HEALTH HISTORY QUESTIONNAIRE

To assist us in providing you with a complete evaluation, please fill out this questionnaire carefully and completely. If there is anything you wish to bring to our attention that is not on this form, please note it in the "Comments" section. Thank you.

CONTACT INFORMATION

Full Name _____ Date _____
First Middle Last

Address _____
Street, Apt City State Zip

Phone _____ (H/C/W) Alt Phone _____ (H/C/W)

Email _____

Guardian's Name (if under 18) _____ Relation _____

Emergency Contact _____ Relation _____

Emergency Contact Phone(s) _____

Who may we thank for referring you? _____

GENERAL INFORMATION

Gender _____ Age _____ DOB _____ Birth Time _____ ☐AM ☐PM

Birthplace: City _____ State/Region _____ Country _____

Religion/Spiritual Affiliation or Preference _____ Sex _____ Sex at Birth ___

Occupation _____ ☐Retired ☐Disabled ☐Unemployed

Race or Ethnicity (check all that apply and add details)

☐ Native American or Alaska Native _____
☐ Asian _____
☐ Black or African American _____
☐ Native Hawaiian or Pacific Islander _____
☐ White or Caucasian _____
☐ Hispanic or Latino _____
☐ Other _____

Family Status

☐ Single
☐ Married
☐ Widowed/Widower
☐ Divorced or Separated
☐ Children No. _____
☐ Caregiver (ex. Elder care)

Primary Care Physician's Name _____ **Phone** _____

Last physical examination: Date _____ Height _____ Weight _____

Are you currently under physician's care for a specific condition? ☐Yes ☐No
If yes, for what? _____

Have you ever been treated with Acupuncture? ☐Yes ☐No
Have you ever been treated with Herbal medicine? ☐Yes ☐No
Have you ever been treated with Diet or Lifestyle changes? ☐Yes ☐No

Have you ever been treated with Yoga Therapy? ☐Yes ☐No

HEALTH CONCERNS AND OBJECTIVES

Primary concern/condition you would like you help with (please be specific).

When did this problem begin?

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

How does this problem affect your daily activities?

What therapies you have tried to treat this condition?

☐Western Medicine ☐Acupuncture ☐Diet ☐Herbs ☐Massage ☐Physical Therapy
☐Yoga ☐Chiropractor ☐Reiki ☐Homeopathy ☐Qigong ☐Cosmology ☐Other_____

Results?_____

What therapies are you willing to consider trying to treat this condition?

☐Western Medicine ☐Acupuncture ☐Diet ☐Herbs ☐Massage ☐Physical Therapy
☐Yoga ☐Chiropractor ☐Reiki ☐Homeopathy ☐Qigong ☐Cosmology ☐Other_____

Please check the item(s) that reflect your primary health objective(s):

☐ Resolution of Primary concern/condition
☐ Find an alternative approach to allopathic medicine for managing illness and disease
☐ Improve my general health/wellness
☐ Reduce my vulnerability to illness and disease
☐ Improve my lifestyle and dietary practices to improve my health
☐ Change my habits and behavioral patterns to attain greater emotional stability
☐ Manage stress, tension, and/or pain

Please list the stressful areas of your life.

List other major concerns/conditions in order of significance and rate their severity.

	Severe	Moderate	Slight	Normal
1. _____	☐	☐	☐	☐
2. _____	☐	☐	☐	☐
3. _____	☐	☐	☐	☐
4. _____	☐	☐	☐	☐
5. _____	☐	☐	☐	☐

Do you have a regular exercise program? ☐Yes ☐No If yes, please describe.

Do you follow a special diet (ex. vegan, Halal, Medical, etc)? ☐Yes ☐No If yes, what type.

History of smoking cigarettes? ☐Yes ☐No If currently smoking, how many per day? _____
If history of smoking, date(s) and how many per day _____

Do you use THC/CBD? ☐Yes ☐No If yes, How many mg/oz. per week?_____

History of recreational drug use? ☐Yes ☐No if yes, what drug and dates _____

How many cups of caffeinated coffee, tea, or cola do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

How many glasses (8oz) of water do you drink per day? _____

MEDICAL HISTORY OF SIGNIFICANT EVENTS: Do you or your family members have a history of
S = Self; M = Mother; and F = Father

	S	M	F		S	M	F
Allergies	☐	☐	☐	Cancer	☐	☐	☐
Asthma	☐	☐	☐	Emphysema or COPD	☐	☐	☐
Pneumonia	☐	☐	☐	Meningitis	☐	☐	☐
Mononucleosis	☐	☐	☐	Jaundice	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	Gallstones	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Kidney Disease or Stone	☐	☐	☐
Heart Murmur	☐	☐	☐	Vein condition	☐	☐	☐
Heart Attack	☐	☐	☐	Bladder Disease	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Condition/Meds	☐	☐	☐
Angina	☐	☐	☐	Traumatic Brain Injury	☐	☐	☐
High Blood Pressure	☐	☐	☐	Ulcers	☐	☐	☐
Low Blood Pressure	☐	☐	☐	Intestinal Bleeding	☐	☐	☐
Severe Dental Issues	☐	☐	☐	IBS/Crohn's Disease	☐	☐	☐
Severe Eye Disorder	☐	☐	☐	Chronic Constipation	☐	☐	☐
Epilepsy	☐	☐	☐	Recurring Diarrhea	☐	☐	☐
Stroke (CVA)	☐	☐	☐	Hemophilia	☐	☐	☐
Glaucoma	☐	☐	☐	Anemia	☐	☐	☐
Alzheimer's or Dementia	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐
Psychiatric Illness	☐	☐	☐	Diabetes	☐	☐	☐
Substance use disorder	☐	☐	☐	Hepatitis	☐	☐	☐
Obesity	☐	☐	☐	Paralysis	☐	☐	☐
PTSD	☐	☐	☐	Multiple Sclerosis	☐	☐	☐
Surgery	☐	☐	☐	Venereal Disease (STIs)	☐	☐	☐
Implant	☐	☐	☐	COVID	☐	☐	☐
Arthritis	☐	☐	☐	Immunology Disorders	☐	☐	☐
Prosthesis	☐	☐	☐	Chronic Pain	☐	☐	☐
Sleep Disorders	☐	☐	☐	Other:	☐	☐	☐

Have you ever been treated for emotional or psychological problems? ☐ Yes ☐No

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

Other significant stressors, diseases or illnesses? (Include dates if known) Please list any other significant illnesses, diseases, stressful life changes/transitions/conditions, injuries/trauma (auto accidents, falls, abuse, etc.), or anything else to help clearly describe your health history.

If you have allergies (drugs, chemicals, metals, foods) please list them below.

History of hospitalizations/surgeries (include dates)?

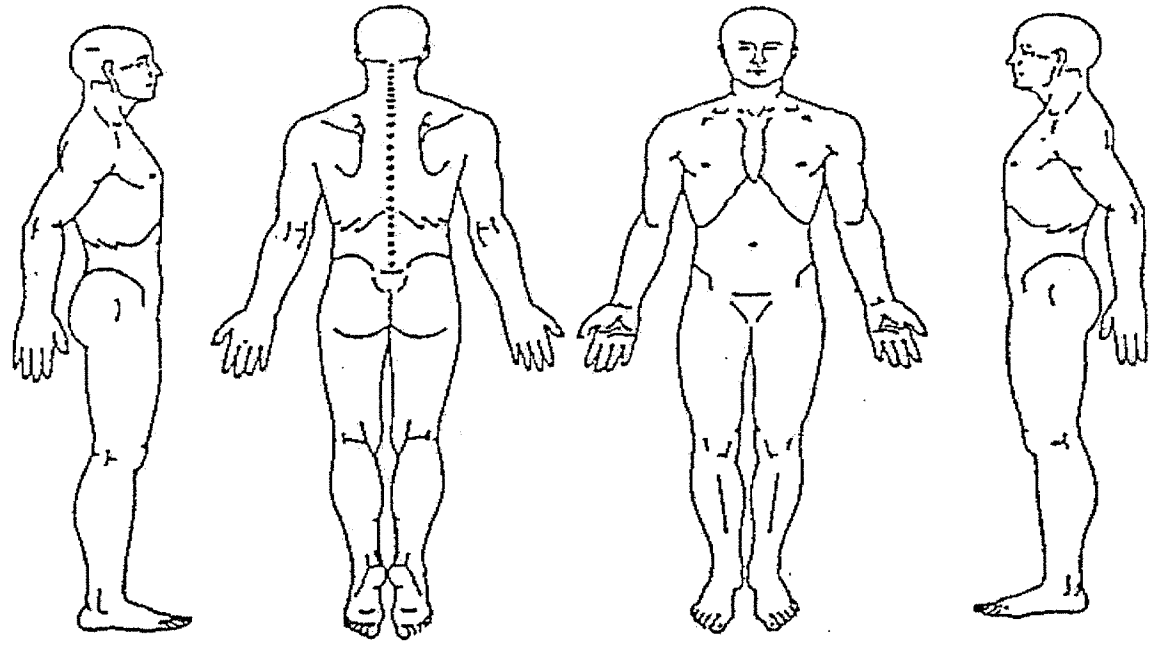
How was your childhood health?

Prescription drugs or medications taken within the last six months

Prescription/Drug	Reason	Duration Taken	Current Dosage	Frequency (per day)	Before/after/ between meals

Herbs/Vitamins/Supplements	Reason	Duration Taken	Current Dosage	Frequency (per day)	Before/after/ between meals

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following in the <u>past three months</u>:

Musculoskeletal & Muscle Reactivity	☐Twitching ☐Cramping ☐Weakness ☐Numbness ☐Tingling ☐Spasms	☐Tenderness to touch ☐Sore ☐Excess heat ☐Fever ☐Chills	☐Tumors ☐Cysts ☐Growth ☐Generalized Weakness ☐Fatigue
Musculoskeletal Pain	☐General muscle pain ☐Muscle weakness ☐Sprain/strains ☐Tendonitis ☐Arthritis ☐Back Pain ☐Upper ☐Middle ☐Low	☐Head ☐Face ☐Jaw ☐Neck ☐Shoulder ☐Rotator cuff ☐Elbow ☐Wrist ☐Hand	☐Hip ☐Knee ☐Ankle ☐Foot ☐Soreness/weakness of lower body (back, hip, knee, ankle, foot)

Joints & Bones	☐Painful ☐Popping ☐Cracking ☐Stiffness ☐Loose ☐Osteopenia ☐Osteoporosis ☐Fractures ☐Scoliosis	☐Inflamed ☐Hot/feverish ☐Tender ☐Osteomyelitis ☐Bursitis	☐Swollen ☐Bone tumors ☐Bone spurs ☐Osteosarcoma ☐Hard/Sclerosis
Pain	☐Shifting/moving ☐Tearing ☐Vague ☐Throbbing ☐Colicky ☐Cutting ☐Excruciating with breathlessness/fear/anxiety	☐Burning ☐Sharp ☐Hot ☐Pain with fever/nausea/irritability ☐Intense	☐Dull ☐Fixed ☐Deep ache ☐Unable to sleep through pain
Digestion	☐Irregular digestion ☐Bloating ☐Gas/Flatulence ☐Abdominal Discomfort ☐Gurgling Intestines ☐Breathlessness after eating ☐Bad Breath ☐Belching ☐Abdominal Hernia	☐Quick digestion ☐Acid reflux/GERD ☐Burning pain ☐Nausea ☐Vomiting ☐IBS ☐Crohn's disease ☐Bleeding gums ☐Colitis	☐Slow digestion ☐Feeling of heaviness ☐Lethargy after eating ☐Sleepy after eating ☐Low energy after meals ☐Excess mucus secretions ☐Food stagnation
Appetite	☐Irregular appetite ☐Late night eating	☐Excessive appetite ☐Strong hunger ☐Strong thirst	☐Decreased appetite ☐Emotional eating
Elimination	☐Tendency to constipation ☐Dry ☐Irregular ☐Defecation without satisfaction ☐Gas during elimination	☐Loose stools ☐Diarrhea ☐Black stools ☐Blood in stools ☐Hemorrhoids	☐Mucous in stools ☐Frequent stools (> 2/day) ☐Chronic laxative use ☐Rectal pain

Urinary	☐Frequent uriination ☐Scanty ☐Unusual urine color _____	☐Urgency ☐Pain with urination ☐Blood in urine	☐Excess ☐Impotency ☐Unable to hold urine

	☐Unusual urine odor _____	☐Cloudy urine	☐Kidney stones
Cravings	☐Fried food ☐Hot spicy food ☐Meat or protein	☐Sweets ☐Cold food and drinks ☐Salty food	☐Dry food ☐Wine/alcohol ☐Sour/fermented food
Food Sensitivity	☐Night shades ☐Left-overs ☐Dry fruits ☐Raw foods	☐Hot Spicy food ☐Sour food ☐Fermented food	☐Dairy Products ☐Gluten ☐Wheat ☐Soy
Body Weight	☐Variable ☐Difficulty gaining weight ☐Unusual weight loss	☐Hyper metabolism	☐Weight gain ☐Over weight
Seasonal Allergies	☐Breathlessness ☐Wheezing ☐Constricted Breathing	☐Rash ☐Itching Eyes ☐Hives ☐Irritation ☐Inflammation	☐Runny nose ☐Watery eyes ☐Congestion
Skin & Hair	☐Dry ☐Cracked ☐Rough ☐Thin ☐Discolored ☐Patchy ☐Dandruff ☐Change in skin/hair texture	☐Hives ☐Rash ☐Acne ☐Pimples ☐Tender ☐Warm/hot to touch ☐Redness ☐Boils ☐Itching ☐Psoriasis ☐Hair loss ☐Dermatitis	☐Oily ☐Thick ☐Pallor ☐Cold/clammy ☐Shiny ☐Eczema ☐Recent moles
Circulation & Cardiovascular	☐Cold hands/feet ☐Fainting ☐Palpitations at rest ☐Palpitations ☐Low blood pressure ☐Irregular heart beat	☐Hot hands/feet ☐Bruises easily ☐Bleeding easily ☐Chest pain ☐High blood pressure ☐Phlebitis	☐Cold clammy hands ☐Varicose veins ☐Spider veins ☐Blood clots ☐Swelling hands ☐Swelling feet
Sweat	☐Scanty or no sweat ☐Night Sweats	☐Excess sweating ☐Profuse body odor	☐Cold/clammy sweat

Respiratory	☐Cough ☐Dry cough ☐Chest tightness ☐Wheezing	☐Coughing blood ☐Bronchitis ☐Pain with deep breath ☐Asthma ☐Pneumonia	☐Productive cough ☐Phlegm, color_____ ☐Difficulty breathing when lying down
Neurological & Mental/ Emotional	☐Concussion ☐Seizures ☐ Dizziness ☐ Transient depression ☐Difficulty concentrating ☐Forgetful ☐Worry ☐Fear ☐Anxiety ☐Insecurity ☐Nervousness ☐Grief ☐Restlessness ☐Repetitive Thoughts ☐Talkative ☐Uncertain ☐Anxious ☐Lonely ☐Insecure ☐Excitable ☐Shy ☐Spacey	☐ADD/ADHD ☐Depression with suicidal thoughts ☐Anger ☐Rage ☐Resentment ☐Judgmental ☐Critical ☐Envy ☐Sharp tongued ☐Vengeful ☐Intolerant ☐Irritable ☐Aggression ☐Ambitious ☐Perfectionist ☐Competitive ☐Curious ☐Easily susceptible to stress ☐Seeker of power and/or prestige	☐Vertigo ☐Poor coordination ☐Prolonged depression ☐Sluggish thinking ☐Confused ☐Greed ☐Attachment ☐Mental lethargy ☐Resistant to change ☐Laziness ☐Procrastination ☐Unforgiving ☐Stubbornness ☐Boredom ☐Withdrawn ☐Self-sacrificing ☐Manic Depression
Sleep	☐Insomnia ☐Needs night light to sleep ☐Restless sleep ☐Difficulty falling asleep Poor sleep ☐Sudden energy drop, time of day_____	☐Interrupted sleep ☐Needs complete darkness to sleep ☐Needs to read/TV to sleep ☐Excessive dreams ☐Vivid dreams	☐Excess sleep ☐Daytime napping ☐Heavy sleeper ☐Slow to awaken ☐Hypersomnia

Head, Eyes, Ears, Nose, & Throat	☐Dizziness ☐Jaw clicking ☐Jaw clenching ☐Teeth grinding ☐Teeth problems ☐Poor hearing ☐Recurrent sore throats ☐ Unusual smells_____	☐Eye Strain ☐Eye pain ☐Eye Edema/Puffiness ☐Floaters in vision ☐Poor vision ☐Blurry vision ☐Night blindness ☐Recurrent Headaches ☐Nose bleeds ☐Facial Pain	☐Sinus problems ☐Post nasal drip ☐Lip or tongue sores ☐Cataracts ☐Color blindness ☐Ringing in ears ☐Poor hearing ☐Ear aches ☐Anosmia (loss of smell) ☐Ageusia (loss of taste)
Reproductive	☐Sterility ☐Irregular Periods ☐Vaginal dryness ☐Sterility ☐Irregular Periods ☐Low Libido	☐High sexual desire ☐Painful periods ☐Genital Sores ☐Genital rash ☐Polycystic ovarian disease ☐Hysterectomy	☐Vaginal/Penal discharge ☐Enlarged Prostate ☐Breast lumps/fibrocystic ☐Endometriosis ☐Uterine fibroids

GYNOCOLOGY

Are you pregnant? ☐Yes ☐No, if so number of weeks___ Could you be pregnant? ☐Yes ☐No

Number of pregnancies _____ Live births_____ Miscarriages_____ Abortions_____

Number of Difficult past pregnancies_____ Complications_____

Birth Control: ☐Yes ☐No, What type_____ How long_____

Do you experience?

	Severe	Moderate	Slight	Normal
☐ Vaginal discharge	☐	☐	☐	☐
☐ Bleeding between periods	☐	☐	☐	☐
☐ Vaginal Itching	☐	☐	☐	☐
☐ Vaginal Odor	☐	☐	☐	☐

Age of first menses_____ Date of last Menses_____ Cycles: ☐Regular ☐Irregular

Length of cycle _____ Days between cycles _____ Age of Menopause_____

PMS Symptoms: ☐Nausea ☐Vomiting ☐Food Cravings ☐Depression ☐Headaches/Migraines ☐Irritability ☐Water Retention ☐Anxiety ☐Breast Swelling ☐Breast Tenderness ☐Cramp/Pain

Other symptoms _____

Complete the following menstrual chart (even if you are menopausal or have amenorrhea)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (ex. red, bright red, pale, brown, rust, dark, purple, etc.)							
Amount (average, heavy, light)							
Pain/cramps (location & quality – dull, sharp, etc.)							
Clots (color & size - large, small)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							

Date of last PAP_____ Urinary tract infections (freq, duration)_____

Yeast infections (freq, duration) _____

Menopausal Stage/symptoms_____

Other Gyn Conditions_____

PROSTATE/TESTES

Prostate Condition_____Other_____

Do you experience?

	Severe	Moderate	Slight	Normal
☐ Swollen testes	☐	☐	☐	☐
☐ Testicular Pain	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐
☐ Premature Ejaculation	☐	☐	☐	☐
☐ Cold/numbness of External Genitalia	☐	☐	☐	☐
☐ Other:	☐	☐	☐	☐

COMMENTS: Please briefly describe any other problems you would like to discuss

Patient Signature_____ Date_____

Signature_____ Date_____

Frankye Riley, MS, MAOM, L.A.c.

ACUPUNCTURE FAQs AND ACKNOWLEDGEMENTS

Please read this entire document carefully prior to signing. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

Is Acupuncture safe?

Yes, but the common side effects of an acupuncture treatment are listed below.

- Drowsiness may occur after a treatment. If you are so affected, you are advised not to drive.
- Minor bleeding or bruising may occur when the needles are removed.
- Indwelling ear needles and or press balls/seeds can become painful or inflamed. If this occurs, promptly remove the needle(s) involved.
- Symptoms can get worse after a treatment. Be sure to tell your doctor about this at your next appointment.
- Fainting may occur in certain patients, particularly at the first treatment.

Cupping and Gua Sha

- These techniques may cause redness and petechiae (small red/purple bumps). This is a normal presentation and no other action needs to be taken
- The redness and bumps will dissipate typically within 1-3 days, but can take up to a week.

Moxibustion

- A burn may occur during the use of moxibustion. This is rare, but can happen
- Notify your provider if a burn shows up after treatment.
- Always let the practitioner know if the moxibustion is getting too hot

In addition, if there are particular risks that apply in your case, your doctor will discuss these with you.

Is there anything your doctor needs to know?

Apart from the usual medical details, it is important to tell you doctor.

- If you have ever become faint or had a seizure,
- If you have a bleeding disorder,
- If you are taking anticoagulants or any other medication,
- If you have a damaged heart valve, a pacemaker or other cardiac problem,
- If you have any other particular risk of infection.
- If you have any type of metal implant, allergy, or significant scarring
- If you are pregnant.

Only single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information. I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature:

Print Name: Date:

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 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. 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 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 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**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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 understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Center for Chiropractic & Wellness
Patient Missed Appointment Policy

Definitions:
Policy—a method or course of action designed to influence and determine decisions/a guiding principle or procedure.
Appointment—a meeting with someone at a certain time or place
Missed—fail to keep, do, or be present at

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results.

If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in you life so that this can occur.
2. If you become ill, we still want you to come in, because your treatment will help you recover.
3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment
4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change the appointment.
5. All canceled or missed appointments must be rescheduled and made up within 1 week.
6. Service charges for missing an appointment are as follows:

Dr. Jennifer Greenfield: Functional Medicine/NET/NAET
15 Minute Appt. $30.00
Frankye Riley, L.Ac.
Acupuncture Initial Consult $25
1 Hour Treatments $40
Dr. Jennifer Greenfield, Dr. Kira Cervenka
15 min. Chiropractic Appointment $40
30 min. Chiropractic Appointment $60
Ion Cleanse:
Cleanse Treatment $25

**** Patients with packages will have one treatment deducted from their package for each 15 minute time slot.**

* Note: Confirmation calls are made the day before each patient's appointment. These calls are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call does NOT validate a missed appointment.

I have read and understand the above policy

Patient's Name: _____ Signature: _____

Doctor's Signature: _____

Consent for Purposes of Treatment, Payment And Healthcare Operations

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Center for Chiropractic & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Center for Chiropractic & Wellness. I understand that Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Frankye Riley, L. Ac., may refuse to diagnose or treat me, if I do not consent to the disclosure of my protected health information for the purposes stated above. (My signature on this document is evidence of this consent).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Chiropractic & Wellness is not required to agree to the restrictions that I may request. However, if Center for Chiropractic & Wellness agrees to a restriction that I request, the restriction is binding on Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Frankye Riley, L. Ac.,

I understand I have a right to review Center for Chiropractic & Wellness' Notice of Privacy Practices prior to signing this document. Center for Chiropractic & Wellness' Notice of Privacy Practices has been provided to me. 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 of Center for Chiropractic & Wellness. The Notice of Privacy Practices for Center for Chiropractic & Wellness is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Center for Chiropractic & Wellness duties with respect to my protected health information.

Center for Chiropractic & Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Center for Chiropractic & Wellness office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing at any time, except to the extent that Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Frankye Riley, L. Ac., have taken action in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Center for Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

Notice of Patient Privacy Policy

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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Alicia Kerins

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

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.ChiropractorNC.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, 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. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent
Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. 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.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *disclosures of psychotherapy notes*
- *uses and disclosures of Protected Health Information for marketing purposes;*
- *disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **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 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied 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. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **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 have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* 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 be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor 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. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.