

Acupuncture Changes Lives

Patient Name _____ Date _____

NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules)

I am notifying Acupuncture Changes Lives of one or more of the following:

- I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.
- I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.
- I am seeking acupuncture and Oriental Medicine for one or more of the following: chronic pain, weight loss, smoking or drug addiction cessation.

PRIVACY NOTICES

Consent for Purposes of Treatment, Payment, and Healthcare Operations...I understand I have a right to review the "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations. "The Notice of Privacy Practices" is available upon request. This Notice of Privacy Practices also describes my rights and Medical Arts Acupuncture's duties with respect to my Protected Health Information.

Appointment Reminders and Health Care Information Authorization...Medical Arts Acupuncture, and other associated practitioners, may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with whoever answers the phone. Thank You cards, appointment reminders, birthday cards, holiday cards and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have the opportunity to request a copy of this authorization.

Authorization For Release Of Health Information...Due to the Federal HIPAA Regulations enacted in April of 2003, your health care practitioners are not allowed to release any information concerning you or appointments without your written consent. Therefore, if you are interested in having someone other than yourself schedule or cancel appointments for you, pick up your herbal prescriptions, or be informed about any aspect of your treatment, you must list their names on the lines below giving us your authorization to communicate with a third party about your information. This written authorization is also necessary for insurance companies seeking knowledge about your treatments to reimburse a claim, or if you wish to have your case discussed with other doctors or practitioners outside my practice.

This form is included in your initial paperwork on your first visit. Please know my authorization to communicate about your treatment is limited only to those people you have listed on this form. We cannot release any information to anyone not listed on your medical records release form. If, at any time, you need to add to or amend this form please see a front desk receptionist.

I hereby authorize Medical Arts Acupuncture, and other associated practitioners the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations receiving the information: (please print)

Patient Signature _____ Date _____

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ARBITRATION AGREEMENT, INFORMED CONSENT, AND OFFICE POLICIES

Page 1 of 2 – Please sign Both Pages

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 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 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 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 inters who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care 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 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 fee of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitration, 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 the 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 the 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 there of 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 here in 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 the 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 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.

Patient Signature _____ Date _____

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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 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 method of treatment may include, but are not limit to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental 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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effect 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. Bruising is a common side effect of cupping or gua sha. 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. Burns and or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 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 know 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 any future condition(s) for which I seek treatment.

APPOINTMENTS

If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hour notice. This enables me to adjust my schedule accordingly. I reserve the right to charge the full fee for appointments canceled with less than twenty-four hours notice or for "no show" appointments.

PAYMENT FOR SERVICES RENDERED

Payment is due at the time of service and may be paid in cash or by check. We reserve the right to charge a small fee for processing if you choose to pay by credit card.

INSURANCE

- 1) In network with verifiable benefits:
This allows us to just charge copay and or deductible.
- 2) In network, benefits questionable; Out of network, with benefits:
For some reason, sometimes we can't get a clear verification of benefits, or we have strong reason to suspect that the information given is inaccurate; or are otherwise not guaranteed payment from the insurance company. In this case, you will be charged our cash price at the time of treatment, we will bill the insurance company, and IF the insurance pays for the treatment, then you will be reimbursed up to the amount you have paid, less copay and/or deductible.
- 3) No acupuncture benefits, in or out of network
Sometimes we KNOW that there will be no reimbursement, but we file because it helps the patient with their medical expense account paperwork.

Patient Signature _____ Date _____

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Patient Name _____ Date _____

Has your contact information changed?

E-Mail Address

Mailing Address

Home Phone Number

Best time to call
AM / Noon / PM

Work Phone Number

Best time to call
AM / Noon / PM

Cell Phone Number

Best time to call
AM / Noon / PM

In case of emergency, contact:

Name

Phone Number

Would you like for us to bill your insurance company?

Yes

No

Has your insurance paid for acupuncture before?

Yes

No

Who is your insurance provider?

Blue Cross/Blue Shield

United Healthcare

PHCS/MultiPlan

Cigna

First Health/Coventry

Other _____

Please provide us with a copy of the front and back of your insurance card.

What medications are you currently taking? (Use additional sheet if necessary)

Medication/Vitamin/Herb Name	Reason for taking it	For how long	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dietary Therapy: