ACUPUNCTURE
WELLNESS LLC
BALANCE. HEALTH. WELLNESS.

PATIENT INFORMATION

(Please Print)

Name: _____

Street: _____

City: _____ State: _____ Zip:_____

Phone number (home) _____(cell)_____

Sex: O Male O Female Date of birth: _____/_____/_____ Age: _____

Height. _____ Weight: _____

Marital Status: O Single O Married O Partner/Significant O Divorced O Separated O Widowed

Occupation: _____ Employer: _____

This office relies on word of mouth referrals. Please let me know how you heard about me so they can be thanked.

Referred By: _____

Family Physician: _____

I, as a patient hereby voluntarily request to receive treatment from ***Acupuncture Wellness, LLC*** or the assigned office staff personnel. I understand that this treatment may include Acupuncture, Tuina (therapeutic Chinese remedial massage) cupping, herbs, nutritional supplements, homeopathic remedies, nutritional/dietary counseling and lifestyle counseling. I also understand the acupuncture and cupping may sometimes cause bruising. I acknowledge that no guarantees have been made to me as to the effectiveness of these treatments. And I maintain the right to refuse any of the treatment methods that are suggested.

X _____Date _____
Patient or Parent

CURRENT MEDICAL CONDITION:

Main problem(s) you would like to address: _____

_____

When did you first notice any symptoms? _____

Is this the result of an accident or injury? _____

Is this condition interfering with your: O Work O Sleep O Daily Routine O Other: _____

List previous diagnosis and treatments for this condition: _____

_____

Previous Doctor(s) seen for this condition: _____

MEDICAL HISTORY

Do you have a pacemaker? O Yes O No

For women only: Are you pregnant? O Yes O No

Are you allergic to any medications? O Yes O No If yes, which ones: Effect? Foods? Chemicals? Drugs?

_____

Medication(s) you now take: O Pain killers O Sleeping Pills O Muscle Relaxers O Tranquilizers
O Blood Thinner O High Blood Pressure Pills O Birth Control O Other

List Medications: _____

_____

_____

Do you take O vitamins or O minerals? _____

Do you take O herbs? If yes, which ones: _____

List surgical operations you have had, and dates: _____

Do you exercise regularly? O Yes O No If yes, describe: _____

Habits/ how much? O tobacco _____ O coffee ___ cups/day O tea ___ cups/day O sugar O salt O food

O caffeine O cigarettes O sex/masturbation O soda ____ servings per day O alcohol____ servings per day

O drugs _____ prescription or over the counter

PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospital visits _____ Date_____

Surgeries or Operations _____ Date _____

Injuries (such as automobile accident, serious falls, sports injuries, broken bones, unconsciousness?)

Type_____ Date_____

Recent tests? (Please indicate test results and date administered)
O Physical O Cholesterol O Blood O Prostate O HIV O STD O Pap Smear O Mammography O Other
Test results and date: _____

Check any conditions **you have/ had** in the past:

O Alcoholism
O Allergies/Hay Fever
O Anorexia/Bulimia
O Anxiety
O Arthritis
O Asthma
O Back trouble
O Bleeding tendency
O Bursitis
O Cancer_____
O Chicken Pox
O Chronic Fatigue Syndrome
O CVA (stroke)
O Depression
O Diabetes
O Digestive Problems
O Drug addiction
O Emphysema
O Emotional Problems
O Epilepsy/Seizure
O Fibromyalgia
O Glaucoma
O Gonorrhea
O Headaches
O Heart Disease
O Hepatitis
O Hernia
O High Blood Pressure
O HIV/AIDS/ Immune Disorder
O Insomnia
O Irritable Bowel Syndrome
O Jaundice
O Kidney Disease
O Low Blood Pressure
O Lupus
O Measles
O Meningitis
O Migraines
O Mononucleosis
O Multiple Sclerosis
O Mumps
O Neck Pain
O Nervous Disorder
O Paralysis
O Pneumonia
O Polio
O Rheumatic Fever
O Sexual Transmitted Disease (STD's)
O Syphilis
O Thyroid Disorder
O Tuberculosis
O Ulcers
O Vein Condition
O Weight Problems
O Whooping Cough
O Other _____

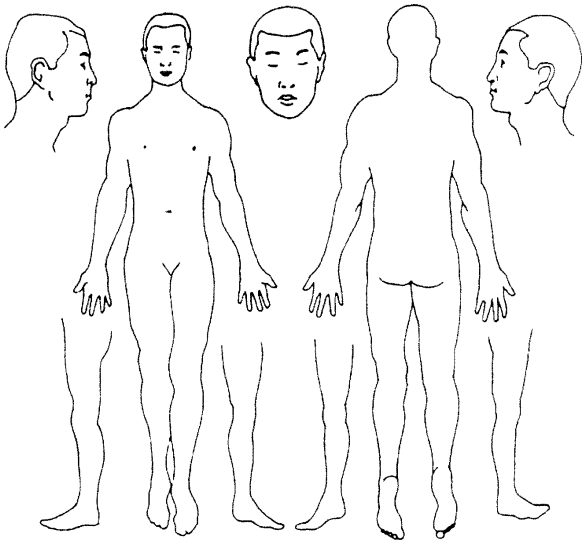
Family Medical History

Check the following that have **occurred in your blood relatives**

O Alcoholism
O Allergies
O Bleeding Tendency
O Cancer
O Diabetes
O Heart Disease
O High Blood Pressure
O Kidney Disease
O Mental Illness
O Obesity
O Nervous Illness
O Stroke
O Other _____

Patient Profiles

Please clearly mark any area of Pain on the diagram below:



Is the pain?
O Sharp O Burning O Aching O Cramping
O Dull O Moving O Fixed O Other

Do any of the following **LESSEN** the pain?
O Pressure O Cold O Heat O Exercise O Other

Do any of the following **WORSEN** the pain?
O Pressure O Cold O Heat O Exercise O Other

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CONSENT TO TREAT

*Thank-you for choosing **Acupuncture Wellness LLC** as your health care provider.*

Please read the following and confirm that you agree to and clearly understand this agreement by signing below.

I, as a patient hereby voluntarily request to receive treatment from *Acupuncture Wellness LLC; or the assigned office staff, personnel* who are Licensed Acupuncture Physician in the State of Florida Such practitioners are Primary Care Physicians with limited Prescriptive Rights. However, Licensed Acupuncturists (AP, DOM) are **not** Medical Doctors (MD)

I understand that this treatment may include Acupuncture, Tuina (Chinese therapeutic remedial bodywork) Cupping, Gwasha therapy, Moxibustion, thermal therapy/heat or cold, herbs, nutritional supplements, homeopathic remedies, nutritional/dietary counseling and lifestyle counseling. Acupuncture involves the insertion of needles into various areas of the body known as meridians, stimulation of the needles after insertion by hand or incorporating an electrical stimulation device, may elicit a feeling of discomfort. I also understand the acupuncture needling and cupping may sometimes cause bruising.
Herbal formulas may be a part of my treatment plan. If I desire, I can refuse any herbal preparation.

The practitioner has been certified to perform Acu-point Injection Therapy by the state of Florida, which means they are allowed to administer the injection of homeopathic, and other nutritional vitamin supplements in the form of sterile substances, these do not include synthetic drugs or pharmaceutical medications.

I recognize that this ***Agreement is NOT a warrantee or guarantee of results***. This agreement deals solely with procedural obligations. I acknowledge that ***no guarantees*** have been made to me as to the effectiveness of these treatments; and I maintain the right to refuse any of the treatment methods that are suggested.

I fully understand that by signing below, I am indicating that I have read and understood the information in this Consent Form; that I have been verbally advised and that I have had an adequate and reasonable opportunity to ask questions, that I have received all of the information I desire about the Practitioner and any and all Procedures, and that all of this information is mentally and physically clear to me, and that I authorize the practitioners of *Acupuncture Wellness LLC* to perform the Procedures.

If I do not sign this consent, treatment will be declined.

Patient's Signature:

Signed: _____ Date: _____/_____/_____

HIPAA Disclosure /Consent / Patient Questionnaire

Please list the family members or significant others, if any,
Whom we may inform about your Medical condition

ONLY IN AN EMERGENCY: Name and phone number

Emergency Contact Name _____ Phone _____

Please print the telephone number(s) and e-mail address where you want to receive calls about your appointments, lab and x-ray results, or other information, postal consent if applicable

Phone# _____ e-mail address_____

Check appropriate boxes

O Okay to leave message with detailed information

O Leave message with callback number only

O Consent to mail via postal service

O Consent to e-mail or fax

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis *(including treatment, payment and health care operations):*

_____

With my consent, ***Acupuncture Wellness, LLC*** may use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations.

* Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures;
Having the right to review the Notice of Privacy Practices prior to signing this consent.
Acupuncture Wellness LLC reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Wes Eades, AP, DOM, Privacy Officer at 15151 S. Hwy 441, Suite 100, Summerfield, FL 34491

With my consent, *Acupuncture Wellness LLC*. *or the assigned office staff personnel* may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment and healthcare operations such as appointment reminders and any call pertaining to my clinical care, including lab results; amongst others.
With my consent, *Acupuncture Wellness LLC*. *or the assigned office staff personnel may* mail or e-mail to my home or other designated location any items that assist the practice in carrying out treatment and healthcare operations such as appointment reminder cards and patient statements and laboratory results as long as they are marked Personal and Confidential.
I have the right to request that *Acupuncture Wellness LLC* restrict how they use or discloses my PHI to carry out treatment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am authorizing and extending consent to ***Acupuncture Wellness LLC*** to use and disclosure of my PHI to carry out treatment and healthcare operations. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent**. If I do not sign this consent, *treatment* may be declined to me.**

X_____ Date _____
Signature of Patient or Legal Guardian

Print Name of Patient _____

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Notice of Privacy Practices
HIPAA COMPLIANCE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction (when required by LAW), but if we do, we shall honor that agreement.

By signing this form, you consent to; our use and disclosure of protected health information (PHI) about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, Signed by you. However, such a revocation shall not affect any disclosure we have already made in relevance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Marketing
This office ***will not use your health information for marketing communications*** without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, e-mail or postal mail. Please inform us if you do not want us to contact you for one of the above reasons. We **DO NOT** sell your information or share with unrelated companies.

The patient understands that:

- Upon written request you have the right to access, review or receive copies of your healthcare records. There is a fee of $1.00 per sheet and this office will need 10 working days to process your request.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information
- You have the right to receive all notices in writing.
- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

I, _____, have read, reviewed, understand and agree to the statement of Privacy for Healthcare services in this Office, This practice has attempted to provide each patient with a statement of privacy policies

X_____ Date _____
Signature of Patient or Legal Guardian

Print Name of Patient _____

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CANCELLATION POLICY and FINANCIAL RESPONSIBILITY

Thank-you for choosing ***Acupuncture Wellness LLC*** as your health care provider.
Please read the following and confirm that you agree to and clearly understand them by signing below.

Financial Information:

All fees are due in full; at the time services are rendered. I acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to *Acupuncture Wellness LLC* for the amount stated. Payment may be made by major credit cards, cash .
Acupuncture Wellness LLC **Does NOT accept insurance or payment from third party payers**.

In the event a refund is necessary; it will be provided by check and paid within 10 business days of a written termination request from the patient. The refunded amount will be based in this agreement for less the number of individual services rendered. The refunded amount will be calculated based on usual and customary schedule for each service rendered minus the last two treatments.

Cancellation Policy:

This agreement assumes full cooperation, between the Patient and Practitioner to remain active in the recommended treatment plan.
In an effort to provide the highest level of treatment success; it is necessary to have consistent scheduling in place that is conducive to your health and healing; helping you to achieve your personal health care goals.
The patients agrees to keep all scheduled appointments to achieve maximum results from the treatment plan.
To accommodate your scheduling parameters; we enforce a strict non-cancellation policy and you will be charged the full amount for your scheduled appointment time in the following circumstances:

- Neglecting to cancel a scheduled appointment with **at least a 24 hour notice**
- Arriving more than 15 minutes late for your scheduled appointment
  In the consideration of the patients who are scheduled for the day; this action will result in rescheduling your appointment and full payment of the missed appointment time.

Disclosure of Health Protected Information:

I authorize the release of my (HPI) Health Protected Information to conduct, plan, direct treatment and follow-up among the multiple healthcare providers who may be involved in my successful treatment either directly or indirectly. Disclosure to law enforcement authorities as allowed by FL State law statutes may be provided. This information may include records of examination, TCM diagnosis, western diagnosis, treatment progress notes and billing information for the duration of care.

I fully understand that by signing below, I am indicating that I have read and understood the information in this Consent Form; that I have been verbally advised and that I have had an adequate and reasonable opportunity to ask questions, that I have received all of the information I desire about the Practitioners and any and all Procedures, and that all of this information is mentally and physically clear to me, and that I authorize the practitioners of Acupuncture Wellness LLC to perform the Procedures. If I do not sign this consent, treatment may be declined.
Patient's Signature:

I _____
(Please print Name)

Signed: _____ Date: _____/_____/_____

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FINANCIAL POLICY AND FEE CAPITATED PLANS AGREEMENT

Time of service

USUAL AND CUSTOMARY FEES: the number of procedures needed for your treatment determines fees charged. For example, normal fees assessed include:

• Initial Examination	$ 159.00	
• Acupuncture Treatment	$ 99.00	
• Tuina	$ 185.00/hour	99.00/ ½ hour
• Acu-Graph (Digital Meridian Graphing)	$ 79.00	
• Cupping	$ 79.00	
• Auricular (Ear) Therapy	$ 59.00	
• Auricular Acu-Detox	$ 299.00	(3 weeks - 30-45 minute treatments scheduled 3 times per week)
• Anti-Aging Acu-Facial Rejuvenation	$ 269.00	
• Food Therapy/Medical Nutrition	$ 99.00	$49 when combined with initial consultation
• Therapeutic Acu-Point Injection	$ 125.00	+ $20/ampoule of medication

MISSED APPOINTMENTS: **Reminder calls will be made 24 hours in advance**
Appointments must be canceled within 24 hours of your appointment.
A fee at the rate of 50% for the appointment will be assessed to your account for *late cancellations, missed appointments, and arriving more than 15 minutes past* your scheduled time.

ACCOUNTS: Furthermore, I understand I am responsible for full payment of all services at the time of service.

ADDENDUM

For patients to take advantage of cost savings
Wellness Plan pricing, patients must pay for plans in full at the date of signature.

Please speak with your physician regarding cost saving plans.

Patient's Signature:

_____ Date _____

Guardian, as needed _____ Date _____/_____/_____