

Acupuncture & Skin Rejuvenation Center

PATIENT INFORMATION

Name: _____ Date: ____/____/____

Sex: Male _____ Female _____

Date of Birth: ____/____/____ Age: _____
(month) (day) (year)

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ # of Children _____

Social Security Number: _____ (optional)

Driver's License or
Photo ID REQUIRED: _____
(State) (ID Number)

Home Address: _____

Home Number: _____

E-Mail Address: _____ Cell Phone Number: _____

Occupation: _____ Work Number: _____

WHO WOULD WE CALL IN CASE OF EMERGENCY?

NAME: _____

EMERGENCY TELEPHONE NUMBER: _____

Do you have health insurance? Yes _____ No _____

If yes, does your insurer cover acupuncture? Yes _____ No _____

Name & Policy Number of Insurer (REQUIRED):

(Insurance Company)

(Policy Number)

Whom may we thank for referring you to our office? _____

Please list any known allergies

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

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

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 methods of treatment may include, but are not limited 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 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. 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. 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 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.

PATIENT SIGNATURE X (Or Patient Representative)	Date	(Indicate relationship if signing for patient)
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OFFICE SIGNATURE	Date
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PLEASE SIGN REVERSE SIDE ALSO

**Acupuncture by Fran Ammons
121 Edinburgh Dr. South, Suite 202
Cary, NC 27511
919-481-6777**

Notice of Patient Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

A complete, detailed copy of HIPAA is available to read in our lobby. If you wish to take a copy for your records please ask the receptionist and they would be glad to assist you.

Authorization to use and disclose your protected health information for a special purpose

Patient's Name: _____ Date of Birth: _____

I authorize my Protected Health Information to be used or disclosed for:

Yes	No	Situation
		Health Insurance Claim Processing
		Updating my primary care physician
		Leaving test results on my answering machine
		Leaving appointment reminders on my answering machine
		Leaving billing messages on my answering machine
		Leaving messages via email. Email address:

I authorize the following people to receive my protected health information:

(Examples include another doctor besides your primary care physician, your spouse, another family member)

I understand that if my health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that my revocation is not effective to the extent that the persons I have authorized to use and or disclose my protected health information have acted in reliance on this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. However, I understand I will be responsible to pay for my medical care in full and file claims myself if I refuse disclosure to my health insurance company.

I have had the chance to read the content of this authorization form and I agree with all statements made herein. I give this authorization voluntarily.

This authorization expires one year from date below unless revoked.

Signature of patient or patient's personal representative Relationship to patient

Date: _____

You Have A Right To A Copy Of This Form After You Sign It – Please Ask And One Will Be Created

Fran Ammons, Licensed Acupuncturist

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment and insurance reporting, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment-** Information obtained by your practitioner by this office will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- **Insurance-** You may receive a receipt from this office upon request, in order to file for insurance re-imbusement or for other record keeping. This receipt is written documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and drug Administration (FDA)-** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation-** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health-** This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by to report communicable disease, injury, or disability.
- **Law Enforcement-**(1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of health information to appropriate health agencies, public health authorities, or attorneys.

It is Fran Ammons' practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, the office will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Communications with family -** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible with your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Patient signature _____

Date _____

Notice of Cancellation

From: Acupuncture by Fran Ammons
121 Edinburgh Dr. South
Suite 202
Cary, N. C. 27511
919-481-6777

To: New Patients

Please be advised that any appointments scheduled in your behalf have been scheduled specifically for you to enjoy the gift of acupuncture/massage and have an opportunity to experience a new level of wellness.

It is very important that a **48 hour notice of cancellation/rescheduling** be given **Monday-Friday during office hours between 11:15am-5:00pm. Please do not leave cancellation notices on the answering service.**

In the event a 48 hour notice is not given, your account will be charged for the amount of the scheduled office visit. Reminder calls will be attempted but not guaranteed in order to avoid any fees. The appointment made is **YOUR** responsibility to keep. **This office policy is very important and will be enforced.**

Your appointment date can be changed once. Any/all changes after that will carry an additional \$10 fee. Due to the increase in patient load, if an appointment date is cancelled/changed, there may be a delay of two or more weeks in rescheduling your appointment. **Please do not leave rescheduling notices on the answering service.**

It is most important to speak with the office personnel directly for any cancellation/rescheduled appointments.

Thank you for choosing the Acupuncture Clinic for your healthcare. We look forward to working with you. Be well.

Blessings,

Fran Ammons, LAc,B.S.,MSOM
Facial Specialist

Patient Signature _____ Date _____

Pain Supplemental Worksheet

Pain:

Location ~ please describe _____

On a scale from 1 to 10, how is the pain today? (1=best 10=worst) _____

Does the pain impair your ability to:

work exercise sleep perform household tasks drive concentrate

What makes the pain worse?

sitting standing activity heat cold massage stress lifting fatigue

What makes the pain better?

rest activity heat cold massage other _____

Character (check all that apply)

- DULL
- HEAVY
- SHARP
- ACHE
- STABBING
- PULLING

- DISTENDING
- SUPERFICIAL
- DEEP
- THROBBING
- LOCALIZED/FIXED
- CHANGING LOCATIONS

DATE/CAUSE OF INITIAL ONSET: _____

WHAT TRIGGERS THE PAIN? _____

FREQUENCY: occasional
intermittent
constant

Large empty space for additional notes or observations.

MEDICAL CHART

Patient Name	Last	First	Middle	File No.	
				Date	

Height:	Weight:	Lbs.	Pulse:	/min.
Temperature:	Blood Pressure	/	Breathing:	/min.

CHIEF COMPLAINTS

PHYSICAL EXAM. & TEST

PAST MEDICAL HISTORY (Patient)

<input type="checkbox"/> CANCER	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEPATITUS	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> STROKE	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> RHEUMATIC FEVER		

Other:
Surgeries:

Significant Trama: Auto Accident, Fall or Other:

Allergies: Drug, Chemical, Food or Other:

FAMILY MEDICAL HISTORY

<input type="checkbox"/> CANCER OR TUMORS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEPATITUS	<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> STROKE

Other:

PRESENT MEDICAL HISTORY (PATIENT)

HEART

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> EXCESSIVE DREAMS | <input type="checkbox"/> PALPITATION |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> NIGHT SWEATING | <input type="checkbox"/> COLD HANDS OR FEET | <input type="checkbox"/> POOR MEMORY |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> OVERSLEEP | <input type="checkbox"/> EASILY AWAKENED |
| <input type="checkbox"/> IRREGULAR HEARTBEAT | | <input type="checkbox"/> SWELLING OF HANDS OR FEET | |

SLEEP:

OTHER:

LUNG

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> COUGH | <input type="checkbox"/> COUGHING BLOOD | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BRONCHITIS |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> SHORT OF BREATH | <input type="checkbox"/> COMMON COLD | <input type="checkbox"/> LOSS OF VOICE |
| <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> PHLEGM | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SKIN PROBLEM |
| <input type="checkbox"/> SORE THROAT | <input type="checkbox"/> PAIN WITH A DEEP BREATH | | |
| <input type="checkbox"/> SPONTANEOUS SWEATING | <input type="checkbox"/> DIFFICULTY IN BREATHING | | |

OTHER:

SPLEEN & STOMACH

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> STOMACH PAIN | <input type="checkbox"/> GASFULNESS | <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> OVERACIDS |
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> VOMITING | <input type="checkbox"/> BELCHING | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> FOUL BREATH | <input type="checkbox"/> PROLAPSE | <input type="checkbox"/> BRUISE (EASILY) | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> LOOSE STOOL | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> THIRSTY | <input type="checkbox"/> ABDOMINAL DISTENSION | <input type="checkbox"/> ABDOMINAL PAIN OR CRAMPS | |
| <input type="checkbox"/> DESIRE OF COLD OR HOT DRINK? | | | |

APPETITE:

DIGESTION:

BOWEL MOVEMENT:

OTHER:

LIVER

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> EASILY UPSET | <input type="checkbox"/> FACIAL REDNESS | <input type="checkbox"/> EASILY SIGH | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> BITTER TASTE IN MOUTH | <input type="checkbox"/> PAIN IN THE RIBS | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> TWITCHING OR SPASM OF MUSCLE | | <input type="checkbox"/> BRITTLE NAIL | |
| <input type="checkbox"/> EYE PROBLEM | | | |

OTHER:

KIDNEY

- | | | | |
|--|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> EAR RINGING | <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> KNEE PAIN |
| <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> HAIR LOSS | <input type="checkbox"/> FRIGHTENING | <input type="checkbox"/> IMPOTENCY |
| <input type="checkbox"/> EDEMA (WATER RETENTION) | | <input type="checkbox"/> DECREASED SEXUAL DRIVE | |
| <input type="checkbox"/> URINARY PROBLEM | | <input type="checkbox"/> NIGHT URINATION | |

URINATION:

OTHER: