Gainesville Family Wellness

Patient Information Form

Name: _____ Date: _____
Address: _____City: _____ State & Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Occupation: _____
Business Address: _____ City: _____ State & Zip:_____
Place of Birth: _____ Date of Birth: _____Age: _____ Height:_____ Weight: _____
Sex: _____ Male _____ Female Marital Status: (Single, Married, Life Partner, Divorced, Widowed, other)

Contact In Case of Emergency:

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our clinic? _____

When and where did you last receive health care? _____
_____

Have you utilized acupuncture and Chinese medicine prior to coming to our clinic? Yes No

Do you have any reason to believe you may be pregnant? Yes No If so, how far along are you? _____

Do you have any infectious diseases? Yes No If yes, please identify the condition: _____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns. Please rate the extent to which your current complaints affect your daily life (1=minor, 10=major): _____
_____
_____
_____

Please rate your commitment to resolving your problems (1=minor, 10=major): _____
_____

Please list any medications (including natural remedies) you are currently taking or attach a list: _____
_____
_____
_____
_____

Please list any known allergies to food, herbs, or medications: _____
_____

Age: ____ **Sex** (at birth) _____ **Height/Weight:** _____ **Complexion** (pale, red, etc): _____

Chief Complaint: The MAIN reason for seeking care. List one.

_____

☐ You experience frustration or get annoyed
☐ You sigh frequently
☐ You feel overwhelmed sometimes
☐ You blush easily
☐ Your symptoms improve/disappear on vacation

☐ Fatigue, specifically after eating
☐ Cold hands/cold nose
☐ Dizziness, specifically when standing up
☐ Muscle weakness/heaviness
☐ Easy bruising
☐ Carb/sugar/sweets cravings

Bowels:

☐ Daily ☐ Every 2-3 days ☐ 1X/week or less
☐ Formed/log shape
☐ Loose/unformed or diarrhea
☐ Dry/hard to pass stool/pellet shaped
☐ Require excessive wiping (>3-4 times)
☐ Incomplete evacuation (still feel like you have more to go)
☐ Bloating

Thirst
☐ Mouth feels dry ☐ Like to drink water in small sips
☐ Like to drink a lot at once/always thirsty

Urine
☐ Cloudy urine ☐ Dark/concentrated

Other
☐ Phlegm/mucus (from chest, nose, throat, abnormal thick vaginal discharge)

☐ Your symptoms are worse in humid weather

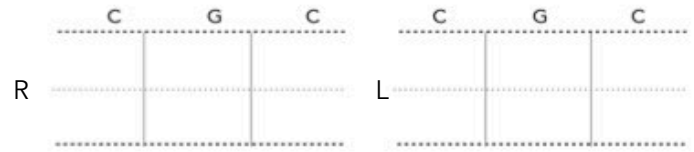
☐ Poor night vision/blurry vision
☐ Cramping/twitching muscles (esp. calfs in the night)
☐ Lightheaded
☐ Pale nails, brittle nails, ridges/lines on nails

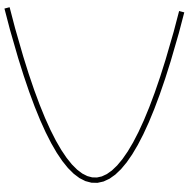
☐ Low Back/Leg/Knees cold/sore/weak
☐ Frequent urination ☐ Wake at night to urinate
☐ Incontinence (leaking urine any time)
☐ Cold feet/toes (constant)
☐ Low libido/Interest in sex
☐ Ringing in the ears/difficulty hearing

☐ Varicose/Spider veins (feet, ankles, legs)
☐ Fixed, sharp/stabbing pain anywhere
☐ Cherry hemangioma (tiny red bumps)
☐ Dark skin spots/Liver spots
☐ Purple lips/spots on lips

Menstruation: (practitioner must ask follow-up questions)

Painful: ☐ Sharp ☐ Fixed ☐ Dull ☐ Achy ☐ Mid-cycle spotting
☐ Heavy bleeding ☐ Mid-cycle Pain ☐ Clots
Cycle length: ☐ 20-27 days ☐ 28-33 days ☐ >33 days
Menses: ☐ 1-2 days ☐ 3-7 days ☐ >7 days





Body	**Coating**	**Sublingual**
Red	Thick	Distended
Pale	Thin	**U M L**
Purple	Yellow	Red
Dusky	White	Pale
Red	Greasy	Yellow

Pattern Dx:

Formula Rx:

Consent For Use and Disclosure of Health Information

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this form. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Privacy Policy at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that the revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or continue treating you if you revoke this consent.

I authorize you to disclose health information to:

_____ No Person at this time.

___ Spouse: _____ _____ _____
Name Address Phone

___ Family Member: _____ _____ _____
Name Address Phone

___ Friend: _____ _____ _____
Name Address Phone

I, _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____
Signature Date

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities, and health care operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked consent.

_____ _____
Signature Date

Cancellation Policy

Please arrive 5 to 10 minutes before your scheduled appointment. You may cancel your appointment without charge up to **24 hours in advance**. This gives us the opportunity to schedule another client for that appointment time. If you are unable to give us 24 hours notice, your card on file will be charged 50% of the session's value. If you do not show up for your appointment and fail to call you will be charged 50% for the missed appointment and full price for any missed appointments there after. We understand emergency situations occur, please let us know as soon as possible if you cannot make your appointment.

I understand and accept these terms: _____ Date: _____
(Client signature)

Print name: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Privacy Practices Policy

Policy: It is the policy of The Healing House, LLC to protect the health information of its patients as required by federal and state law.

Procedures:

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose health information to a physician or healthcare professionals providing treatment to our patients. This may include but is not limited to the primary care physician, PA, nurse, physical therapist, nutritionist, or dentist.

Healthcare Operations: We may use or disclose healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, evaluation of practitioner and provider performance, conducting training programs, certification, licensing or credentialing activities.

Patient Authorization: In addition to our use of health information for treatment, payment or healthcare operations, the patient may give us written authorization to release their health information or to disclose it to anyone for any purpose. If the patient gives us authorization, they may revoke it in writing at any time. Their revocation will not affect any use or disclosures permitted by their authorization while it was in effect.

Family and Persons Involved in their Care: We must disclose health information to the patient. With their authorization, we may disclose their health information to a family member, or other person to the extent necessary to help with their health care or with payment for their healthcare. We may use or disclose healthcare information to communicate, notify, or assist in the notification to the patient. We will also use our professional judgment and our experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to pick up filled herbal prescriptions, medical supplies, or other similar forms of health information.

Required by law: We may use or disclose health information when we are required to do so by law.

> Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public authorities.
>
> Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
>
> Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.
>
> Serious Threat to Health and Safety: We may use and disclose information when necessary to prevent a serious threat to the patient's health and safety or the health and safety of the public or another person.

Acknowledgement of Receipt of Privacy Practices Policy

I, _____, have received a copy of this office's Privacy Practices Policy.

I would like to receive telephone communication or messages via: (check all that apply)

- ○ Home Phone: _____
- ○ Work Phone: _____
- ○ Cell Phone: _____

_____
Print Name

_____
Signature

_____
Date