



East Lake Acupuncture  
1401 Budinger Ave., Ste. B  
St. Cloud, FL 34769  
Phone: (407) 738-7412

## PATIENT INTAKE FORM

### PERSONAL INFORMATION

Patient Name:

Age:

Birth Date:

Gender:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed

Height:

Address:

City:

State:

Zip:

Telephone:

OK to leave a **detailed** message at this number?  Yes  No

May we use email to communicate with you?  Yes  No

*\*Sending messages about your treatment, billing, insurance and specials. Please be advised that use of email does not guarantee privacy.*

Email Address:

Occupation:

Employer:

Is your reason for being seen the result of an auto accident or workplace injury?  Yes  No  
*If yes, please advise the front desk. Additional paperwork and insurance verification may be required and your appointment may need to be rescheduled.*

How did you hear about us?

Who is your primary health care provider/MD?

### EMERGENCY INFORMATION

Name:

Relationship:

Phone:

Address:

### MAIN CONCERN

Please identify your main health concern(s):

How long have you had this problem(s)?

Have you been given a diagnosis for this problem(s)?

What other treatments have you tried and what were the outcomes?

Please list **any** Western Diagnosis (Diabetes, Hypertension, etc.) even if that is not why you are being seen:



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**Certain conditions or drugs may have an impact on or inhibit your treatment, or may interact with certain herbs. Please provide information on the following information:**

Pregnant?  Yes  No      Nursing?  Yes  No      Diabetic?  Yes  No  
On Blood Thinners?  Yes  No      Pacemaker?  Yes  No  
Do you now or have you ever been a smoker?  Yes  No

If yes, please explain when you started and how many packs per day you smoke(d):

Alcohol intake:  Daily  Rarely  Never  Social  Addiction

Illegal drug use or abuse:  Yes  No      Substance:

### MEDICATIONS, HERBS AND SUPPLEMENTS

Please list ALL medications and dosages including herbs, supplements, vitamins you are taking and the reason for each:

Name	Dosage	Reason for taking
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### ALLERGIES

Allergies (medications, herbs, foods, seasonal, etc.) and the reaction you have from allergen (hives, etc.)

Allergic to:	Reaction (hives, etc.)	Severe/mild/moderate	Since: (childhood, etc.)
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### PRIVACY POLICY

All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit written consent from the client (you) or the client's legal guardian, unless legally required by local, state, or federal subpoena, summons or other court order. Copies of our detailed Privacy Policy is attached and additional copies are available upon request, are posted online and are posted near the front desk, and are on most intake clipboards.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of East Lake Acupuncture, LLC Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in East Lake Acupuncture, LLC's Notice of Privacy Practices, please do not hesitate to contact a clinic representative of East Lake Acupuncture, LLC Patient Privacy Officer as indicated on the Notice. A copy is posted in the lobby and copies are secured to all clipboards.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## OFFICE POLICIES

**NO SHOW/LATE CANCELLATIONS.** If an appointment is missed or not cancelled with 24 hours prior notice to the scheduled time, a fee of \$30.00 will be charged if that time slot cannot be filled. We are closed Sunday and Monday. **Tuesday appointments MUST be cancelled no later than 2pm on Saturday** as we will be unable to fill the spot if it's cancelled while we are closed. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. Insurance will not reimburse the patient for this charge, nor will we bill the insurance for the visit. Our office staff makes appointment confirmation by phone as courtesy to our patient. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

**AFTER-HOURS APPOINTMENTS.** All appointments made outside regular hours require staff to come in on their day off or after hours. Should you miss or cancel an after-hour appointment, you may be charged for the **entire visit**. There are **no exceptions**. A credit card may be required to hold your appointment and it will be charged the full amount of your visit should you not show or cancel outside a reasonable time.

**MEDICAL RECORDS RELEASE.** Should you need copies of your records or other documents including receipts and income tax-related documentation, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. A completed and signed record release must be done before any records are released. If records are not being directly released to another physician's office, there will be a fee of \$1.00 per page for the first 25 pages and 0.25 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of reproduction, payable prior to release.

**AFTER HOURS AND EMERGENCIES.** In the event of an emergency situation, call 911 or go to the nearest Emergency Room. If you have an urgent concern that you need to discuss with the physician, please call our office to schedule your appointment. All phone messages left in the voicemail will be returned within 24 hours by the office Tuesday – Saturday. We are closed Sundays and Mondays and major holidays.

**POLICY REGARDING SMALL CHILDREN.** We love children at East Lake Acupuncture & Wellness; however, due to safety and noise issues, we ask that all children under the age of nine (9) be left at home. The exception is children receiving treatment. Zen-like moments can be disturbed by fighting or crying children, and parents will have a difficult time relaxing when worried about the little ones. For safety reasons, children are prohibited from waiting in a treatment room while parents/guardians receive treatment.

**TREATMENT OF MINOR CHILDREN.** Children under twelve (12) being seen for treatment **MUST** be accompanied by a parent or guardian who is legally able to consent to treatment and make medical decisions on behalf of the minor child.

**FAMILY & FRIENDS IN THE TREATMENT ROOM.** With the exception of a parent accompanying a minor or a caretaker accompanying a disabled or unsteady individual, family and friends are asked to wait in the lobby.

**COMPLIANCE.** A treatment plan will be tailored to your condition. Missing appointments and otherwise not adhering to your treatment plan will interfere with your progress. Patients who deviate from the prescribed treatment plan may be discharged for non-compliance.

**REFUNDS.** Refunds on herbs will only be offered if they are returned within seven (days) of the date of purchase and are unopened, with the seal still intact. There are no refunds on services or opened products for any reason. Refunds on remaining package treatments will be refunded at the amount of the regular/full price service, not the discounted price as the package pricing would no longer apply.

**TIMED SERVICES.** Massage and timed services are timed per industry standard, which is a 50-minute hour and 25-minute half hour. Time to disrobe and conduct intake is factored in. To get the most time out of your service, please arrive at least 15 minutes prior to your service to allow time for check in. To get the most hands-on service time it is recommended you do not wait until your service is to start to arrive/check in and/or use the restroom. Services will not be extended to accommodate late arrivals as there is likely another service booked following yours. A timer is kept visible in each treatment room. Please monitor the time display on the timer as you may be required to sign for timed services (if we are billing your insurance.)



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**CELL PHONES.** To help promote our relaxing atmosphere, we require phones be turned off or on vibrate while inside the clinic and no phone calls during treatment. Phone calls should be taken outside. Rest, relax, breathe and disconnect. Let the healing being.

**FORMS AND REPORTS.** There will be a \$25-\$75 administrative fee for forms such as disability reports and letters of medical necessity. The fee will be determined based on the complexity of the document. Please allow seven (7) to ten (10) days for these reports to be completed.

**RECIPTS & TAX DOCUMENTS.** Please save your receipts. Each year we get dozens of requests from patients who lost or failed to save their copies. The forms and reports fees apply to compiling of copies of receipts and payment information.

**CHECK POLICY.** No personal checks will be accepted on NEW PATIENT visits. Any returned checks will incur a \$30.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections agency, there will be a \$50.00 fee for each account and you are responsible for any collection, court, or attorney fees. It is the responsibility of the patient to fully understand the rules and regulations of their insurance company and plan coverage.

I, \_\_\_\_\_, have read the above policies and understand my rights and agree to abide by said policies.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS

I hereby authorize Jeannette Kerns and/or any other licensed provider at East Lake Acupuncture, LLC (hereinafter "Provider") to furnish acupuncture and/or other therapeutic treatments within said provider's scope of practice.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys. I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say I owe, and that the Provider will bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pay all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider.

I, understand that Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full and agree to remit payment to East Lake Acupuncture, LLC, or make payment arrangements within fourteen (14) days from receipt of bill for balance due.

I hereby request that my insurance carrier make payment directly to East Lake Acupuncture, LLC or the rendering physician for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including interest, court costs, collection agency fees and/or attorney fees.

Charges related to Workers Compensation or injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

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Patient or if a minor, Patient's Guardian

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Date



## FAINTING

**Fainting during acupuncture.** Acupuncture is considered a safe treatment; however, a small number of patients experience light-headedness and some faint. This does not happen often and is generally caused by nervousness, though dehydration and sudden changes in blood pressure or blood sugar can play a role. To help prevent fainting, you should drink plenty of water and eat a light snack (not a heavy meal) prior to each treatment.

**Fainting Causes.** Fainting (syncope) is a sudden loss of consciousness from a lack of blood flow to the brain. Fainting victims usually wake up quickly after collapsing because once a person goes from vertical to horizontal, blood starts flowing back into the brain and they begin to wake up. It can be quick or it can take a while; everybody's different. Most fainting is triggered by the vagus nerve, which connects the digestive system to the brain, and its job is to manage blood flow to the gut. Unfortunately, the vagus nerve can get a little too excited and pull too much blood from the brain, resulting in fainting.

### Symptoms of fainting

Before fainting, a victim can exhibit or feel all or some of these signs and symptoms, depending on the cause of the fainting:

- Dizziness or feeling lightheaded
- Confusion
- Nausea
- Sudden trouble hearing
- Tunnel vision or blurred vision
- Sweating
- Flushed or pale color
- Feeling hot
- Weakness
- Trembling or shaking
- Eye shaking (nystagmus)
- Headache
- Shortness of breath

### Common symptoms that can occur after fainting:

- Sweating stops
- Color begins to return
- Rapid pulse or "racing heart"
- Loss of bowel or bladder control

### Common triggers of fainting during acupuncture:

**Psychological Triggers.** Anxiety or nervousness and stress can stimulate the vagus nerve in some people and lead to a loss of consciousness. In regard to acupuncture, those who faint are most often first-timers, experiencing some anxiety over the needles.

**Dehydration.** Too little water in the bloodstream lowers blood pressure, stimulating the vagus nerve. Dehydration coupled with nervousness over acupuncture creates a double-whammy. Toss in failing to eat a light snack prior to treatment and the odds of fainting or at least becoming light-headed are increased.

**Fainting facts and general information.** There are other causes of fainting, including, but not limited to, heart conditions; however, nervousness and dehydration are the most common in regard to acupuncture. All by itself, fainting is not life-threatening; however, sudden cardiac arrest looks a lot like fainting and requires immediate treatment.

If you feel suddenly flushed, hot, nauseated or break out in a cold sweat, don't try to stand up. Lie down until it passes. If it doesn't pass in a few minutes or you begin to experience chest pain or shortness of breath it is our policy to call 911. Whenever someone passes out in our office and fails to become fully alert (recite day, month, year and name of president) within a few minutes of fainting or feeling light-headed, it is our policy to call 911. Your safety is our primary concern.

I, \_\_\_\_\_, have read the above information on fainting and understand that eating a light snack and drinking plenty of water prior to acupuncture is important and failing to do so may cause light-headedness and in some cases, fainting.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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**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 agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as 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 the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here \_\_\_\_\_. Effective as the date of first professional services.

If any provision of the Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE (or Patient Representative)	X		Date: _____  _____ (indicate relationship if signing for patient)
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**CONSENT TO TREAT FORM**

I hereby request and consent to the provision of services rendered by Jeannette Kerns and/or other licensed providers at East Lake Acupuncture, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, manual therapy, massage, electrostimulation, ultrasound therapy, neuromuscular reeducation and/or other physical therapy modalities, cupping therapy, bleeding therapy, Gua- Sha, injection therapy, recommendations for herbs and supplements, kinesiology taping, ultrasound therapy, laser therapy, Migun® therapy, injections, electrical stimulation, massage, Tui-Na (Oriental massage), Oriental herbal medicine, nutritional counseling and other modalities within the provider's scope of practice. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell and/or taste.

I understand that post treatment flare-ups (increased symptoms) are a normal and expected part of healing, however, I will immediately notify East Lake Acupuncture, LLC of any increased pain or symptoms or if I am worried or concerned about any aspect of treatment or recommendations made by the provider. I understand the front desk and support staff and massage therapists are not qualified to give me medical advice or treatment recommendations.

I have been informed that acupuncture and the above-referenced adjunctive therapies are generally safe methods of treatment, but that it may have some side effects, including but not limited to, soreness, bruising, numbness or tingling near the needling sites of needle insertion or manual work, nerve damage, dizziness or fainting. Bruising and tenderness are common side effects of acupuncture, injections, and massage and physical medicine modalities.

Rare or 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 disposable sterile needles and maintains a clean and safe environment. Some potential risks of injections of any type are bruising, tenderness, allergic reaction to products or devices, numbness, muscle soreness or nerve damage. Some of injections are manufactured with lidocaine. If you've ever had a reaction to lidocaine or any local anesthetic, please inform us. Burns and/or scarring are a potential risk of moxibustion and fire cupping and heat lamps and heat packs.

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 Oriental Medicine, although some may be toxic in large doses. I agree to inform the provider at time of product recommendation if I am on blood thinners, have a heart condition, am breast feeding, have diabetes or am on any medications, though ultimately it is my responsibility to research herb-drug interaction before choosing to take any herbs, vitamins or supplements that are recommended. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, 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 or are nursing, on blood thinners, have a change in medication, new diagnosis or symptoms, change in symptoms, have or get a pace-maker, have diabetes, hypertension, thyroid issues or other health conditions arise or change. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports and my records may be shared with my insurance company to facilitate payment, but all my records will be kept confidential and will not be released without my written consent.

**Notification of no health claims or other representations.** Herbal products are food supplements. All statements made describing all products that are sold and or distributed by East Lake Acupuncture, LLC have not been evaluated by the Food and Drug Administration. All herbal and homeopathic products sold by East Lake Acupuncture, LLC are not meant to treat, cure or prevent disease. Under no circumstances does East Lake Acupuncture, LLC imply that all (any) products and formulas are meant to diagnose, treat, cure or prevent any disease. It is advisable to always check supplement ingredients against medications and other supplements for contraindications. **Herb and Supplement Caution.** Use caution when taking supplements or herbs if you are on blood thinners, are pregnant or nursing or suffer from diseases or conditions including but not limited to hypertension and diabetes.

**Things you need to know:**

- Are you taking any other herbs, supplements or natural remedies? They could interact, or you may be taking too much. Herbs can heal, and herbs can harm. Be informed. Research herbs and supplements before taking them.
- Are you taking any prescription or nonprescription medications? If so, they may interact with herbs or supplements and should be checked for interactions.
- Some herbs and supplements are mild blood thinners and should not be taken if you are on blood thinners or should be taken with caution. This includes but is not limited to fish oils and many herbal supplements for pain.
- Some herbs and supplements could cause changes in blood pressure and those suffering from high or low blood pressure should closely monitor their levels daily.
- Some herbs and supplements are not safe for pregnant women or those who are breastfeeding. **Please check the labels before purchasing herbs and supplements.**
- In very high doses most herbs and supplements can have adverse effects. Please follow dosage guidelines.
- Like drugs, herbs can have side effects such as digestive upset, sedation and more.
- There are a number of online resources to check herb-drug interactions including but not limited to <http://reference.medscape.com/drug-interactionchecker>.

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.

OFFICE SIGNATURE		Date: _____
PATIENT SIGNATURE (or Patient Representative)	<b>X</b>	Date: _____ <small>(indicate relationship if signing for patient)</small>





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## DECLARATION OF CLIENT REQUEST, AUTHORIZATION & AGREEMENT

I, the undersigned, request that Jeannette Kerns and provide me educational assistance, teaching, tutoring and coaching to facilitate a better understanding of health & nutrition, inclusive of actions I might take that might assist me in bringing about more vitality, balance and adaptive energy for a fuller and healthier life.

In participating in this proactive health advocacy process, any body part, fluid or tissue I choose to tender to learn and help with my own health and for the auditing of it via any mechanical, optical, electrical, photonic or other means is at my sole discretion and done under retained right, and I agree compensation for such service discussed or outlined elsewhere is appropriate.

I understand that Jeannette Kerns has received non-accredited certification in Applied Microscope & Nutrition Technology for Health Advocacy & Audit Processes through private professional training, has a Bachelor of Professional Health Studies and a Master of Science in Oriental Medicine from the Florida College of Integrative Medicine and has taken a number of training seminars pertaining to health and/or nutrition but is not an M.D., nutritionist or dietician and that the herbal or supplement suggestions are made at my request for the purpose of enhancing my health. Jeannette Kerns is not offering or providing service to me under any government grant, insurance, registration, certification or license as a laboratory, health, agricultural or diet professional. I understand that while Jeannette Kerns is a licensed acupuncturist in the State of Florida, she is not providing this services in her capacity as an acupuncturist.

I understand that the requested service under this agreement is not a substitute for regular medical or other licensed care and does not, cannot, and will not provide any diagnosis, prescription, or treatment options for any medical or government defined health condition wherein only a government certified, registered or licensed professional may be deemed competent or authorized to address such issues. Should miscommunication lead to a perception that I am being provided such a service, I acknowledge that I alone bear full responsibility for any actions taken as a result.

### AMENDMENT IX, U.S. CONSTITUTION

*"The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the People."*

Under the 9th. Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care and education. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy, device or product recommended by any therapist, doctor, practitioner, consultant or advocate of my choice, deemed by anyone else right or wrong, accepted or not. The enumeration in this declaration shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

### CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of law, intentionally interferes with the free exercise of the rights retained by me, that they may be in violation of my private property rights under contract as well as my civil and constitutionally protected rights (see Title 42, U.S.C. 1983 seq. and Title 18, Section 241).

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



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**PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE RELATED INFORMATION**

Your privacy is important to us. We will not so much as confirm your appointment with anyone else unless you authorize it in advance. Please select from the items below what you authorize us to discuss and any limitations you desire. You may change or revoke this authorization in writing at any time.

I, \_\_\_\_\_, hereby authorize East Lake Acupuncture, LLC and/or Jeannette R. Kerns and/or Yolanda M. Rice to discuss the details of my treatment as identified below to:

- Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_
- (initials) My case including my progress, treatment plan and herbs or supplements prescribed;
  - (initials) Make and/or change or confirm appointments on my behalf;
  - (initials) Insurance benefits and payment;
  - (initials) May be present during my treatments. The provider may speak freely in the presence of the individual named above unless a topic is specified below as being off limits.

- I do  do not authorize the disclosure of information regarding my mental, emotional or psychological state to the person listed above.
- I do  do not authorize the disclosure of information any substance abuse/use to the person listed above.
- I do  do not authorize the disclosure of information about sexually transmitted diseases to the person listed above.

I do not want the following discussed or disclosed with or in the presence the person listed above:

Is there a phone number at which we can confirm your appointments?

Can we leave detailed messages at this number that related to your treatment and/or appointments?  
 Yes  No

Can we email you information about your treatment, appointments or lab results?  Yes  No

This authorization shall remain in effect indefinitely or until revoked in writing or until the date listed below:

Date authorization expires: \_\_\_\_\_

PRINT PATIENT NAME: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\*A separate form will need to be filled out for each person you wish to authorize.