

Boone Community Acupuncture Clinic

<http://www.BooneClinic.org> Clinic: 828-278-0045, Cell: 828-719-1819

Location: 206 Southgate Drive, Suite # 21, Boone, NC 28607

New Patient Orientation Sheet

Welcome to **Boone Community Acupuncture Clinic**. We are glad you decided to try us for your health care. You have an important role in the success of this clinic and we rely on YOU to help spread the word about Boone Community Acupuncture Clinic.

The following guidelines will help you get the most out of your visit to the Clinic:

- Print and fill in all the forms in this document – 1. Orientation Sheet, 2. Intake Form, 3. Informed Consent Form, 4. Privacy Statement Form, 5. Financial Agreement Form and 6. Arbitration Agreement Form, from our website (BooneClinic.org) ahead of time. We are currently waiving the \$10 New Patient Fee, if you bring all these forms properly filled up and **signed**, with you before or at the time of your first treatment. If you need special assistance with reading, translating or walking, please bring someone to help you.
- Arrive at least 10 minutes before your treatment time to pay (Sliding scale of \$20-\$25-\$30 for community room, and \$40-\$45-\$50 for private room) for your session and to schedule your next appointment before your treatment. Bring a pair of shorts/loose pants and loose T-shirt (half-sleeved) especially if you are coming directly from work (or in winter). You will need this extra time to change clothes and to use the restroom, if you feel the need.
- **Please turn off your cell phone** (and other communication devices) before entering the clinic, so you will not be disturbed during your own treatment as well as by fellow patients. Remember that this clinic is a place of quiet and serenity, so please come in quietly and speak in a low voice.
- Before treatment, please take off your shoes, socks, any jewelry (especially wrist and fingers). Roll up your sleeves (if full sleeved), and pants. It is a good idea to lie on a reclining chair (community room) or treatment table (private room) before an acupuncturist treats you. It calms the body and mind. Acupuncture relies heavily on pulse and tongue diagnosis, and there is little need for acupuncturist to know all possible medical details of your case.
- Before each treatment, let the acupuncturist and/or staff know, if you are:
 - ** Pregnant, possibly pregnant or trying to get pregnant.
 - ** Taking blood thinners (Coumadin...) or on medication for high or low blood pressure.
 - ** Under the influence of drugs and / or alcohol (best to avoid on treatment day).
 - ** If you are using a pacemaker, insulin pump, or other health care devices.
- During the treatment, you will be given a buzzer to alert us if you need assistance at any time while you are resting on the table.
- Eat a sustaining meal or snack two to three hours before your treatment.
- If possible, avoid alcohol, heavy exercise, and stressful situations on the treatment day.
- If possible, avoid strong perfume or aftershave before treatment as other patients may be allergic to it.
- Don't cancel because of cold, headache or hangovers. These can be treated quite well.

We look forward to helping you in your healing process. We also love your feedback to us and telling your friends about us. Please sign below to acknowledge.

Name: _____ Signature: _____ Date: _____

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New Patient Intake Form

Date: _____ Patient Name: _____ Email: _____ (for reminders

only) Phone: (Home) _____ Work _____ Cell _____

Address _____ City: _____

State _____ ZIP _____ Occupation: _____

Date of Birth: _____ Ht. _____ Wt. _____ lbs Marital Status: _____

Emergency Contact: (Name) _____ Phone _____

Chief complaint: _____ since when? _____ Physician's Diagnosis _____

Are there other problems you would like to have addressed? _____

Do you have pain? Yes / No When and where? _____

Is your illness affected by seasonal changes? Please describe _____

Physician's Name: _____ Phone _____ Date last visited _____

Can we contact and communicate with your physician? Yes / No

How did you hear about us? _____

Your Past Medical History:

Please circle/write all illnesses you currently have or have had in the past (some examples below):

AIDS/HIV, Alcoholism, Allergies, Appendicitis, Arteriosclerosis, Asthma, Cancer, Chicken Pox, Chronic fatigue, Depression, Diabetes, Emphysema, Epilepsy, Goiter, Heart Disease, Hepatitis, Herpes, Measles, Multiple Sclerosis, Obesity, Pacemaker, Polio, Rheumatic fever, Shingles, Stomach ulcers, STDs. Stroke, Seizures, Thyroid, Tuberculosis. Other: _____

Current medications, herbs, vitamins, others (aspirin, antacid etc.) being taken:

List any surgeries you have had, with date _____

List past accidents / traumas (car, fall etc.) with dates:

Please circle if applicable.

General Symptoms: Poor appetite, Poor sleep, Bodily heaviness, Chills, Excess appetite, Heavy sleep, Bruise easily, Cold hands & feet, Like cold drinks, Dreams in sleep, Bleed easily, Night sweats, Like hot drinks, Fatigue, Shortness of breath, Poor circulation, Recent wt loss/gain, Lack of strength, Fever, Dizziness, Other _____

Head, Eyes, Ears, Nose, Throat: Wear glasses, Night blindness, Sores on lips or tongue, Headaches, Eyestrain, Glaucoma, Dry mouth, Lumps in throat, Eye pain, Cataracts, Excessive saliva, Enlarged thyroid, Red eyes, Teeth problems, Sinus problems, Nose bleeds, Itchy eyes, Grinding teeth, Excessive phlegm, Ringing in the ears, Blurred vision, TMJ, Color of phlegm _____, Poor hearing, Spots in eyes, Gum problems _____, Earaches, Poor vision, Facial pain, Migraines, Other problems: _____

Respiratory: Difficulty breathing, Chest tightness, Cough, Pneumonia, When lying down, Asthma, Color of phlegm _____, Shortness of breath, Coughing blood, Thick or thin _____

Cardiovascular: High blood pressure, Chest pain, Tachycardia, Phlebitis, Low blood pressure, Fainting, Heart palpitations, Irregular heartbeat, other _____

Gastrointestinal: Nausea, Diarrhea, Abdominal pain, Bowel movements Frequency_____, Vomiting, Constipation, Itchy anus, Gas, Laxative use, Burning anus, Stool Color & Texture/form_____, Acid reflux, Black stools, Hemorrhoids, Hiccups, Bloody stools, Anal fissures, Odor, Bad breath, Mucus in stools

Musculoskeletal: Neck pain, Upper back pain, Joint pain, Limited range of motion, Shoulder pain, Lower back pain, Rib pain, Muscle Pain, other (describe):_____

Skin and Hair: Rashes, Eczema, Dandruff, Change in hair/skin texture, Hives, Psoriasis, Itching, Fungal infections, Ulcerations, Acne, Hair loss, other (describe):_____

Neuropsychological: Seizures, Poor memory, Irritability, Suicidal thoughts, Numbness, Depression, Easily stressed, seeing a therapist, Tics, Anxiety, Abuse survivor, other (describe):_____

Urogenital: Painful urination, Blood in urine, increased libido, Impotence, Urgent urination, Incontinence, Decreased libido, premature ejaculation, STD, Bedwetting, Kidney stone, other (describe):_____

Family Medical History:

For each family member, indicate any major illnesses, and cause and age at death, if deceased.

Father: _____ Mother: _____

Siblings: _____

What do you like to eat: _____

Your Lifestyle: Alcohol How much_____ Cigarettes (packs) _____ Coffee/tea (cups) _____

Do you exercise? Yes/No Frequency: _____

What do you enjoy doing: _____

Describe your sleep habits: _____

Gynecology:

Is there any chance that you could be pregnant? YES / NO Menstrual cycles: Regular / Irregular /

Early / Late Menstrual flow: Heavy / Normal / Light. Is the blood: Normal / Purplish / Dark / Light

Vaginal discharge: white and thin / Yellow and thick / Clear / Painful

Menstrual blood: _____ Odor _____ Clots Y / N Color _____

PMS? (please describe) _____

Pain/itching/soreness of genitalia: _____

Vaginal infections/discharges (describe color): _____

Urinary tract infections: _____ How frequent: _____

Uterine fibroids _____ Endometriosis _____ Other _____

Pap smear: Normal / Abnormal Date of last Pap smear: _____

Number of children _____ Number of miscarriages _____ Number of abortions _____

Date of Menopause (if applicable) _____ any bleeding since menopause? _____

Any other symptoms experienced _____

Current method of contraception _____ past methods _____

Other symptoms: _____

I certify that the above information is correct to the best of my knowledge.

Signature _____

Date _____

Please provide any additional information about yourself or your condition that may be helpful in your treatment and that is not covered by the above questions, at the back of these sheets.

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Informed Consent Form

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 named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working for or associated with or serving as backup 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 tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff or 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 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. 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 tongue. I will immediately notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff 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 clinic staff thinks at the time, based upon the facts then known is in my best interest. I understand that the results are not guaranteed.

I understand that the clinical staff 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 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 may seek treatment.

PATIENT NAME _____ Date _____

PATIENT/REPRESENTATIVE SIGNATURE _____
(Indicate relationship if patient representative)

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CERTIFICATE OF PRIVACY ASSURANCE TO PATIENTS

Welcome to our Community Acupuncture Clinic. The protection of your health information is a high priority in our office, acupuncturists, and staff.

The confidence and trust you have placed with us is appreciated and honored. Under the new federal rules connected with the Health Insurance Portability and Accountability Act (HIPAA), your personal and health care information could be obtained by many third parties (including government agencies) without your consent. The new rules for HIPAA entity offices only require a notice or a log to be created when your records, in many situations, are used or disclosed.

Any health care provider (physician, doctor) who engages in any standard electronic transactions with others is considered under the law to be a HIPAA entity. The initial objective of the law was to stop and prevent the abuses that took place when patient health information entered the electronic world. However, under this HIPAA law-which has expanded, thousands of workers and many government agencies could have virtually unrestricted access to your health care records without your consent.

It would not be possible for us to give maximum protection to your patient information if we were a HIPAA entity. Therefore, our office has chosen to be a "HIPAA-Free" office. In our opinion, it is currently the best "protected health information" option available for our patients. We will not engage in any electronic transaction with others, as defined by HIPAA. Our office will not subject your information to the vulnerability and risks of the electronic world. Once your records enter into computer networks, your privacy is at risk -no matter how many rules are allegedly in force to protect you. Additionally, we will be better able to serve your needs by concentrating on your health care problems and concerns instead of having to constantly respond to complex and ever changing HIPAA rules and regulations.

IN SUMMARY: our office will not be subject to HIPAA because we do not do electronic transactions. Additionally, we do not file insurance claims or communicate with insurance providers electronically or not. Be assured that your records will NOT be disclosed nor released to anyone outside of our practice without your written consent unless specifically required to do so by law. If you or another practitioner requires a copy of your records, you will need to allow us 1 week's notice and pick them up at our office; the cost is \$2 per page. If you need the release form and records mailed, there is an additional \$6 processing fee. We will continue to honor your trust in us and to protect your health information. As a Community Acupuncture Clinic, we can and will maintain the highest standards of excellence in privacy matters.

Name: _____ Signature _____

Date _____

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FINANCIAL AGREEMENT

Boone Community Acupuncture Clinic makes every attempt to make alternative health care, as acupuncture and Chinese medicine, available to as many people as possible, at the most affordable rates.

Unlike many doctors' offices, we do not make you wait for up to 2 hours by overbooking in advance. To show respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary for you to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged a \$15 fee. If appointments have been purchased in advance, then any missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding,
Boone Community Acupuncture Clinic Staff

Print Name

Signature of Client/
Person Authorized to Consent

Date

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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 such dispute decided in 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, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds 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 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 the patients 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.

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 of 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: The 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 the patient intends 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 service.

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 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/Rep. Name:	Date:
Patient/Rep. Signature:	Relationship