New Patient Intake - Acupuncture

* Patient Name: ______________________________ * DOB: ____ /____ /____ * Age:_____

* Sex: ☐ Male ☐ Female / * Phone (C):____________________ Phone (H):____________________

* Address:______________________________ City:________________ State:____ Zip:______

* Email Address:______________________________ Referred By:______________________________

* Have you ever had acupuncture before? ☐ Yes ☐ No

* Pregnant? ☐ Yes ☐ No / * Pacemaker? ☐ Yes ☐ No * Height: __________ * Weight: ________ lbs.

Current Complaints

Main Complaint:

1.____

How did it start?______________________________ When? ____________________

Have you had X-rays or MRI of areas of complaint? If yes, When? ______________________________

Other Complaints:

2.______________________________ How did it start?______________________________ When?________

3.______________________________ How did it start?______________________________ When?________

Please list any **medications and/or supplements** you are currently taking

Medication/Supplement + Dosage:	Reason:

Medical History

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Stroke ☐ HIV/AIDS ☐ Liver Disease ☐ High Cholesterol ☐ Autoimmune Disorder ☐ Kidney Disease ☐ Seizures ☐ Arthritis ☐ Alcoholism ☐ Mental Illness ☐ Diabetes

Family History

☐ Alcoholism ☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Stroke ☐ Seizures ☐ Diabetes ☐ Mental Illness

Gynecology

\# of Pregnancies: _____ # of Births: _____ # of Miscarriages: _____ # of Abortions: _____

Last Period: ____ /____ /____ Length of Cycle (day 1 to day 1): ____ days Days of Menstrual Flow: ____ days

Age of Menopause: ____ yrs old Hormone Replacement Therapy (HRT)? ☐ Yes ☐ No

Lifestyle

Do you drink alcohol? ☐ Yes ☐ No How much? _________ per ☐ day ☐ week

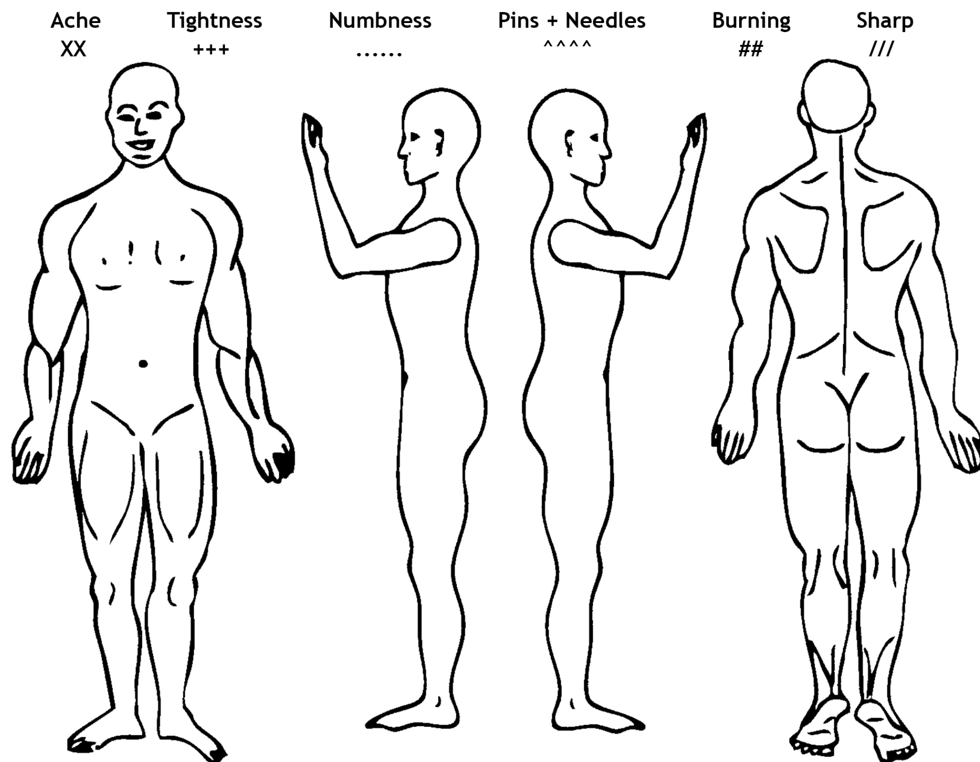
Do you smoke cigarettes? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, please describe what you do: ______________________________

Stress Level: ☐ High ☐ Low ☐ Medium Source of stress: ______________________________

Pain

Please indicate areas of pain below:



Describe your pain and the symptoms that you are experiencing: ______________________________

____

____

____

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine, including carious modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now, or in the future treat me while employed by, working or associated with, or serving as a back-up for the treating acupuncturist named below, including those working at the clinic or office listed or any other office or clinic, whether signatories to this form or not.

I understand that treatments may include acupuncture, diagnostic techniques (questioning, pulse evaluation, palpation, observation, active and passive range of motion, muscle and orthopedic testing), massage techniques, joint and/or visceral manipulation, heat and/or cold therapy, electrical stimulation (e-stim), instrument assisted soft tissue manipulation (cupping, gua sha), moxibustion, recommendation of herbal and homeopathic preparations for ingestion and/or external application, dietary recommendations, and healthy lifestyle counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand and am informed that acupuncture is a safe method of treatment, however, as in allopathic medicine, there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to bleeding, bruising, nerve pain, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. I do not expect the practitioner to be able to anticipate and explain all risks and complications and wish to rely on the practitioner to exercise such judgement to be in my best interest based on the known facts at the time. I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that treatment from the acupuncturist named below does not substitute for appropriate medical evaluation and treatment by a licensed physician. I have been advised to consult with a licensed physician if there is worsening of my ailment/condition, if it does not improve within an estimated timeframe or if a new ailment/condition arises. If I am presently under the care of a physician, I have been advised to continue all treatments and medications as prescribed.

I have read, or have had read to me this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend that this consent form covers the entire course of treatment for my present and any future conditions for which I seek treatment with this practitioner.

______________________________	______________________________	_____ / _____ / _____
Patient Name (Please print)	Patient (or Patient's Representative) Signature	Date

HIPAA Compliance
Authorization to Release Information
Financial Policy
Assignment of Benefits

Patient consent to the use and disclosure of private health information for the treatment, payment and/or healthcare operations.

I, ____ , understand that as part of my healthcare, Sherine Blair, L.Ac. originates and maintains paper, and/or electronic records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify services billed were provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, in disclosure, via electronic fax.

It is our office policy that the patient is responsible for the total fees for medical services at the time of the visit. We accept cash, check, money order and credit card. Visa, MasterCard, American Express and Discover are allowable forms of credit card payment. As a condition of our contract with the insurance companies, we will do the insurance billing for you and will accept assignment on the claim. It is your responsibility to provide us with a copy of your insurance coverage in order for us to determine if your coverage is through one of our contracted carriers. If not, then we will provide you with a Superbill (itemized billing statement) in order for you to seek reimbursement from your insurance company. In either event, you are ultimately responsible for the resolution of your account.

I understand that it is my responsibility to notify Sherine Blair, L.Ac. of any changes in my health care coverage and that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

I hereby authorize to verify eligibility for services rendered by them. I request that payment from my insurance company be made directly to the treating provider(s). I certify that the information I have reported with regard to my insurance coverage is correct.

____ _____ /_____ / _____

Patient's Signature Date

Notice of Privacy Practices

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

The Health Information Portability & Accountability Act ("HIPAA") is a federal program that requires that all medical records and other individually identifies health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care operations. An example of this would include referral services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilizations review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all referenced to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be interested to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health Information, including those related to disclosures to family members, other relatives, close Personal friends, or any other person, identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health Information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 1st, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information what we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Effective Date: November 1, 2014.

Cancellation/Missed Appointment Policy

We request/prefer at least a 48 hour notice for all rescheduled appointments and cancellations. Due to the nature and size of our business, we REQUIRE a proper 24 hour notice before incurring a "no show" or late cancellation fee. This policy enables us to better utilize available appointments for our patients needing immediate care. While we understand that situations come up and emergencies happen, we do not double-book the schedule and late cancellations and missed appointments *greatly* impact our business.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please CALL or TEXT 858.480.6890. If you do not reach the receptionist or the acupuncturist, you may leave a detailed message on the voicemail (which will count as adequate notice). If you would like to reschedule your appointment, please be sure to leave us your name and phone number and we will return your call within the business day. You may also cancel/reschedule your appointment via your emailed appointment link, if it is done within the cancellation period.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the provider. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". A "no- show" will result in an automatic fee of $20.00. If a patient accumulates 3 "no-shows", he/she may be asked to leave the practice.

Late Cancellations:

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will never be assessed a cancellation fee.

I understand this policy and authorize *Sherine Blair, L.Ac.* to assess late cancellation and "no- show" fees according to the above outlined policy.

____ ______/______/______

Patient's Signature Date

PROVIDER ARBITRATION AGREEMENT

This arbitration agreement is entered into by and between the healthcare provider and the undersigned provider, ("Provider") and the undersigned patient ("Patient"). For purposes of this agreement, "Provider" shall mean and include undersigned provider and each of the provider's employees, independent contractors, agents, representatives, contractors, legal representatives, successors and assigns, and "Patient" shall mean and include Patient and all parties whose claims may arise out of or relate to the treatment or services provided by Provider for Patient, including Patient's spouse, heirs, beneficiaries, and legal representatives and any children, whether born or unborn at the time of the occurrence giving rise to any claim against Provider. If Patient is a pregnant mother, the term "Patient" shall mean both the mother and the mother's expected child or children.

Article 1. Agreement to Arbitrate. It is understood that any dispute as to professional malpractice, that is as to whether any services rendered by Provider for Patient were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All disagreements, controversies, disputes, claims and counterclaims arising out of, related to or in connection with Provider's provision of services for Patient, whether based on statute, tort, contract, common law or otherwise (collectively, "Dispute") shall be resolved by binding arbitration as set forth in this agreement.

Article 2. Procedures and Applicable Law. Except as provided in this paragraph, the Federal Arbitration Act (the "Act") shall govern the arbitrability of Disputes under this agreement. If for any reason the Act is deemed inapplicable, then the arbitrability of Disputes shall be determined under applicable California arbitration statutes and laws. Arbitration of all Disputes shall be administered by the Judicial Arbitration and Mediation Services ("JAMS") pursuant to its Comprehensive Arbitration Rules and Procedures (the "Rules"). To the extent the Act or Rules conflict with any term of this paragraph, the terms of this paragraph shall control. To commence arbitration of a Dispute under this agreement, either party may contact the local office of JAMS. The arbitration shall be conducted before a single neutral arbitrator who is a retired judicial officer selected in accordance with the Rules and shall take place in San Diego, California. The arbitration proceeding shall be completed within 60 days after appointment of the arbitrator, unless the parties otherwise agree. The arbitrator shall have jurisdiction over the Dispute, and the decision of the arbitrator shall be final and binding upon the parties. Depositions may be taken and discovery may be conducted in the manner agreed to by the parties or designated by the arbitrator with good cause shown by the parties. The cost of the arbitration and the arbitrator's fees shall be shared equally by the parties. Each party shall be responsible for the payment of its/his/her own attorneys' fees and costs unless otherwise required by applicable law. Judgment upon the arbitration award may be entered in any court having jurisdiction, or application may be made to such court for a judicial acceptance of the award and an order of enforcement, as applicable. The parties may, by mutual written agreement only, stay the arbitration proceedings to allow for any form of negotiation or mediation of the Dispute.

Article 3. Retroactive Effect. If Patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment), Patient should initial below:

Article 4. Right to Rescind. Patient understands Patient may rescind this agreement by providing written notice to Provider within 30 days after the agreement is signed.

Article 5. General Provisions. This agreement represents the entire agreement between the parties with respect to the subject matter set forth in this agreement and supersedes all prior and contemporaneous oral and written agreements, communications, representations, commitments and understandings of the parties. Other than as set forth in this agreement, no provision of this agreement may be altered, amended or repealed in whole or in part other than by the written consent of the parties to this agreement. This agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, beneficiaries, legal representatives, successors and assigns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature (or Patient Representative):	✗ ______________________	Date: _____ / _____ / _____
Provider/Office Signature:	✗ ______________________	Date: _____ / _____ / _____