REGISTRATION
(PLEASE PRINT)

East Lake Acupuncture, LLC
1401 Budinger Ave., Ste. B
Saint Cloud, FL 34769

Phone: (407) 738-74412
Fax: (321) 250-7841

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. East Lake Acupuncture, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Other	

Occupational

Check (✓) if your work exposes you to:

☐	Stress	☐	Hazardous Substances
☐	Heavy Lifting	☐	Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Reason(s) for being seen_____

_____

☐ Auto Accident ☐ Work Injury ☐ Slip-&-Fall ***If yes, please notify us before proceeding**

Veteran ☐ Yes ☐ No If yes, do you have a VA authorization? ☐ Yes ☐ No **(if no please notify us before proceeding)**

How did you hear about us?_____

Who is your primary health care provider/MD?_____

How long have you had this condition? _____ Date of injury?_____

Have you been hospitalized or gone to an ER as a result of this condition? Y/N Approximate Date(s)_____

Are you taking any medications for this condition? ☐ Yes ☐ No If yes, please list:_____

Related Tests (X-rays, etc.) Y/N Estimated Dates:_____

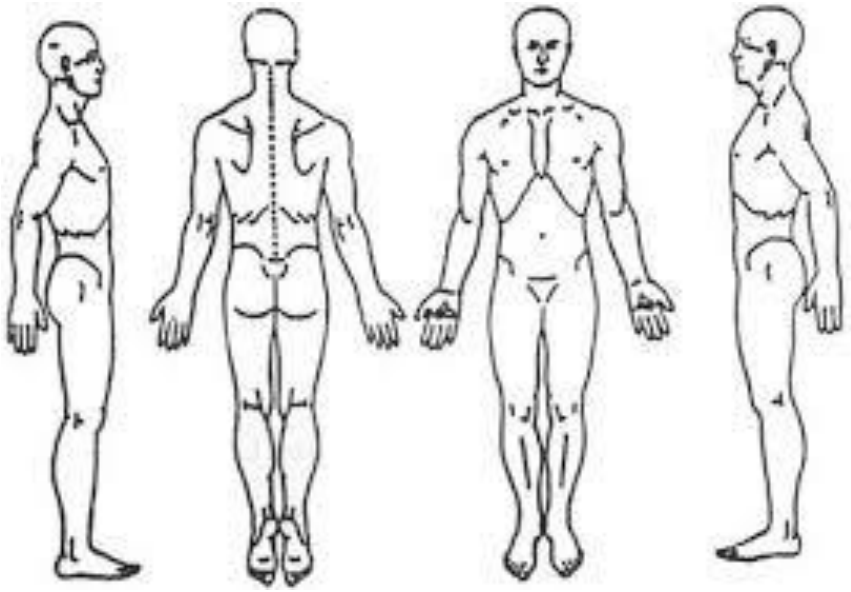
Results/Diagnosis:_____

Related surgeries Y/N Estimated Dates(s)_____ Details:_____

_____

_____

On the body diagram below, please indicate painful and/or injured areas which you are experiencing



Current pain Level

- ☐ Minimal: Annoying pain but causes no functional limitations.
- ☐ Slight: A pain that can be tolerated, but could and sometimes does cause some limitation in the performance of an activity, possibly preventing the activity from taking place
- ☐ Moderate: Pain that can be tolerated but causes marked limitation in the performance of an activity.
- ☐ Severe: Pain that precludes an activity from taking place.

Frequency:

- ☐ Occasional: Symptoms that occur approximately 25 percent of the time.
- ☐ Intermittent: Symptoms that occur approximately 50 percent of the time.
- ☐ Frequent: Symptoms that occur approximately 75 percent of the time.
- ☐ Constant: Symptoms that occur approximately 90-100 percent of the time

Improved by: ☐ Heat ☐ Cold ☐ Rest ☐ Movement ☐ Other_____
Aggravated by: ☐ Heat ☐ Cold ☐ Rest ☐ Movement ☐ Other_____
Is the pain well controlled by medications? ☐ Yes ☐ No

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

Request for Services: I have requested medical services ELA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon receipt of a. A photocopy of this assignment is to be considered as valid as the original.

Authorization: I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to ELA. I hereby authorize that photocopies of this form to be valid as the original. I hereby assign my rights to payment to my provider and I certify to the best of my knowledge that: I (or my dependent) received or intend to receive services from East Lake Acupuncture, LLC and I want East Lake Acupuncture/Provider to seek payment for services rendered, from my insurance carrier. I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Financial Responsibility: I agree to make full payment immediately upon receipt of an ELA billing statement whether it is an interim or final bill. I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service or immediately upon receiving a bill for a balance due. I understand that I am responsible for all fees and charges related to all services and durable goods provided to me through ELA and its providers from my first date of examination or treatment forward, as well as any balance due after payment by my insurance company.

Remittance: I request that my insurance carrier make payment directly to the treating physician or to provider, East Lake Acupuncture, for all services rendered at this facility. If my current policy prohibits direct payment to Provider, I instruct and direct my insurance carrier to make the check out in my name but send the check to Provider, not to me (or my dependents). Additionally, If my insurance carrier makes payments to me, I agree to immediately sign over/pay over these funds to Provider. I also authorize Provider, to deposit any check(s) made out to me, and bearing my endorsement. I

I understand and agree that if I fail to make any of the payments or tum over funds paid to me by my insurance company, for which I am responsible, within thirty (30) days, I am responsible for a $50 processing fee as well as the actual costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

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

I understand that any quote of benefits provider received from my insurance carrier are not a guarantee of benefits, and as the patient, legal guardian or parent, I am responsible for any and all co-payments, co-insurance and the deductibles at the time of service or upon receipts of an itemized invoice.

Collections & Legal Fees. I understand that if for any reason my insurance company does not pay my bill within 90-days, I will be fully responsible for payment. 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 collection agency, there will be a $50.00 fee for each account and that I am responsible for any actual collection, court, or attorney fees. I also acknowledge that it is my responsibility to fully understand the rules and regulations of my insurance company as well as the details of coverage including any restrictions.

Authorization to Release Information. I hereby authorize ELA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime; (4) initiate a complaint to the insurance carrier and/or Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so. This order will remain in effect until revoked by me in writing.

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

Verification of Benefits. I understand that the quote of benefits Provider receives from my insurance carrier at the time of verification and/or of service, are not a guarantee of coverage and that Provider does not have control over benefits or coverage. 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, co-insurance any deductible at the time of service.

Printed Name of Patient or Parent/Guardian	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES

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 are available upon request and a are posted near the front desk and are on most intake clipboards. By my signature below, I certify that I been given the opportunity to review and request a copy of East Lake Acupuncture, LLC's Notice of Privacy Practices and Office Policies (posted in the reception area & on intake clipboards) on the date indicated below. 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 your Notice

Printed Name of Patient or Parent/Guardian	Signature	Date

OFFICE POLICIES

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.

Forms & 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.

Receipts & 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. There will be a $25-$75 administrative fee for such records.

Policy Regarding Small Children. We love children at East Lake Acupuncture; 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. Staff are prohibited from babysitting/watching children.

Treatment of Minors. Children under eighteen (18) being treated or getting a massage, 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. A parent or legal guardian must be present in completing intake paper to sign the policies.

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 whenever possible.

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.

Medical Advice. The front desk, support staff and massage therapists are not qualified to give me medical advice or treatment recommendations and are not allowed to answer questions related to treatment or provide medical advice.

Refunds. Refunds on products 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. **Medical Supplies**: Medical supplies purchased are payable at the time of service. We will provide you with a receipt so you may seek reimbursement from your insurance company. Medical supplies, or products for which you received or intent to request reimbursement from insurance or other means, are not refundable.

Timed Services Massage, cupping and other timed services are timed per industry standard. A one-hour or half hour massage session includes massage or facial and time for consultation and undressing, which are factored into the "hour" or "half" hour, thus on average, massages are 50-minutes or 25-minutes. To get the most time out of your service, please arrive at least 10-15 minutes prior to your service to allow time for parking and 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.

No-Show/Late Cancellation Policy If an appointment is missed or not cancelled with 24-hours prior notice to the scheduled time, a fee of $30.00 for the first two occurrences and $50 for each session, thereafter, 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 text as courtesy. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

Cell Phones: To help promote our relaxing atmosphere, we ask that phones be turned off or on vibrate while inside the clinic. Phone calls should be taken outside whenever possible and phone conversations in the lobby of public areas are prohibited.

Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, sexual orientation, nationality, political affiliation, disability or age. All patients whom come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964. Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Payment Options: We accept personal checks, cash and credit cards. Insurance co-payments are due at the time of service. If we must bill your co-pay to you, a $5 service fee will be added to your bill. Any portion of your treatment that is not covered by your insurance is your responsibility and is due within 30 days. Interest may be charged at a rate of 1% each month (12% annually) for unpaid balances over thirty (30) days old. A $50 fee will be charged for all checks returned as insufficient funds. No personal checks will be accepted on NEW PATIENT visits. Any returned checks will incur a $30.00 minimum returned check fee.

Collections & Delinquent Accounts: In the event the account becomes delinquent and is turned over to a collection's agency, there will be a $50.00 fee for each account, as well as interest of up to 12% per year and actual collection, court, or attorney fees or other fees incurred in our attempts to collect.

Workers Compensation Claims: We will bill your open, approved worker's compensation claim. Please be advised that in the event all or part of your claim is denied, you are financially responsible for all charges.

Out of Network Benefits: We will bill your insurance as a courtesy; however, if your insurance is out of network, they may send payment for services directly to you and expect you to pay us directly, or, they may send a check made out to you or your dependent to the clinic. Please be advised these funds are to cover the cost of your services and you are responsible for the full amount. If you cash the check and spend the funds, you will still be responsible for the amount and failure to sign the funds over or remit full payment may result in service, late, collections and/or legal fees as well as interested of up to 12% per year.

Responsibility for Personal Valuables: We do not provide facilities for safekeeping of valuables and are not responsible for lost, stolen or damaged personal items that you or anyone accompanying you may bring into the facility. Please monitor your belongings and be sure to take your belongings with you when you leave.

After-Hours: If you require emergency medical care, call 911 or go the nearest emergency room. You may leave us a voicemail 24/7 at 407-738-7412 or text us using our secure medical texting application Klara® to 407-439-2949 or by visiting www.Klara.com.

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

_____	_____	_____
Printed Name	Signature	Date

CONSENT TO TREAT

Please read carefully. This is an informed consent that explains the expectations and risks associated with Acupuncture, Oriental Medicine & other therapies you may receive at this facility. Your safety is our primary concern. Please, take all the time you need and be sure to address any questions or concerns with your provider(s) prior to treatment.

Nature of Treatment: Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, massage, Gua Sha (dermal friction), Infra-Red (heat lamps), Chinese herbs, manual therapies, myofascial or trigger point release, heat/cold therapy, injection therapy, therapeutic exercises and dietary counseling based on the fundamentals of Chinese Medicine and RDA guidelines and/or physical medicine and rehabilitation modalities, as deemed appropriate by your provider. A detailed description of each therapy is posted in the lobby and available upon request. **Purpose of Treatment**: The purpose of the treatment is to resolve or improve the condition for which you are seeking treatment.

Benefit of Treatment: Though acupuncture, Chinese Medicine and adjunctive therapies and/or procedures have been used effectively to treat a variety of conditions without pharmaceuticals, surgery or other conventional 'Western' medical procedures, we cannot guarantee the outcome of any course of treatment.

Risks of Treatment: While acupuncture, Chinese medicine, and other therapies/procedures provided by this office have been shown to be effective in reducing or correcting many conditions and maintaining overall health and well-being, practitioners are required to advise patients that there may be some risks. It is important you are aware of these risks prior to treatment so you may make in informed decision regarding treatment, ask questions and discuss any concerns. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual, we do our best to monitor our patients for any adverse reactions and adjust treatment accordingly. **Rare or unusual risks**: Rare, but possible risks of treatment (acupuncture, cupping, injections or the following side effects can occur other therapies) may include, nerve damage and organ puncture, fainting, dizziness, itching, rash, infection at the site of needle insertion. Other unusual but possible risks or side effects could include redness or localized swelling, tenderness, allergic reaction to products or devices, numbness, muscle soreness or nerve damage. Some of our injections may contain lidocaine. If you've ever had a reaction to lidocaine or any local anesthetic, please inform us. Burns, blisters and/or scarring are a potential risk of moxibustion and fire cupping. It is important to inform all your healthcare providers of all medications, herbs or supplements.

Acupuncture & Pregnancy: Acupuncture has been practiced for centuries and is generally considered safe during pregnancy. Although the safety of acupuncture *per se* in pregnancy is reasonably well accepted, there remains some debate regarding needling at points historically considered to be *"forbidden"* during pregnancy for fear of inducing labor or causing a miscarriage. According to a 2015 study, it was determined that the positive gain for the patient is likely to outweigh the purely historical or theoretical risks. See *Carr DJ. Acupuncture Med 2015; 33:413–419*. Though the likelihood of miscarriage/labor by needling *"forbidden"* points during pregnancy is minimal, it is our policy not to needle those points on pregnant women.

Herbs & Nutritional Supplements: The herbs and nutritional supplements we may recommend are traditionally considered safe, although some may be toxic in large doses. **Allergy risk:** Many herbs and supplements contain common allergens such as shellfish, insect venom, bee pollen or tree nuts. There is also the possibility of an **herb-drug interaction.** Please use caution when taking supplements or herbs if you are on blood thinners, are pregnant or nursing or suffer from diseases or conditions including hypertension, thyroid disorders or diabetes. Some herbs and supplements are mild blood thinners and should not be taken with other 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. Like drugs, herbs can have side effects such as (but not limited to) digestive upset, sedation, nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and and tingling of the tongue. We do our best to check for potential herb-drug interactions; however, your safety is our primary concern and we suggest that you also check for herb-drug interactions. There a number of online resources to check herb-drug interactions including but not limited to http://reference.medscape.com/drug-interactionchecker.

Severe Allergic Reactions (anaphylaxis): Herbal remedies often contain allergens such as shellfish, bee pollen, insect venom and tree nuts. **If you have any severe allergies to anything** (even latex or adhesive)**,** please mention them to your provider each and every time a recommendation is made for herbs or supplements. **Anaphylaxis** is a severe, potentially life-threatening allergic reaction. It can occur within seconds or minutes of ingesting something or being exposed to something you're severely allergic to, such as shellfish, peanuts or bee stings. Anaphylaxis causes the immune system to release a flood of chemicals that can cause shock. **Symptoms:** Blood pressure drops suddenly and the throat swells, causing airways to narrow, blocking breathing. Other symptoms may include a rapid, weak pulse; a skin rash; and nausea and vomiting. Common triggers include certain foods, some medications, insect venom and latex. Anaphylaxis requires an injection of epinephrine and a follow-up trip to an emergency room. If you don't have epinephrine (Epi Pen), call 911 or go to an emergency room immediately (911 is best). **If anaphylaxis isn't treated right away, it can be fatal**.

Surgical Procedures: Disclose all herbs or supplements to your surgical team. Most surgeons will ask that you stop taking them about two weeks prior to surgery. It is important they know everything you are taking.

INFORMED CONSENT:

I, _____, certify that I have read, or have had read to me, the above consent, am aware of the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions and I authorize East Lake Acupuncture (ELA), its providers including physicians and other qualified personnel, to perform evaluation and treatment services and procedures as may be medically necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

I agree to inform my provider prior to each treatment or purchasing products, of any allergies that may be triggered by treatment (latex, alcohol, adhesive, nuts, oils, food, etc.) I will also notify my provider in writing, if I have a change in medication, herbs or supplement, new diagnosis, symptoms or allergy, have a significant change in symptoms, have or get a pace-maker, become pregnant or start nursing, have diabetes, take blood thinners, have hypertension, thyroid issues or other health conditions that arise or change. If I am signing as a parent/guardian, I understand I have the same duties and responsibilities.

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 at ELA. I have been provided with contact information for the clinic, including after-hours and urgent contact options and I agree to contact the clinic within a reasonable time-frame if I experience any unpleasant, worrisome or unusual effects following treatment. I have been advised to call/text/email the clinic immediately should I have any adverse reactions, questions or concerns and to call 911 or go to the nearest emergency room if I have any severe or life-threatening symptoms.

_____	_____	_____
Printed Name of Patient or Parent/Guardian	Signature	Date

ARBITRATION AGREEMENT

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION: The attached below contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates, and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts. By signing this agreement, you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and you may still hire an attorney of your choice. This agreement generally helps to lower litigation time and costs for both patients and providers. Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to whether any medical services rendered under this Agreement/contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily 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 binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, assigns, clinics, and/or providers (hereinafter collectively referred to as "Provider") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "Patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Provider of any action in any court by the Provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against 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 notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Provider, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to the relevant Florida Revised Statutes and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of the Florida Revised Statues.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Provider within seven (7) days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Florida and federal law.

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. QUESTIONS? PLEASE REQUEST ACCESS TO A COPY OF THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT" IF A COPY IS NOT INCLUDED IN THIS PACKET.

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

Witnessed by (clinic authorized representative): Name:_____ Signature:_____ Date:_____

Translator: Name:_____ Relationship to patient:_____ Signature:_____ Date:_____

A signed copy of this document is to be given to the patient upon request.

Fainting

Fainting during acupuncture

Acupuncture is a safe treatment; however, I a ***small*** number of patients experience light-headedness and some faint. This is generally caused by nervousness, though dehydration and sudden changes in 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 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 regards 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 greatly 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 regards 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/or fails to become fully alert (recite day, month, year and name of president) within a few moments of fainting or feeling light-headed, it is our policy to call 911. Your safety is our primary concern.

I, _____(please print), 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

Copy of this document available upon request

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