Bryan Reisinger, L.Ac., CMT(#54384)
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New Patient Registration Form Today's Date: / /

Please PRINT the following information:

Name:_____.
First Middle Last

Sex: ◯ Male ◯ Female ◯ Non-binary Date of Birth:____/____/____.

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed Height:_____ Weight:_____

Address:_____
Street # City State Zip

Phone: Cell:_____ Home:_____ Work:_____

Email:_____ Occupation:_____

In case of Emergency:_____ Phone:_____

Referred by: ◯ Doctor ◯ Friend/Family ◯ Internet ◯ Lawyer ◯ Other:_____
Name of Referrer:_____

We do not currently accept Insurance as an In-Network Provider. You may have Out-Of-Network Benefits that cover Acupuncture and Manual Therapies. If you would like us to check your benefits, please provide the following information regarding your policy:

Carrier:_____

Name of Insured(if other than patient name):_____ Date of Birth:___/___/___.

Sex: ◯ Male ◯ Female ◯ Non-binary Phone:_____ Employer:_____

Address:_____
Street # City State Zip

Member ID#:_____ Policy/Group#:_____

Plan/Program Name:_____ Relation: ◯ Self ◯ Spouse ◯ Child ◯ Other

_____ *The fees for office services are payable at the time of the visit. I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service, I may be billed and held responsible for all fees and charges.*

_____ I hereby authorize Dao Wellness Center / Bryan Reisinger, L.Ac., CMT to release any and all necessary medical information to my insurance and/or medical professionals involved in my case.

_____ **I understand and agree** that failure to arrive for my appointment **may** result in a **$50 Missed Appointment Fee.**

_____ **I understand and agree** that failure to provide **24 hours notice** to cancel my appointment **may** result in a **$50 Missed Appointment Fee.**

Signature:_____ Date:___/___/_____.
Patient or Guardian/Parent

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Patient Health History

What is the reason for your visit today:

How long has this been an issue: | **Was there an initial cause?**

Does anything make it better?

What other therapies do you engage in?

What makes it worse?

Are you currently under the care of a Physician? ◯ Yes ◯ No | **For what reason?**

Physician's Name: | **Physician's ph#:**

Please list any medications or supplements you current take:

Do you have any secondary or tertiary issues you would like to address?

Have you had acupuncture before? ◯ Yes ◯ No | **For what reason?**

Are you Pregnant or Trying to be? ◯ Yes ◯ No | **Have you been Pregnant?** ◯ Yes ◯ No

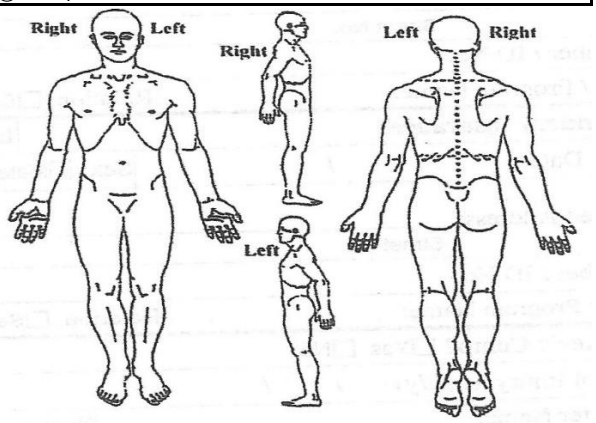
Family Medical History: ◯ Allergies ◯ Asthma ◯ Cancer ◯ Diabetes ◯ Heart Disease ◯ Hypertension ◯ Arthritis ◯ Mental Illness ◯ Addiction

Your Medical History: ◯ AIDS/HIV ◯ Hepatitis ◯ Acid reflux ◯ Allergies ◯ Arthritis ◯ Addiction ◯ Asthma ◯ Cancer ◯ Diabetes ◯ Heart Disease ◯ Hypertension ◯ Seizures ◯ Stroke

Please list any surgeries you have had:

Life Style: ◯ Alcohol ◯ Cannabis ◯ Tobacco ◯ Drugs ◯ Stress ◯ Occupational Hazards

Please indicate areas of concern on the diagram →



Please indicate if you suffer from any of the following:
◯ Bleed / Bruise easily ◯ Body Heaviness ◯ Fatigue
◯ Shortness of Breath ◯ Irregular Heartbeat
◯ Tightness in Chest ◯ Chest Pain ◯ Poor Circulation
◯ Difficulty Breathing ◯ Rib Pain ◯ Numb / Tingle
◯ Recent Weight Gain/Loss ◯ Flu/Cold

◯ Freq. Migraine/Headache ◯ Vertigo/Dizzy
◯ Foggy/Cloudy Head ◯ Poor Memory

◯ Anxiety/Panic ◯ Depression ◯ Irritation
◯ Easily Stressed ◯ Constant Worry ◯ Fear ◯ Mania

How is your sleep? ◯ Heavy ◯ Light
◯ Difficulty falling asleep ◯ Difficulty Staying Asleep
◯ Waking Early ◯ Disturbed Sleep ◯ Waking Tired
◯ Vivid / Unpleasant Dreams

Preferred Room Temperature?
◯ 65° ◯ 70° ◯ 75° ◯ 80° ◯ 85°

Body often feels:
◯ Hot ◯ Cold ◯ Especially in Hands/Feet

Preferred Beverage Temperature?
◯ Hot ◯ Room Temperature ◯ Cold

Perspiration?
◯ Easy Sweat ◯ Lots of Sweat ◯ Nightsweat

Skin Condition? ◯ Acne ◯ Itching ◯ Eczema ◯ Psoriasis ◯ Hives ◯ Rashes ◯ Fungal Infection

Nail Condition? ◯ Brittle ◯ Easy Break ◯ Fungal Infection ◯ Thin

Digestion Review (please mark all that apply, even if not related to current complaint) ◯ Gas/Bloat after eating ◯ Tired after eat ◯ Acid Reflux ◯ Loose Stool ◯ Especially first thing a.m. ◯ Diarrhea ◯ Constipation ◯ Mucus in stool ◯ Blood in stool, is ◯ bright red ◯ dark and tarry

Urination ◯ Frequent, ◯ Especially at night ◯ Painful ◯ Difficult to start ◯ Dribbling / Incontinence ◯ Blood in urine

Women ◯ Menstruating:_____# days cycle_____date of last cycle ◯ Menopaused ◯ Irregular ◯ Heavy ◯ Light
Color is ◯ Light/Watery ◯ Red ◯ Scarlet ◯ Dark **Duration is** ◯ Less than 3 days ◯ More than 5 days ◯ **Clots that are** ◯ Large ◯ Small ◯ Numerous; ◯ **Painful, especially** ◯ Before Cycle ◯ During Cycle ◯ After cycle **Vaginal** ◯ Odor ◯ Sores ◯ Itchiness
Discharge that is ◯ white/clear ◯ yellow ◯ red ◯ other

Men ◯ ED/LT ◯ Pain/Coldness in genitalia ◯ Prostate problems ◯ Seminal Emissions, ◯ day ◯ night ◯ Vasectomy

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Arbitration Agreement & Informed Consent – Please Read & Sign

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 Law, and not by a lawsuit or resort to court process except as California 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 the intention of the Parties that this Agreement bind all Parties whose claims may arise out of or related 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 the patient while employed by, working or associated with or serving as 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, or Punitive Damages. Filing of any action in any court by the Health Care Provider to collect any fee from patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the Health Care Provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by Arbitration.

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 30 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 feed, 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 of this arbitration of any person or entity that would otherwise be a proper additional party in a court action, an upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the 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 judgement 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 Provisions: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one processing. 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 California 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 processional services received by the patient.

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 the Arbitration Agreement is help 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

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right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

I hereby request and consent to the performance of acupuncture treatment and other Oriental Medicine procedures, as well as Massage Therapy modalities, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible for) by the below named licensed acupuncturist and/or other licensed acupuncturists who now or in the future treat me while employed by, working, or associated with, or service as back-up for the acupuncturist named below, including those working at this office or clinic, 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, tuina, guasha, Chinese or western herbal medicine, nutritional counseling, and/or the application of western massage techniques such as Trigger Point Therapy and Myofascial Release. 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 unpleasant to 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 had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures. Acupuncture effects to normalize physiological function, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including but not limited to, bruising, numbness, or tingling near the needling sites that may persist for a few days, and dizziness or fainting (syncope/near syncope). 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 potential risks of moxibustion and cupping. 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 if I am trying to become or have become pregnant

I do not expect the clinical staff to be able to anticipate and explain all possible ristks and complications from treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment with 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.

I have been informed that I have a right to refuse any form of treatment. 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 any questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature:_____ Date:__/__/____.

(or Patient Representative) Relationship is signing for patient:_____

Practitioner Information:
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HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

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You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.