Family Acupuncture and Wellness Center / Community Acupuncture

Registration Form / Health History Questionnaire **Today's Date**: _____

I. Personal Information:

Legal Name_____ Preferred Name _____

Email: _____ want newsletters **Yes** No (We do **NOT** sell or share your information)

Phone # Home: _____ Cell: _____ Receive Text Messages **Yes** No

Can we leave _____ detail message _____Appointment confirmation?

Home Address: _____

STREET NUMBER, STREET, APT#, CITY, STATE, ZIP CODE

Occupation: _____ Company Name: _____

Emergency Contact: _____Relationship: _____Phone number: _____

Gender: _____ Marital Status: _____ Date of Birth ____/_____/_____ Age: _____

Have you had Acupuncture Before, If yes where and for what? _____

How did you hear about us? _____ Friend: _____

Who is your Primary Care Physician? _____ Phone Number: _____

Are you **currently pregnant**? _____ Are **you actively trying** to get pregnant? _____

II: Insurance

As a courtesy we will file Insurances, We do our very best to have the Insurance pay for your treatments, however there is no guarantee that the Insurance will pay, and you are responsible for any unpaid balance. **Initial:** _____

PRIMARY INSURANCE

Insurance Co. Name: _____ID#: _____ Group#: _____

SECONDARY INSURANCE

Insurance Co. Name: _____ Pone:_____

ID#: _____ Group#: _____ Effective Date: _____

ACCIDENT RELATED

Work Related: Y / N On-set / Accident Date: _____ **Auto Accident : Y / N On-set / Accident Date:**_____

Workers Compensation / Auto Insurance Information

Insurance Co. Name: _____Phone: _____

Address: _____

Adjuster's Name: _____ Phone: _____ext._____

Claim #: _____

Attorney Information:

Name: _____Phone: _____Address: _____

III. Goals

Goals: What would you most like to achieve through your work at Family Acupuncture and Wellness Center?

1._____

2._____

3._____

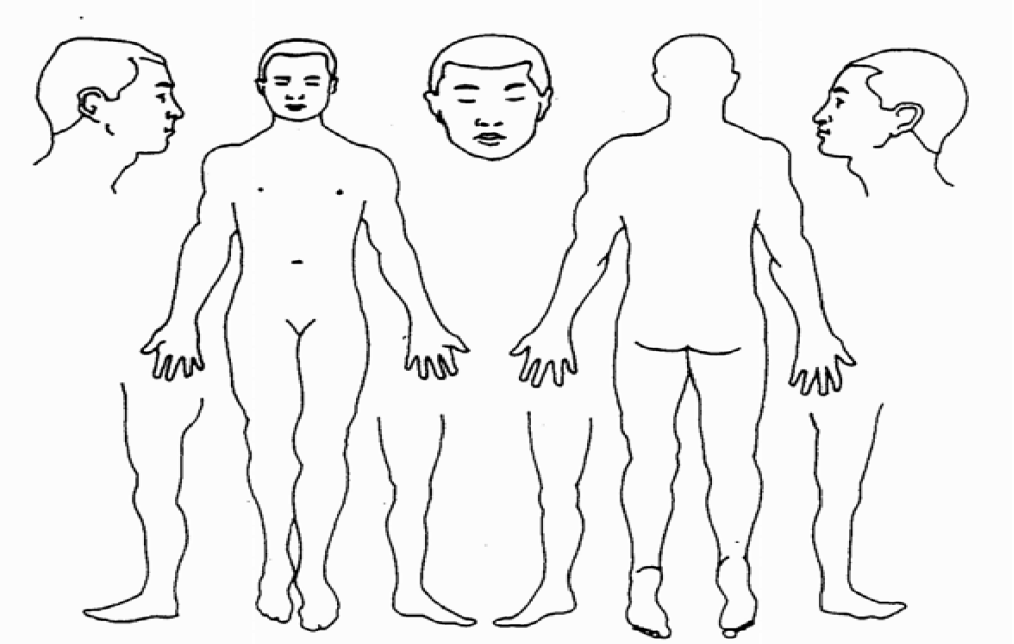
Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(Most concerning to least, along with the duration of the symptom)

1._____

2._____

3._____ _____

Use the following illustration to indicate painful or distressed areas:



Keys:

XXX	sharp/stabbing
PPP	Pins & Needles
DDD	Dull/ Aching
NNN	Numbness

Are you experiencing pain/discomfort in any area of your body? Y/N If yes, using the models above, please indicate the location of the discomfort by using the symbol that best describes the feeling

IV. Medical History

Diabetes	___/___/____	High Cholesterol	___/___/____	Insulin Pump	___/__/_____
Heart Disease	___/___/____	High Blood Pressure	__/___/____	Pain Pump	___/___/____
Thyroid Disease	___/___/____	Seizures	___/___/____	Pacemaker	____/____/____
Cancer	___/___/____	Hepatitis	___/___/____	Other: _____	
HIV / AIDS	___/___/____	Defibrillator	___/___/____		

Allergies

Allergen	Reaction	Severity	Last encounter

For Women:

1. Are you pregnant now? ___Yes ___ No ___Unsure

2. Indicate number of occurrences: Live Births _____ Pregnancies_____ Miscarriages _____

3. Age: First period _____ Menopause (if applicable) _____

4. Is your menses cycle regular? ___ Yes ___ No Where are you on your cycle today_____

   a) Average number of days of flow _____

   b) The flow is: ___Normal ___ Heavy ___ Light

   c) The color is: ___ Dark ___ Purple ___ Light Brown ___ Brown _____Other

5. Do you have the following menstruation related signs/symptoms?

___ Difficulty with orgasm ___ Cramps ___ PMS ___ Heavy vaginal discharge between periods

___ Pain with Intercourse ___Nausea ___ Bleeding between periods

___ Blood clots ___ Breast Distention ___ Vaginal discharge – Color_____, Smell ___Yes ____No

Taking or Taken Birth Control ___ Yes ___No, If Yes how long and reason _____

6. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?

_____

For Men:

1. Do you have any bothersome urinary symptoms? ___ Yes ___ No Describe: _____

2. Check all that apply:

___ Feeling of coldness/numbness in genitalia ___ Erectile dysfunction ___ Difficulty with orgasm

___ Impotence/ erectile dysfunction ___ Premature ejaculation ___ Pain/Swelling of testicles

___ Frequent need to urinate at night

3. Do you get up at night to urinate? ___ Yes ___ No How often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?

_____

V. Nutrition

1) Do you follow a special diet? ___ Yes ___ No. If yes, how would you describe the diet? _____
(i.e. Vegetarian, Vegan, Low Carb, Low fat, ect.)

2. What do you eat on a "typical" day? _____

   a) Breakfast _____

   b) Lunch _____

   c) Dinner _____

   d) Snacks _____

   e) Foods you tend to **crave** _____

f) Foods you dislike _____

g) Pain with foods _____

VI. Surgical History

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

VII. Medications / Supplements: Please list ALL / ANY medications, Herbs and Supplements you are currently taking, please include the doses and reason you are taking them.

Medication	Reasons	Date Started	Dosages	Helps Yes or No

Supplements / Vitamins	Reasons	Date Started	Dosages	Helps Yes or No

VIII. Family History

Please check all that apply and state how you are related to the family member with that condition

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Depression					
Other Mental Illness					
Substance Abuse					
Osteoporosis					
Diabetes					
Glaucoma					

IX. Social History

1. How much per day do you use of the following?
   a) Coffee, tea, soft drinks: _____
   b) Alcohol: _____
   c) Cigarettes, cigars, other tobacco: _____
   d) Other drugs: _____
2. Have you ever had a problem with *alcohol* or *alcoholism*? ___ Yes ___ No
3. Have you ever had a problem with *dependency* on other drugs? ___ Yes ____ No
4. If yes, for what and when? _____
5. In the past month, how many days have been significantly affected by your health? _____
6. How many days did you feel generally poor? _____
7. How many times were you in the hospital in the past year? _____
8. Please describe your current exercise regimen:
   Hours per week: _____ Activities: _____ No Exercise ____
9. How many hours of sleep do you usually get per night during the week? _____
10. Do you wake up? ____ Yes ___ No, If **yes** how many times _____, and for what (ie: Pain, restroom)_____
11. Do you awake feeling rested? ___ Yes ___ No

X. Other Information

Have you been treated for emotional issues? ___ Yes ___ No

Have you ever considered or attempted suicide? ___ Yes ___ No

Do you have any other neurological or psychological problem? ___ Yes ___ No

Please provide us with any other information that you think is relevant for us to know:

_____

_____

PLEASE READ: In Community Acupuncture there are other people in the Community room, Please TURN your phone **OFF or on silence it**! Please **NO** perfumes / cologne, heavy soaps! **Initials**_____

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

For purposes of this Notice of Privacy Practices, "We" or "Us" refers to Family Acupuncture and Wellness Center of Florida, our doctors and office staff. We understand that health information about you and your health care is personal. We are committed to protecting your information. We create a record (chart) of the care and services you receive from us. We need this record (chart) to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records (chart) of your care generated by this office, whether made by your individual doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to: give you this Notice of our legal duties & privacy practices with respect to health information about you; make sure that health information that identifies you is kept private; and Follow the terms of our HIPPA Notice that is currently in effect at all times. How we may use, and disclose, health information about you, in relation to, or as requested:

- Treatment
- Payment
- Healthcare operations
- Appointment reminders
- As required by Law;
- To avert a serious threat to health & safety
- Public Health Risks
- Health oversight activities
- Law enforcement
- Lawsuits and disputes
- Coroners, health examiners & funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates
- As required by the Military, Veterans and
- Workers Compensation

Your rights regarding Health Information about you, right to:

- Inspect and copy
- Request Restrictions
- Amend
- An Accounting of Disclosures
- Request Confidential Communications
- A Paper copy of our Full Notice, available upon request

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current Notice in our Office with the current effective date on the first page. Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact Dr. Arbogast to file a complaint. Acknowledgement of Receipt of this Notice: We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records. This acknowledgment provides that you have declined to accept the Complete Notice and instead requested this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our Office. Effective Date: November 1, 2015.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

Electronic Communication Agreement By signing this document I hereby give consent to Christina Arbogast AP and us, to communicate with me via email, text message and voice message communications regarding the following aspects of my medical care:

- Appointment Bookings
- Text Messaging
- Test Results
- Prescriptions
- Billing
- Consultations & Advice
- Patient Education Material

By signing this document you understand and agree to the following: Please read and initial:

____ I understand and agree that email and text messages are **not confidential** methods of communication. **Unless thought the Acusmiple patient/client portal.**

____ I understand and agree that there is always a risk associated with text messaging & email communications between myself and staff / independent contractors at Family Acupuncture and Wellness Center of Florid regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended third parties.

____I understand and agree that any text message and/or email communication between myself and staff / Independent contractors at Family Acupuncture and Wellness Center of Florida regarding my medical care and treatment will be printed out and made a part of my permanent health record.

____ **Staff / Independent contractors at Family Acupuncture and Wellness Center of Florida will NOT reply to schedule changes or requests for Medical records via email or text messaging ONLY written request.**

____I understand and agree that in an **urgent or emergency situation** that I **should call my primary care provider** or Immediately utilize Emergency Medical Services by **dialing 911**.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

Scope of Practice The "scope of practice" for an acupuncturist is the state of Florida includes but is not limited to the following list of techniques: Use of acupuncture needles to stimulate acupuncture points and meridians. Use of electrical, mechanical or magnetic devices stimulate acupuncture points and meridian Acupressure, Laser puncture , Dietary advice based on traditional Chinese medical that I recognize the potential risks/side effects and benefits of these procedures as described below: Potential risks/side effects may include, but are not limited to following: Pain following treatment in insertion area Temporary discoloration of the skin Aggravation of symptoms existing PRIOR to treatment, Minor bruising broken needle, Infection Needle sickness NOTE: Patients with bleeding disorder, pacemakers, seizure disorders, or women, who are currently pregnant, PLEASE notify the practitioner. Potential benefits may include, but are not limited to the following: Drugless relief of presenting symptoms Improved general health Elimination of the presenting problem Reduction of pain and associated symptoms With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Community Acupuncture of Vero Beach, regarding cure or improvement of condition. I hereby release Community Acupuncture of Vero Beach from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

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 a licensed acupuncturists at the Family Acupuncture and Wellness Center of Florida now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist Christina Arbogast, and 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

Family Acupuncture and Wellness Center - Christina Arbogast, AP

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

Policies:

Privacy:

We follow the Health Insurance Portability and Accountability Act (Privacy Law). There is a copy on the website at: Www.AcupunctureOsceola.com or we can give you a copy.

Booking and Payment:

Booking online is the easiest and best way to ensure your time. www.AcupunctureOSceola.com If you don't have access to a computer / internet just contact us (Please leave a voice mail and we will get back to you ASAP)

NO TEXT MESSAGES We do **NOT accept text messages for appointment time, changes or cancelations. If a text message is sent and you do not show up, the cancelation policy will be applied.**

Advance payment is required to book all appointments. Scheduling appointments happens in the reception area before each treatment, so you can relax and enjoy each treatment. Payment can be made with cash, Visa, MasterCard, and other Charge Cards.

NO Checks accepted.

Community Acupuncture is **NOT** covered by insurance, however we will provide you with an invoice for reimbursement. ($25.00 fee for adding CPT and Diagnoses codes)

Private Acupuncture Treatments are covered by most insurance, however there is no guarantee that the Insurance will pay, and you are responsible for any unpaid balance

Cancelation Policy:

There is a 24 hour Cancellation policy for all appointments. We understand and acknowledge how busy you are, and how appointments can be overlooked or forgotten, as sometimes cancelations are unavoidable. However, in fairness to all, the following policies have been established. If you know more than 24 hours in advance that you need to cancel or reschedule your appointment, please CALL (NO TEXT MESSAGES) us at 407-792-5660. If there is no answer please leave a voice message. Within 24 hours before your appointment time so we may accommodate another patient in your place. Cancelation / reschedule made before 24 hours before a scheduled appointment will not incur a penalty or fee.
No charges will be assessed for appointment cancelled/reschedule in less in 24 hours if our permits us to reschedule another appointment on the same day, otherwise it is considered a cancellation. Patients with treatment packages who cancel / reschedule in less than 24 hours as courtesy will be given one pass (no penalty per package, therefore they will lose one treatment for each subsequent incident). Patients without a treatment package cancelation / reschedule made in less than 24 hours will be charged 50% of the service schedule. All Dr. Christina Arbogast, AP, patients in the event that she should cancel / reschedule an appointment in less than 24 hours, no penalty or charges be incurred by the patient, and as compensation we will receive a FREE treatment package (extensions will be given if warranted.)

Lateness policy:

Appointments may occur every 10 - 15 minutes. We need you to be ready at your scheduled time so that you receive a quality treatment. If you arrive more than 15 minutes after your scheduled appointment you may be asked to wait, and if treated, your treatment time may be cut short. If we have a full schedule, we may not be able to treat you. Patients more than 15 minutes late are considered NO call / no show and will consider it as a missed appointment. In this event the cancellation policy will apply. No call / No show – missed appointments Patients without treatments packages will be charged the full amount of the service. Patient with treatment packages will lose one treatment.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

RBITRATION AGREEMENT AND INFORMED CONSENT **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, 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 preceptor ship 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. **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 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 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.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

CREDIT CARD ON FILE POLICY

At Family Acupuncture and Wellness Center, we require keeping your credit or debit card on file as a method of payment for cancellations made less than 24 hours and/or missed appointments.

Your credit card information is kept confidential and secure and payments to your card are only processed if you miss an appointment or fail to notify Family Acupuncture and Wellness Clinic at least 24 hours in advance of your appointment.

I, _____(your name) authorize Christina Arbogast A.P of Family Acupuncture and Wellness Center to charge **up to the full price** of the missed acupuncture treatment to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date ____ / ____ / ____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I, the undersigned, authorize Christina Arbogast A.P from Family Acupuncture and Wellness Center to charge my credit card, indicated above, for balances due for missed or late cancelled appointments.

This authorization relates to all payments for missed or last minute cancellations as stated and signed by me in the Family Acupuncture and Wellness Centers office policies.

_____ _____

Print Full Legal Name Date

_____ _____

Patient Signature (Or Patient Representative: Indicate relationship if signing for patient.) Date

_____ _____

Witness Date