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Acupuncture New Patient Questionnaire

Name: _____ Date: _____

Address: _____

Email: _____

Phone: _____ Date of Birth: _____ Age: _____

Emergency Contact: _____ Phone: _____

What are your main concerns today? _____

_____

_____

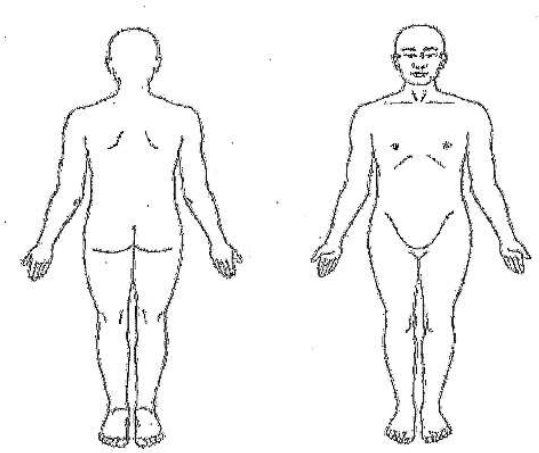
Are you currently receiving other forms of treatment? If yes, please list provider(s):

_____

Please use the illustration to indicate painful areas and rate your pain level
1 2 3 4 5 6 7 8 9 10

Indicate the location of the discomfort by using the symbol that best describes the feeling:

XXX- Sharp/ Stabbing
DDD- Dull/Aching
NNN- Numbness
TTT- Tightness/Spasm



Please check all that apply:

Muscles, Joints and bones

___ Pain worse with pressure
___ Pain better with pressure
___ Swollen joints
___ Cramping
___ Joint replacements (where?) _____
___ Pain worse in morning
___ Pain worse in evening
___ Arthritis
___ Fractured bones

Other: _____

Cardiovascular

___ Chest pain
___ Easy bruising
___ High blood pressure
___ Varicose veins
___ Palpitations
___ Irregular heart beat
___ Low blood pressure
___ Poor circulation

Other: _____

Respiratory, Eyes, Ears, Throat

___ Snoring
___ Frequent colds
___ Painful or dry eyes
___ Dry mouth
___ Chronic bronchitis
___ Dizziness
___ Sinus infections
___ Coughing
___ Shortness of breath
___ Poor vision
___ Ear ringing/ Tinnitus
___ Nosebleeds
___ Migraines/ headaches

Other: _____

Gastrointestinal and bowel movements

___ Belching
___ Bloating
___ Hernia
___ Gas
___ Loose stool
___ Ulcers
___ Heartburn
___ Indigestion
___ Constipation
___ Hard and dry stool
___ Nausea/vomiting
___ Acid reflux
___ Stomach pain
___ Diarrhea
___ Incomplete evacuation

Other: _____

Urination and thirst

___ Frequent urination
___ Difficulty starting
___ Urinary tract infections
___ Pain with urination
___ Foul smelling urine
___ Excessive thirst
___ Dry mouth
___ Incontinence
___ Kidney stones
___ Dribbling
___ Burning with urination
___ Dark color urine
___ Drink large amounts
___ Little or no desire to drink

Other: _____

Skin and Hair

___ Dry skin
___ Eczema
___ Rashes
___ Hives
___ Itching
___ Acne
___ Hair loss
___ Early graying

Other: _____

Temperature and sweating

___ Feel cold easily
___ Cold hands
___ Cold feet
___ Sensitive to weather changes
___ Sweat excessively
___ Feel hot easily
___ Hot flashes
___Alternating hot and cold
___ Night sweats
___ Sweat very little

Other: _____

Emotions and energy

___ Anxiety
___ Depression
___ Sadness
___ Exhaustion
___ Panic attack
___ Worry
___ Sensitive
___ Hyperactivity
___ Over-excitement
___ Anger
___ Burnout
___ PTSD

Other: _____

Allergies (Food & Environmental)

___Dairy
___Seasonal / pollen
___Gluten
___Dust
___Corn
___ Mold
___Soy

Other: _____

Sleep pattern and dreams

___ Insomnia
___ Difficult falling asleep
___ Daytime napping
___ Nightmares
___ Grinding teeth
___ Waking up during the night
___ Unable to fall back to sleep
___ Wake feeling unrefreshed
___ Restless sleep
___ Vivid or excessive dreaming

Other: _____

Physical Activity / Movement Patterns

___ Little to no regular movement
___ Inconsistent activity
___ Movement causes fatigue
___ Gentle movement (walking, stretching, yoga)
___ Moderate exercise (2–4 times per week)
___ Difficulty resting or overexercising
___ Pain limits movement
___ Movement improves energy
___ Intense exercise or training

Other: _____

Past Medical history

___ Cancer
___ Diabetes Type I or II (circle)
___ Emphysema
___ Fibromyalgia
___ Thyroid disorder
___ Osteoporosis
___ Heart disease
___ Multiple Sclerosis
___ Pacemaker
___ Seizure
___ Autoimmune condition
___ Asthma

Other: _____

Please list any major surgeries: _____

Medications and Supplements

Please list all medications and supplements you are currently taking:

_____

_____

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 California 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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**

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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: Melissa Brizzie, L.Ac.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged an interest of up to 15% per annum based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you may be charged a $50 fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received or had the opportunity to view our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE FOR PROVIDERS

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

SECTION 1785.27 CIVIL CODE

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

CURRENT CUSTOMARY FEE SCHEDULE / TIME OF SERVICE DISCOUNT / WAIVER OF NO SURPRISE ACT

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. According to (California Business and Professions Code 657), we offer a Pay at Time of Service Discount (TOS) which you may qualify for. All fees listed below may change without notice. Waiver of No Surprise Act: With my signature I am saying I agree to get any services listed below and am consenting of my own free will and not being coerced or pressured that I am giving up some consumer billing protections under federal law. I may get a bill for the full charges for these services or have to pay out-of-cost sharing under my health plan. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit. I can end this agreement by notifying the provider or facility in writing before getting services.

Initial Exam	99202	Expanded	$150.00
(New Patient)	99203	Detailed	$250.00
	99204	Comprehensive	$375.00

Re-Exam	99211	Minimal	$50.00
(Established Patient)	99212	Limited	$125.00
(Treated within 3 years)	99213	Expanded	$175.00
	99214	Detailed	$250.00

Acupuncture	97810	$90.00	1-2 regions
	97811	$50.00	3-4 regions
	97813	$100.00	Estim
	97814	$60.00	Estim +15 minutes

Manual Therapies	97140	$65.00
-includes cupping and gua sha		
Infrared heat lamp	97026	$15.00

PRINT NAME _____ SIGNATURE _____ DATE _____

AcuTap101— 330 Rancheros Dr, Ste 202, San Marcos, CA 92069 — Ph: 760.630.8060

AcuTap101

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **AcuTap101.**

I understand that the Notice describes the uses and disclosures of my protected health information by **AcuTap101** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*