PATIENT INTAKE FORM

Personal Information

Patient Name:_____ Age: _____ Birth Date:___/___/____ Gender: M/F

Marital Status: ____Single ___Married ___Divorced ___ Widowed Height:_____

Address:_____City:_____ State: _____Zip:_____

Telephone:_____ Is it okay to leave a **detailed** message at this number? Y/N

May we use email to communicate with you? Y/N Email Address:_____
*Please be advised that use of email does not guarantee privacy.

Pregnant Y/N Nursing? Y/N Diabetic? Y/N Blood thinners? Y/N Pacemaker? Y/N

Smoker?_____ Communicable (contagious) conditions?_____

Occupation:_____ Employer:_____

Is your reason for being seen the result of an auto accident or workplace injury?_____
If yes, please advised the front desk. Additional paperwork and insurance verification may be required and your appointment may need to be rescheduled.

How did you hear about us?_____

Who is your primary health care provider/MD?_____

Insurance Information:

Primary Insurance Company:_____

Name of Policy Holder_____ Policy ID No. _____

Group No._____ SSN:_____Phone Number:_____

Secondary Insurance Company:_____

Name of Policy Holder_____ Policy ID No. _____

Group No._____ SSN:_____Phone Number:_____

Emergency Contact Information

Name:_____ Relationship:_____ Phone:_____

Address:_____

Main Concern

Please identify your main health concern(s)

How long have you had this problem(s)

Have you been given a diagnosis for this problem(s)?

What other treatments have you tried and what were the outcomes?

Please list **any** Western Diagnosis (Diabetes, Hypertension, etc.) even if that is not why you are being seen.

Please list ALL medications and dosage including herbs, supplements, vitamins you are taking **and the reason each:**

Medication/Herb/Supplement	Dosage	Reason you are taking it

Allergies (Medications, herbs, foods, seasonal, etc.) **and the reaction you have from allergen** (hives, etc)**.**

Allergic to:	Reaction (hives, etc.)	Severe/mild/moderate	Since: childhood, adulthood, etc.

Do you now, or have you had in the past:	yes	no
1. History of heart problems, chest pain or stroke?	___	___
2. Increased blood pressure?	___	___
3. Any chronic illness or condition?	___	___
4. Do you ever get dizzy, lose your balance or lose consciousness?	___	___
5. Difficulty with physical exercise?	___	___
6. Advice from physician not to exercise?	___	___
7. Recent surgery (last 12 months)?	___	___
8. Pregnancy (now or within last 3 months)?	___	___
9. History of breathing or lung problems?	___	___
10. Swollen, stiff, or painful joints?	___	___
11. Foot problems?	___	___
12. Back problems?	___	___
13. Any significant vision or hearing problems?	___	___
14. Diabetes or thyroid condition?	___	___
15. Increased blood cholesterol?	___	___
16. History of heart problems in immediate family?	___	___
17. Do you currently smoke?	___	___
18. Have you ever been a smoker?	___	___
• **If no**, have you ever smoked? Y/N How long ago?_____		
• If yes, how many packs per day?_____		
• How many years have you smoked? _____		
19. Do you drink alcohol?	___	___
• If yes, how much and how often?_____		
20. Do you use recreational/illegal drugs?	___	___
• If yes, how much and how often?_____		

FAMILY HISTORY

Father

Current age if living: ____

Father's general health is: excellent ___ good ___ fair ___ poor ___

Reason for fair/poor health is? _____

Mother

Current age if living: ____

Mother's general health is: excellent ___ good ___ fair ___ poor ___

Reason for fair/poor health is? _____

Siblings

Number of brothers _____ Number of sisters _____ Age range _____

Any health problems? Please explain. _____

Have any of your BLOOD relatives had:	yes	no
1. Heart disease?	___	___
2. Stroke?	___	___
3. High blood pressure?	___	___
4. Elevated cholesterol?	___	___
5. Diabetes?	___	___
6. Obesity?	___	___
7. Leukemia or cancer?	___	___

If yes explain:_____

_____

Please indicate any symptoms you've had in the last 1-2 months or have regularly

General

- ❑Poor Appetite
- ❑Changes in Appetite
- ❑Food Cravings (salty/sweet/other)
- ❑Weight Loss/Gain
- ❑Weakness
- ❑Fatigue
- ❑Sudden Energy Drops
- ❑Hearing Loss
- ❑Ear Infections
- ❑Puffiness/Edema/Swelling
- ❑Sudden onset/Gradual
- ❑Strong Thirst
- ❑Preferred Temperature of drinks
- ❑Thirsty w/no desire to drink
- ❑Desire to drink but only in small sips
- ❑Tinnitus/Ringing in Ears (Low/High
- ❑pitched/sudden onset/gradual)
- ❑Bruise Easily/Bleed Easily
- ❑Night Sweats
- ❑Spontaneous Sweating (all over/head/other)
- ❑Easy to Sweat
- ❑Hot Flashes
- ❑Heat Sensation in
- ❑Hands/Feet/Chest/Face/Head
- ❑Low Libido/Sex Drive
- ❑Insomnia/sleep problems

Skin & Hair

- ❑Rashes
- ❑Itching
- ❑Dry Skin
- ❑History of Eczema/Psoriasis/Shingles/Other
- ❑Hair Loss
- ❑Change in Hair Texture
- ❑Brittle Hair
- ❑Dry Hair
- ❑Brittle Nails
- ❑Nail Fungus
- ❑Other Nail Problems

Head, Eyes, Ears, Nose, and Throat

- ❑Headaches/Frontal/Temples/Behind
- ❑Eyes/Vertex/Occipital/Throbbing/Stabbing/ Dull/Band around Head/Other
- ❑Head Injury
- ❑Dizziness
- ❑Vision Changes
- ❑Blurry Vision
- ❑Night Blindness
- ❑Dry Eyes
- ❑Red Eyes
- ❑Itchy Eyes
- ❑Floaters
- ❑Cataracts
- ❑Other Eye Problem_____
- ❑Sinus Problems
- ❑Allergies_____
- ❑Nose Bleeds
- ❑Poor Sense of Smell
- ❑Snoring
- ❑Facial Pain or paralysis
- ❑TMJ Pain
- ❑Poor Sense of Taste
- ❑Mouth Pain
- ❑Mouth Sores
- ❑Recurrent Sore Throat
- ❑Sensation of something stuck in throat
- ❑Thyroid Problems

Cardiovascular

- ❑High blood Pressure/Hypertension
- ❑Low Blood Pressure
- ❑Irregular Heartbeat
- ❑Arrhythmia
- ❑Palpitations
- ❑Pace-Maker
- ❑History of Blood Clots
- ❑Chest Pain
- ❑Heaviness in Chest
- ❑Swelling of Hands/Feet
- ❑Phlebitis
- ❑Fainting/Lightheadedness
- ❑Cold Hands/Feet
- ❑Shortness of Breath

Respiratory

- ❑Cough
- ❑Bronchitis
- ❑Difficulty Breathing
- ❑Phlegm
- ❑Sleep Apnea
- ❑Coughing Up Blood
- ❑Pneumonia
- ❑Asthma
- ❑Use Inhaler/Nebulizer
- ❑Painful Breathing
- ❑Easily Winded
- ❑Shortness of Breath
- ❑On oxygen
- ❑Other Breathing Problem

Urology

- ❑Painful Urination
- ❑Urgency to Urinate
- ❑Unable to Hold Urine
- ❑Incontinence
- ❑Change in Urine Flow
- ❑Frequent Urination
- ❑Blood in Urine
- ❑Cloudy Urine
- ❑Kidney Stones
- ❑Urinary Tract Infections
- ❑Frequent Night Urination
- ❑Pain in Groin Area
- ❑STDs
- ❑Prostate Problems
- ❑Inability/Difficulty to Achieve/Maintain Erection

Gastro-Intestinal

- ❑Nausea
- ❑Vomiting
- ❑Number of BM/Day____
- ❑Constipation (Hard to Pass/Goat Pellets)
- ❑Diarrhea
- ❑Alternate Constipation/Diarrhea
- ❑Loose Stools
- ❑Sticky Stools (use a lot of paper or sticks to toilet)
- ❑Mucus in Stools
- ❑Undigested Food in Stools
- ❑Pain after Bowel Movement
- ❑Diarrhea when upset
- ❑Urgent need for Bowel Movement early in the morning
- ❑Foul Smelling Stools
- ❑Bad Breath
- ❑Ulcers
- ❑Hernia
- ❑Abdominal Pain
- ❑Chronic Laxative Use
- ❑Intestinal Gas
- ❑Indigestion
- ❑Rectal Pain/Burning
- ❑Belching
- ❑Blood in Stools
- ❑Hemorrhoids (Bleeding/Prolapse/Pain)
- ❑Burning/Itching Anus
- ❑Diagnosed w/Colon Polyps, etc.

Neuro-Psychological

- ❑Seizures
- ❑Areas of Numbness
- ❑Tingling/Pins & Needles
- ❑Concussion
- ❑Twitches (Eye/Fingers/Toes/Other)
- ❑Lack of Coordination
- ❑Depression
- ❑Grief/Sadness
- ❑Anger
- ❑Irritability
- ❑Loss of Balance
- ❑Stress
- ❑Poor Memory
- ❑Anxiety
- ❑Tremors
- ❑Poor Concentration/lack of focus
- ❑Mood swings
- ❑Phobias
- ❑Over thinking/worrying
- ❑Parkinson's/Alzheimer's/other

Gynecology

- ❑Age of Menses
- ❑Irregular Periods
- ❑Clots
- ❑Painful Periods
- ❑PMS
- ❑Date of Last Menses
- ❑Breast Lumps
- ❑Menopausal
- ❑# of Pregnancies
- ❑# of Births
- ❑Miscarriages/Abortions
- ❑Spotting
- ❑Yeast Infections
- ❑Vaginal Discharge
- ❑Irregular cycles
- ❑Fertility Problems
- ❑PCOS/Fibroids/PID/HPV
- ❑Endometriosis
- ❑Uterine Fibroids
- ❑STD
- ❑Other

Musculo-Skeletal

- ❑Injury
- ❑Arthritis
- ❑Sciatica
- ❑Muscle Weakness
- ❑Muscle Cramping
- ❑Muscle Spasms
- ❑Scoliosis
- ❑Joint Pain
- ❑Low Back Pain
- ❑Hand/Finger Pain
- ❑Hand Weakness
- ❑Wrist/Elbow Pain
- ❑Foot/Ankle Pain
- ❑Carpal Tunnel Diagnosis
- ❑Buttock Pain
- ❑Coccyx (Tail Bone) Pain
- ❑Pain Worse W/Damp/Cold/Heat
- ❑Pain With Movement
- ❑Pain Better W/Movement
- ❑Unexplained Pains. Location:
- ❑Pain/Bloating on Sides/Ribs

Other symptom(s) not listed:

OFFICE POLICIES

NO SHOW/LATE CANCELLATIONS

If an appointment is missed or not cancelled with 24 hours prior notice to the scheduled time, a fee of $30.00 will be charged if that time slot cannot be filled. We are closed Sunday and Monday. Tuesday appointments MUST be cancelled no later than 2pm on Saturday as we will be unable to fill the spot if it's cancelled while we are closed. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. Insurance will not reimburse the patient for this charge, nor will we bill the insurance for the visit. Our office staff makes appointment confirmation by phone as courtesy to our patient. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

AFTER-HOURS APPOINTMENTS All appointments made outside regular hours require staff to come in on their day off or after hours. Should you miss or cancel an after-hour appoint you may be charged for the **entire visit** there are **no exceptions**. A credit card may be required to hold your appointment and it will be charged the full amount of your visit should you not show or cancel outside a reasonable time.

MEDICAL RECORDS RELEASE Should you need copies of your records or other documents including receipts and income tax-related documentation, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. A completed and signed record release must be done before any records are released. If records are not being directly released to another physician's office, there will be a fee of $1.00 per page for the first 25 pages and 0.25 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of reproduction, payable prior to release.

AFTER HOURS AND EMERGENCIES In the event of an emergency situation, call 911 or go to the nearest Emergency Room. If you have an urgent concern that you need to discuss with the physician, please call our office to schedule your appointment. All phone message left in the voicemail will be returned within 24 hours by the office Tuesday – Saturday. We are closed Sundays and Mondays and major holidays.

POLICY REGARDING SMALL CHILDREN. We love children at East Lake Acupuncture & Wellness; however, due to safety and noise issues we ask that all children under the age of nine (9) be left at home. The exception is children receiving treatment. Zen-like moments can be disturbed by fighting or crying children and parents will have a difficult time relaxing when worried about the little ones. For safety reasons children are prohibited from waiting in a treatment room while parents/guardians receive treatment.

TREATMENT OF MINOR CHILDREN Children under twelve (12) being seen for treatment MUST be accompanied by a parent or guardian who is legally able to consent to treatment and make medical decisions on behalf of the minor child.

FAMILY & FRIENDS IN THE TREATMENT ROOM. With the exception of a parent accompanying a minor or a caretaker accompanying a disabled or unsteady individual. Family and friends are asked to wait in the lobby.

COMPLAINCE A treatment plan will be tailored to your condition. Missing appointments and otherwise not adhering to your treatment plan will interfere with your progress. Patients who deviate from the prescribed treatment plan may be discharged for non-compliance.

REFUNDS. Refunds on herbs will only be offered if they are returned within seven (days) of the date of purchase and are unopened, with the seal still intact. There are no refunds on services or opened products for any reason. Refunds on remaining package treatments will be refunded at the amount of the regular/full price service, not the discounted price as the package pricing would no longer apply.

TIMED SERVICES Massage and timed services are timed per industry standard. 50 minute hour and 25 minute half hour. Time to disrobe and conduct intake is factored in. To get the most time out of your service, please arrive at least 15 minutes prior to your service to allow time for check in. To get the most hands-on service time it is recommended you do not wait until your service is to start to arrive/check in and/or use the restroom. Services will not be extended to accommodate late arrivals as there is likely another service booked following yours. A timer is kept visible in each treatment room. Please monitor the time display on the timer as you may be required to sign for timed services (if we are billing your insurance.)

TURN OFF CELL PHONES. To help promote our relaxing atmosphere, we require phones be turned off or on vibrate while inside the clinic and no phone calls during treatment. Phone calls should be taken outside. Rest, relax, breathe and disconnect. Let the healing being.

FORMS AND REPORTS There will be a $25-$50 administrative fee for forms such as disability reports and letters of medical necessity. The fee will be determined based on the complexity of the document. Please allow seven (7) to ten (10) days for these reports to be completed. **RECIPTS & TAX DOCUMENTS** Please save your receipts. Each year we get dozens of requests from patients who lost or failed to save their copies. The forms and reports fees apply to compiling of copies of receipts and payment information.

CHECK POLICY. No personal checks will be accepted on NEW PATIENT visits. Any returned checks will incur a $30.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections agency, there will be a $50.00 fee for each account and you are responsible for any collection, court, or attorney fees. It is the responsibility of the patient to fully understand the rules and regulations of their insurance company and plan coverage.

I, _____, have read the above policies and understand my rights and agree to abide by said policies.

_____	_____	_____
Printed Name	Signature	Date

Copy of this document available upon request

Financial Responsibility / Assignment of Benefits

I hereby authorize Jeannette Kerns and/or Yolanda Rice and/or any other licensed provider at East Lake Acupuncture, LLC (hereinafter "Provider) to furnish acupuncture, massage therapy, ultrasound therapy, kinesiology taping, neuromuscular or manual therapy, injection therapy as long as said method of treatment falls within said provider's scope of practice. Moxibustion, gua sha, cupping therapy and/or various other therapeutic treatments and any other therapies within the provider's scope of practice including but not limited to recommending herbs and supplements.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say I owe, and that the Provider will bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the acupuncture treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pay all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider.

I, understand that Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I hereby request that my insurance carrier make payment directly to East Lake Acupuncture, LLC or the rendering physician for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits and are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

_____ _____

Patient or if a minor, Patient's Guardian Date

Fainting

Fainting during acupuncture

Acupuncture is a safe treatment; however, a ***small*** number of patients experience light-headedness and some faint. This a very rare occurrence. This is generally caused by nervousness, though dehydration and sudden changes in blood sugar can play a role. To help prevent fainting, you should drink plenty of water and eat a light snack (not a heavy meal) prior to each treatment.

Fainting Causes

Fainting (syncope) is a sudden loss of consciousness from a lack of blood flow to the brain. Fainting victims usually wake up quickly after collapsing because once a person goes from vertical to horizontal, blood starts flowing back into the brain and they begin to wake up. It can be quick or it can take a while; everybody's different.

Most fainting is triggered by the vagus nerve, which connects the digestive system to the brain, and its job is to manage blood flow to the gut. Unfortunately, the vagus nerve can get a little too excited and pull too much blood from the brain, resulting in fainting.

Symptoms of fainting

Before fainting, a victim can exhibit or feel all or some of these signs and symptoms, depending on the cause of the fainting:

- Dizziness or feeling lightheaded
- Confusion
- Nausea
- Sudden trouble hearing
- Tunnel vision or blurred vision
- Sweating
- Flushed or pale color
- Feeling hot
- Weakness
- Trembling or shaking
- Eye shaking (nystagmus)
- Headache
- Shortness of breath

Common symptoms that can occur after fainting

- Sweating stops
- Color begins to return
- Rapid pulse or "racing heart"
- Loss of bowel or bladder control

Common triggers fainting during acupuncture

Psychological Triggers

Anxiety or nervousness and stress can stimulate the vagus nerve in some people and lead to a loss of consciousness. In regards to acupuncture, those who faint are most often first-timers, experiencing some anxiety over the needles.

Dehydration

Too little water in the bloodstream lowers blood pressure, stimulating the vagus nerve. Dehydration coupled with nervousness over acupuncture creates a double-whammy. Toss in failing to eat a light snack prior to treatment and the odds of fainting or at least becoming light-headed are increased.

Fainting facts and general information

There are other causes of fainting, including, but not limited to, heart conditions; however, nervousness and dehydration are the most common in regards to acupuncture. All by itself, fainting is not life-threatening; however, sudden cardiac arrest looks a lot like fainting and requires immediate treatment.

If you feel suddenly flushed, hot, nauseated or break out in a cold sweat, don't try to stand up. Lie down until it passes. If it doesn't pass in a few minutes or you begin to experience chest pain or shortness of breath it is our policy to call 911.

Whenever someone passes out in our office and/or fails to become fully alert (recite day, month, year and name of president) within a few moments of fainting or feeling light-headed, it is our policy to call 911. Your safety is our primary concern.

I, _____(please print), have read the above information on fainting and understand that eating a light snack and drinking plenty of water prior to acupuncture is important and failing to do so may cause light-headedness and in some cases, fainting.

_____ _____

Signature Date

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.

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, and 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 or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as 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.

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 the 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 the date of first professional services.

If any provision of the 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.

PATIENT SIGNATURE (or Patient Representative)	X	(Date) (Indicate relationship if signing for patient)

Consent to Treat Form

I hereby request and consent to the provision of services rendered by Jeannette Kerns and/or other licensed providers at East Lake Acupuncture, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, manual therapy, electrostimulation, ultrasound therapy, neuromuscular reeducation and/or other physical therapy modalities, cupping therapy, bleeding therapy, Gua- Sha, vitamin injections, liptropic injections, recommendations for herbs and supplements, kinesiology taping, ultrasound therapy, laser therapy, injections, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling and other modalities within the provider's scope of practice. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell and/or taste.

I understand that post treatment flare-ups (increased symptoms) are a normal and expected part of healing, however, I will immediately notify East Lake Acupuncture, LLC of any increased pain or symptoms or if I am worried or concerned about any aspect of treatment or recommendations made by the provider. I understand the front desk and support staff and massage therapists are not qualified to give me medical advice or treatment recommendations.

I have been informed that acupuncture and physical therapy are generally safe methods of treatment, but that it may have some side effects, including but not limited to, soreness, bruising, numbness or tingling near the needling sites of needle insertion or manual work, dizziness or fainting. Bruising and tenderness are common side effects of acupuncture, injections, and massage and physical medicine modalities.

Rare or 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 disposable sterile needles and maintains a clean and safe environment. Some potential risks of injections of any type are bruising, tenderness, allergic reaction to products or devices, numbness, muscle soreness or nerve damage. Some of our injections are manufactured with lidocaine. If you've ever had a reaction to lidocaine or any local anesthetic, please inform us. Burns and/or scarring are a potential risk of moxibustion and fire cupping.

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 Oriental Medicine, although some may be toxic in large doses. I agree to inform the provider at time of product recommendation if I am on blood thinners, have a heart condition, am breast feeding, have diabetes or am on any medications, though ultimately it is my responsibility to research herb-drug interaction before choosing to take any herbs, vitamins or supplements that are recommended. 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 and my records may be shared with my insurance company to facilitate payment 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.

OFFICE SIGNATURE	(Date)
PATIENT SIGNATURE X	(Date) (Indicate relationship if signing for patient)

Copy of this document available upon request

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE RELATED INFORMATION

Your privacy is important to us. We will not so much as confirm your appointment with anyone else unless you authorize it in advance. Please select from the items below what you authorize us to discuss and any limitations you desire. You may change or revoke this authorization in writing at any time.

I, _____, hereby authorize East Lake Acupuncture, LLC and/or Jeannette R. Kerns and/or Yolanda M. Rice to discuss the details of my treatment as identified below to:

Name:_____ Relationship to the patient:_____

_____ (initials) My case including my progress, treatment plan and herbs or supplements prescribed;

_____ (initials) Make and/or change or confirm appointments on my behalf;

_____ (initials) Insurance benefits and payment;

_____ (initials) May be present during my treatments. The provider may speak freely in the presence of the individual named above unless a topic is specified below as being off limits.

_____ I do _____ do not authorize the disclosure of information regarding my mental, emotional or psychological state to the person listed above.

_____ I do _____ do not authorize the disclosure of information any substance abuse/use to the person listed above.

_____ I do _____ do not authorize the disclosure of information about sexually transmitted diseases to the person listed above.

I do not want the following discussed or disclosed with or in the presence the person listed above:_____

_____

_____

_____

Is there a phone number at which we can confirm your appointments? _____

Can we leave detailed messages at this number that related to your treatment and/or appointments? Y/N

Can we email you information about your treatment, appointments or lab results? Y/N

This authorization shall remain in effect indefinitely or until revoked in writing or until the date listed below:

Date authorization expires:_____

PRINT PATIENT NAME: _____ Date: _____

Signature of patient or guardian: _____ Date: _____

*A separate form will need to be filled out for each person you wish to authorize.

PAIN CONDITION INTAKE

PLEASE FILL OUT FOR ALL INJURIES OR CONDITIONS INVOLVING PAIN

Name: _____ Date: _____

Reason for Seeking Treatment: _____

_____

_____

Is this Condition a result of an auto accident? _____ A result of a job-related activity?_____

If this condition was caused by an injury or event, when did it occur and where were you when it happened?

_____

_____

_____

Did you have any testing (x-rays, lab work, MRI, etcetera) for this condition? _____

If yes, how long ago? _____

What were the results? _____

_____

_____

_____

What, if anything, makes your symptoms worse? _____

_____

What, if anything, makes your symptoms feel better? _____

_____

What methods of pain control have you tried AND how did they affect your condition? (NSAIDs, injections, prescription pain medications, anti-inflammatories, exercise, yoga, massage, acupuncture, surgery, etcetera)

_____

_____

_____

Please ask the front desk for a Pain Index Form. You must fill one out each visit if you are being seen for pain.

Privacy Policy

All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit **written** consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons or other court order. Copies of our detailed Privacy Policy is attached and additional copies are available upon request, are posted online and are posted near the front desk and are on most intake clipboards.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of East Lake Acupuncture & Wellness, LLC Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in East Lake Acupuncture, LLC's Notice of Privacy Practices, please do not hesitate to contact a clinic representative of East Lake Acupuncture & Wellness, LLC Patient Privacy Officer as indicated on your Notice.

Patient Name/Patient Representative (Printed): _____

Signature: _____