date:___________ Practitioner: ________________________

Update Since Last Tx:____

Observations:____

Treatments

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Clear Histio:

Pathogens/Gu/Chong Treated With EM *Full Life Cycle Stage Treatment:*

Practitioner Signature:___________________________

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Practitioner Name

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY IT EXPLAINS HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

YOUR PRIVACY IS OF UTMOST IMPORTANCE.

MY LEGAL RESPONSIBILITY

Federal and state law requires all healthcare workers to maintain the confidentiality of your healthcare information. Within this notice you will find information about how I maintain your privacy, my legal responsibilities, and your rights to your own healthcare information. This notice takes into effect November 2003 and will remain in effect until it is replaced. Upon replacement of this notice, you may request a copy of the new notice at any time. I reserve the right to alter my privacy practices, including the maintenance of healthcare information received prior to any policy change, at any time as permitted by Federal and state law.

Additional copies of this notice will be made available to you at any time upon request. You may also contact me by phone, email, or postal mail to ask any questions you might have.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about your treatment, payment and healthcare operations as follows:

Treatment: Unless you request in writing to have your information disclosed with another healthcare provider or insurance company, I do not share the contents of your treatments with any other provider. I may on occasion discuss your case with other providers withholding your name and replacing it with a pseudonym. I may on occasion publish articles in which I replace my patients' names with pseudonyms.

Payment: I may use and disclose your healthcare information to obtain payment for services I provide to you. At times, I may need to call or write to you. By calling, I may leave a message on your voicemail that may be accessible to others, or I may speak with someone at your number and disclose the reason for my call. By writing, I may send you email or postal mail that may be visible to third parties.

Quality Assessment: I may send you postal mail or email containing a Quality Assessment survey which may be visible to third parties.

Your Authorization: You have the right to give me written authorization to use your healthcare information or to disclose it to anyone for any purpose. You may also revoke your authorization at any time. This revocation will not affect any disclosures permitted by your authorization while it was in effect. Without your written authorization, I cannot use or disclose your healthcare information in any other way except for the purposes described in this notice.

Your Family and Friends: With your written authorization, I may disclose your healthcare information to family members, friends or any other person to assist with your healthcare, scheduling, or with payment. Allowing family members in the treatment room while you receive treatment is your authorization that I may openly discuss your healthcare situation in their presence.

Marketing Health-Related Services: Your healthcare information will not be used for marketing purposes unless you provide written authorization to do so.

Required by Law: I will disclose your health information when required to by law.

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Abuse/Neglect/Suicidal Ideations: Under certain circumstances, I am required by law to disclose suspected abuse. If I am concerned about your immediate safety, I retain the right to contact any healthcare provider whose information you provide to me for immediate consult.

Appointment Reminders: I may call, leave a voicemail, send you email, or send you letters or postcards to remind you of appointments.

PATIENT RIGHTS

Access: At any time, and upon your written request, you may receive copies or facsimiles of your health records.

Amendment: Upon your written request, and provided a thorough explanation as to why an amendment should be made, your healthcare information can be amended. I have the right to deny such a request under certain circumstances.

Electronic Notice: This notice is posted at my website. You may also request a hardcopy.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me at the number and/or address listed below.

I support your right to the privacy of your health information and will not retaliate in any form should you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

Contact Officer: <your name>

Telephone: <phone>
Address: <address>
Email: <email>

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Notice of Privacy Practices

By signing below, I agree that I have received a copy of Notice of Privacy Practices.

Date: __________

______________________________ Patient's Name (Print please)	______________________________ Legal Guardian's Name (Print please)
______________________________ Patient's Signature	______________________________ Legal Guardian's Signature

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Informed Consent

EM Eminus Mirus

I hereby authorize ____________ (hereinafter "my practitioner") to administer Eminus Mirus (EM) to provide care relevant to my diagnosis and treatment (or relevant to the patient named below, for whom I am legally responsible).

I understand that EM diagnosis and treatment are performed without touching me and that at no time will I be asked to disrobe.

I understand that I may refuse any form of treatment. I understand the nature of the treatment for which I have made an appointment and have had an opportunity prior to signing this form to inquire about the potential risks involved.

EM is contraindicated during pregnancy. I will, therefore, inform my practitioner *immediately* if I am or become pregnant.

In the case of a medical emergency, I know that I should contact my primary care physician immediately and/or go to the hospital emergency room and seek emergency medical care before attempting to contact my practitioner.

I have read, or have had read to me, the above consent and by signing below I agree to the above-named procedures. This consent form will cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Date: __________

___________________________	____________________________
Patient's Name (Print please)	Legal Guardian's Name (Print please)
___________________________	_____________________________
Patient's Signature	Legal Guardian's Signature

____

Name & Number of Primary Care Physician (for emergency reasons only):

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