MEDICAL ACUPUNCTURE

Phone: 407.690.7696
www.MedicalAcupunctureFL.com
Office Hours: Monday-Thursday, 8:30am-5pm

Welcome New Patients:

Thank you for choosing Medical Acupuncture for your health care needs. You now have a partner in your quest for optimum health!

Our practice is comprised of a multi-disciplinary team and includes Allopathic Medicine, Eastern Medicine, Acupuncture, and Herbal Medicine. Our Mission is to utilize and tailor the integration of these services to assist you achieve your goal(s), whatever they may be. Our entire staff is dedicated to the revitalization of your health! Our practice is unique because our clinicians will take the time to listen to your concerns. Your practitioner will assist you through education and treatment.

We would like to take a moment to introduce a few fair and simple office policies, revolving around you, our patient(s).

The following is information needed for your first visit. **Complete all forms entirely** and bring them to your appointment. **PLEASE ARRIVE AT LEAST 30 MINUTES BEFORE** your scheduled appointment time so that we may process your paperwork. It is critical that our patients schedule appointments to allow our clinic to maintain a safe and comfortable workflow. It is our goal to always provide our patients with access to the practitioners and scheduling your appointment will assist us in satisfying that goal.

Please remember to bring the following to your appointment:

1. **Insurance Card(s) and/or VA community care card.**
2. **Driver's license or photo ID.**
3. **Any Labs and/or test results or records are relevant to your condition.**
4. **A list of all your medication and dosages you are currently taking (including over the counter medications).**
5. **Any copy, deductible, and/or coinsurance you are responsible for will be collected upon check-in.**

Please contact our office or your insurance company prior to appointment if you are not sure what your copay, deductible, or coinsurance might be.

We only accept Cash, Visa, MasterCard, American Express, or Discover Card. NO PERSONAL CHECKS.

Thank you again for the opportunity and confidence in allowing us to participate in your care!

_____ _____

Patient Signature Date

MEDICAL ACUPUNCTURE

Our ability to draw effective conclusions about the present state of your health and how to improve it depends to a large degree, on your ability to respond thoroughly and accurately. Other written questionnaires and questions will be posed by the physicians and staff during your consultation to correct what's bothering you. Your team at Authentic Oriental Healthcare dba Medical Acupuncture will be the only people to review these forms with your consent. Your confidentiality will be strictly maintained. Your careful consideration of each of the following questions will enhance our efficiency in treating you and will provide more effective use of your scheduled consultation time. Thank you for your time in advance and we look forward to working with you to help you achieve your health goals with Authentic Oriental Healthcare dba Medical Acupuncture.

General Patient Information

Name: Last _____ First _____ M.I. __ Today's Date _____

Street Address _____

City _____ State _____ Zip _____ Marital Status: M / S Other_____

Social Security #_____Date of Birth _____Age _____

Gender: _____ E-mail address: _____

Phone #: Home _____ Cell _____Work_____

Place of Employment _____Occupation _____

Emergency Contact _____ Relationship _____ Phone # _____

How did you hear about us? Referred by (Name) _____

VA: ___ Internet: ___ Drive-by: ___ Other: _____ Your PCP: Dr. _____

Pacemaker: Y/N. Are you on a special Diet? Y/N, if Yes, please list: _____

Social History (currently): Alcohol Coffee or Tea Tobacco Illicit drugs

What problem(s) are you currently having? And how long do you have it?

1. Major Complaint: _____ Since Month _____Year_____

2. Secondary Complaint: _____Since Month _____Year_____

3. Other Complaint: _____Since Month _____Year_____

How do these conditions impair your daily activities? _____

_____

_____

_____

Patient Medical History

Check any you have had in the past:

○Alcoholism	○COPD	○High Blood Pressure	○Pneumonia
○Allergies: drug/environment	○Depression	○HIV	○PTSD
○Arthritis: osteo/ rheumatoid	○Diabetes: type _____	○Irritable Bowel Syndrome	○Stroke
○Asthma	○Drug Addiction	○Kidney Disease	○Syphilis
○Autoimmune Disease: _____	○Emphysema	○Lupus (SLE)	○Thyroid Disorder
○Cancer: _____	○Epilepsy/ Seizure	○Measles	○Tuberculosis
○Cholesterol	○Fibromyalgia	○Migraines	
○Chronic Fatigue Syndrome	○Heart Disease	○Multiple Sclerosis	
	○Hepatitis: A B C other	○Paralysis	

Any Others? YES / NO, if Yes, please list below: _____

Have you ever had to be ***HOSPITALIZED***? YES / NO, if Yes, please list below:

Reason 1. _____ Month _____Year _____

Reason 2. _____ Month _____Year _____

Reason 3. _____ Month _____Year _____

Any Others? YES / NO, if Yes, please list on the back of this page.

Have you ever had any ***SURGERIES*** or ***OPERATIONS***? YES /NO, if Yes, please list below:

Surgery 1. _____ Month _____Year _____

Surgery 2. _____ Month _____Year _____

Surgery 3. _____ Month _____Year _____

Any Others? YES / NO, if Yes, please list on the back of this page. _____

Have you ever had any ***INJURIES***? YES / NO (such as automobile accident, serious falls, sports injuries, broken bones, getting knocked unconscious.), if yes, please list below:

Injury 1: _____ Month _____ Year _____

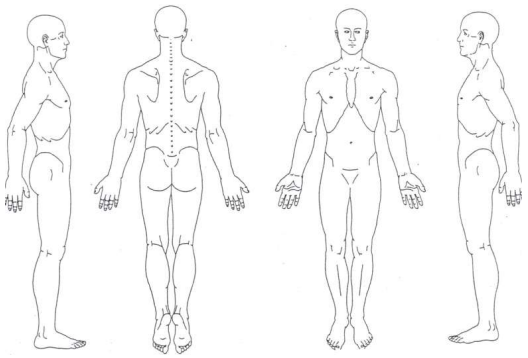
Injury 2: _____ Month _____ Year _____

Injury 3: _____ Month _____ Year _____

Any Others? YES / NO, if Yes, please list on the back of this page.

Patient Profile

Please clearly **mark** any areas of ***PAIN*** on the diagram below:



How is the pain & pain scale from 0-10 (10 being the worst): _____ (NO meds)

○Sharp ○Numb ○Dull Aching ○Cramping ○Shooting
○Throbbing ○Burning ○Nagging ○Stabbing ○Pins & Needles

Frequency of the pain? ○Constant ○Intermittent ○Motion trigger

Pain worsen at ○First wake up ○With more activities ○During sleep
○When tired ○Sit or stand too long ○Beginning of movement

What makes the condition BETTER:

○Pressure ○Cold/Heat ○Activity ○Rest ○Medicine:_____

What makes the condition WORSE:

○Pressure ○Cold/Heat ○Activity ○Other:

Please check any of the following that pertain to you:

Overall, in General:

○Aversion To Cold	○Easily Catch Colds	○Lack of Perspiration	○Preference for Cold Drinks
○Aversion To Heat	○Fevers	○Low Energy/ Fatigue	○Preference for Warm Fluids
○Chills	○General Weakness	○Night Sweats	○Sweaty Hands/ Feet
○Cold Hands/ Feet	○Hot Flushes	○Perspire Easily	○Unintentional Weight Loss

Heart Function:

○Anxiety	Memory	○Palpitations	○Swelling of Ankles
○Blood Pressure Problem	○Insomnia/Sleep Problem	○Poor Circulation	
○Chest Pain/Compression	○Mental Confusion/Fogginess	○Mental Restlessness	
○Forgetfulness/Poor	○Pacemaker	○Sores on Tongue	

Lung Function:

○Asthma	○Dry Mouth/ Throat	○Phlegm Production	○Smoke Cigarettes:
○Body Aches	○Dry Nose	○Short of Breath	○Sneezing
○Cough	○Melancholy	○Sinus Congestion	○Sore Throat
○Difficult Breathing	○Nose Bleeds	○Skin Problem	○Wheezing

○Nasal Discharge: Color: Clear / Yellow / Green / Others: _____

○Are you allergic to any Medications/ Food/ Pollens/ Others: _____

The EFFECTS on you: (please describe) _____. Mild/Moderate/Severe.

○Headache: Dull/ Sharp, Location: Top/ Temple/ Occipital/ Front/ Whole Head, how often: _____

SP/ ST Function:

○Abrupt Weight Change	○Canker Sores	○Heartburn/Acid Reflux	○Organ Prolapsed
○Abdominal Distention	○Constipation	○Heaviness Sensation	○Over-Thinking
○Bad Breath	○Diarrhea	○Hemorrhoids	○Poor Appetite
○Belching	○Easily Bruise	○Hiccups	○Stomach Pain
○Black Stools	○Excess Hunger	○Incomplete Stools	○Ulcer
○Bleeding or Swollen Gums	○Fatigue after Eating	○Loose Stools	○Undigested Food in Stools
○Bloating	○Gas	○Mucous in Stools	○Vomiting
○Blood in Stools	○Gurgling Stomach	○Nausea	○Worry

LIV/GB Function:

○Anger Easily	○Frequent Headaches	○Lump in Throat	○Red Face or Eyes
○Bitter taste	○Frustration	○Muscle Tension	○Ringing in Ears
○Blurry Vision	○Gallstones	○Muscles Spasms	○Seizures/ Convulsions
○Depression	○Hypochondriac Pain	○Nervousness	○Sexual Disease
○Dizziness/ Vertigo	○Irritability	○Numbness/Tingling	○Stiff Neck
○Alternating Diarrhea & Constipation			

KID/UB Function:

○Easily Broken Bones	○Fearful	○Low Back Pain	○Night Sweats
○Excessive Hair Loss	○Kidney Stones	○Low Libido	○Sore/ Weak Knees
○Leg Edema	○Lack of Bladder Control	○Memory Problems	○Tinnitus

Urination:

○Blood or Pus in Urine	○Dark Yellow Color	○Incontinence	○Scanty
○Burning	○Difficult	○Painful	○Strong Odor
○Cloudy	○Frequent	○Profuse	○Urgent

Family Medical History

Check the following that have occurred in your blood relatives:

○Alcoholism	○Diabetes	○High Blood Pressure
○Allergies	○Drug abuse	○Mental Illness
○Arthritis	○Epilepsy/ Seizure	○Obesity
○Cancer: _____	○Heart Disease	○Stroke

Any Others? YES / NO, if Yes, please list on the back of this page. _____

Men only:

Last DRE (digital rectal examination, prostate examination): Month _____Year_____
Were the results Normal? YES / NO
Last PSA (prostate specific antigen): Month _____ Year_____
Were the results Normal? YES / NO
○Genital Pain ○Swollen Testes ○Penile Discharge ○Premature Ejaculation ○Impotence

Women only:

Are you *Pregnant* now? YES / NO

If not, the first day of *Last Menstrual Period*: Month _____Day _____Year _____

Age of first menses: _____ Y/O
Age of menopause: _____ Y/O
Number of pregnancies: _____
Number of living children: _____
Number of miscarriages: _____
Number of abortions: _____

Last *Breast Examination* by a physician: Month _____ Year _____. Were the results normal? YES / NO

Last *Pelvic Examination* by a physician: Month _____ Year _____. Were the results normal? YES / NO

Last *Papanicolaou Smear*: Month _____ Year _____. Were the results normal? YES / NO

Last *Mammography*: Month _____ Year _____. Were the results normal? YES / NO

Last *CA-125* ovarian cancer screen (a blood test): Month ___ Year _____. Were the results normal? YES / NO

Do you have any *Vaginal Discharge* between cycles? YES / NO, if Yes:

When: _____, Color: _____, Thin / Thick, Strong odor: YES / NO

Do you experience any of the following pre-menstrual syndromes (PMS):

○Anxiety ○Depression ○Headaches ○Nausea
○Breast Tenderness ○Emotional ○Irritability ○Vomiting
○Cramps ○Food Cravings ○Migraines ○Water Retention

Do you have *a regular* menstrual cycle? YES / NO Days in *Menstrual Cycle*: _____ Days

Any *Abnormal Bleeding* between cycles? YES / NO Average number *Days of Flow*: _____ Days

Menstrual Chart:

	Day 1	***Day 2***	***Day 3***	***Day 4***	***Day 5***	***Day 6***	***Day 7***
Color (bright red, pale, dark)							
Amount of flow (heavy, light)							
Cramps (dull, sharp)							
Clots (large, small, purple, red)							

Recent Tests, Results and Dates:

○Blood Sugar: Month ___Year _____ Result: Normal / Abnormal
○Cholesterol: Month ____Year _____ Result: Normal / Abnormal
○HIV: Month ____Year _____ Result: Normal / Abnormal
○Physical: Month ___Year _____ Result: Normal / Abnormal

Any Others? YES / NO, if Yes, please list below: _____

MEDICAL ACUPUNCTURE

Phone: 407.690.7696
Fax: 407.610.0287

AUTHORIZATION FORM FOR RELEASE OF MEDICAL RECORDS

I, _____ authorize Authentic Oriental Healthcare/dba Medical Acupuncture to: Release / Obtain the records indicated below from:

Name: _____

Address: _____

Fax: _____

___ Complete Medical Record
___ Lab Report(s)
___ Office Note(s)
___ Surgical Procedure(s)
___ Other _____

For the dates of service from _____ to _____

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Today's Date

MEDICATION LIST

PATIENT NAME: _____ **DATE:** _____

NAME OF MEDICATION	DOSE	FREQUENCY
OVER THE COUNTER/SUPPLEMENTS:		
ALLERGIES: (MEDS, FOOD, SEASONAL)		**REACTION:**

Notice of Privacy Practices

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

We maintain the privacy of your Protected Health Information ("PHI") according to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and provide you with this notice of our duties and privacy practices with respect to such PHI ("Notice").

We will abide by the terms of the Notice currently in effect. We reserve the right to change the terms of our Notice at any time and to make the new notice provisions effective for all PHI that we maintain. If we change the terms of our Notice, you will be notified at your next visit.

Acknowledgment of Receipt of This Notice

You will be asked to provide a signed Acknowledgment of Receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. The delivery of your services will in no way depend upon your signed Acknowledgment. If you decline to sign an Acknowledgment, we will continue to provide your services. We will also use and disclose your PHI for treatment, payment and health care operations, when necessary.

How We May Use or Disclose Your Health Information

Except as may be otherwise prohibited by state or federal law, the following describes the purposes for which we are permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization, and you may revoke such authorization in writing at any time, except to the extent that we have already relied on the authorization.

Personal Financial Information: We collect and use several types of financial information to carry out our business activities. This includes information that you give to us on applications or other forms, such as your name, address, age, and dependents. We keep and share financial records such as insurance coverage and payment history, when necessary, with our employees, affiliates, business associates, or others who need it to provide services, to do business, for health care operations, or other legally allowed or required purposes.

Treatment: We may use or disclose your health information to provide you with medical treatment, services, or supplies. For example, we may obtain information that may help us manage your treatment plan or your overall health or may disclose information to coordinate or manage your healthcare, such as consulting with your doctor or another pharmacy regarding your medications, treatment, or condition. We may contact you regarding refill reminders or to notify you of a discontinued product and suggest alternatives.

Payment: We may use or disclose your health information in order to process claims or make payment for covered services or supplies. For example, we may submit a claim to your insurance carrier for payment. The claim form will include information that identifies you, your diagnosis, and treatment or supplies used during treatment. Your information may be disclosed to one or more intermediaries employed by your plan sponsor, including, but not limited to, insurers, pharmacy benefits managers, and claims administrators.

Health Care Operations: We may use or disclose your health information for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, employee review and development activities, review and audit activities, management and general administrative activities. For example, we may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided to our organization through contracts with third-party "business associates." Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Required by Law: We will disclose medical information about you when required to do so by applicable federal, state, or local law.

Communication with Family, Caregivers, and Close Friends: We may disclose your PHI to a family member, another relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if: (1) we obtain your written agreement or provide you with the opportunity to object to the disclosure and you do not object; or (2) we reasonably believe that you do not object to the disclosure. If you are not present for or unavailable prior to a disclosure (i.e., when we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information under such circumstances, we will disclose only information that is directly relevant to the person's involvement with your care.

Public Health: Consistent with applicable federal and state laws, we may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect, elder abuse, domestic violence or any other form of abuse to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence; (3) to any state agency in conjunction with a federal or state health benefit program; (4) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; (6) to prevent a serious threat to your health and safety or the health and safety of the public or another person; and (7) as required by state law for other public health activities.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.

Marketing: We may, as permitted by law, use or disclose your health information, as necessary, to provide you with recommendations for alternative treatments, therapies, health care providers, or care settings.

Research: We may disclose de-identified information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Fund Raising: We may contact you as part of a fund-raising effort. You have the right to opt-out of these communications.

Workers' Compensation: We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

Specialized Government Functions: We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State, under certain circumstances required by law.

Law Enforcement Purposes: We may disclose your PHI to the police or other law enforcement officials as required by law or in compliance with a subpoena or court order.

Lawsuits and Disputes: We may disclose health information about you in response to a subpoena, discovery request, or other lawful order from a court.

Judicial and Administrative Proceedings: We may disclose your PHI during a judicial or administrative proceeding in response to a legal order or other lawful process.

Decedents: We may disclose PHI to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement: If you are an organ donor, we may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Additional Requirements by Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

Authorization: We will get your written permission before we use or share your PHI for any other purpose unless otherwise stated or referred to specifically or generally in this Notice. You are not required to authorize any additional uses or disclosures of your PHI, and you may withdraw any authorization you do provide at any time, in writing. We will then stop using your information for that purpose. If, however, we have already used or shared your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you.

Right to Request Restrictions: You have the right to request that we restrict uses or disclosures of your health information to carry out treatment, payment, health care operations, or communications with family or friends. We are not required to agree to a restriction. If, however, you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer, and we must agree to that restriction unless disclosure is otherwise provided by law.

Right to Receive Confidential Communications: You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We will accommodate your request if it is reasonable, and you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy: You may inspect and copy health information that we maintain about you in a designated record set. A "designated record set" is a group of records that we maintain such as enrollment, supply order history, or payment. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying, postage, and preparation cost of an explanation or summary, if such is requested. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend: You have the right to ask us to amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not available for inspections as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures: Upon request, you may obtain an accounting of certain disclosures of your PHI made by us in the six years prior to the date on which the accounting is requested. If you request an accounting more than once during a twelve (12)-month period, we will charge you a reasonable, cost-based fee for the accounting statement.

Right to Obtain a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

Potential Impact of Other Applicable Law: The HIPAA Privacy Rule generally does not preempt or override state privacy or other applicable laws that provide individuals with greater privacy protections. As a result, state privacy laws that provide for a stricter privacy standard will be followed.

Please answer the following questions concerning the disclosure of your PHI:

- May we call you at home or on your cell to confirm appointments? **Yes No**
- May we email you to confirm appointments? **Yes No**
- May we send a text message to confirm appointments? **Yes No**
- May we leave a message on your answering machine at home or on your cell phone? **Yes No**
- May we discuss your medical condition with any member of your family? **Yes No**

If yes, please identify below the individuals to whom Authentic Oriental Healthcare ("AOH") dba Medical Acupuncture may disclose your PHI:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____ _

Name: _____ Relationship to Patient: _____

Signature of Patient (Or Authorized Representative) **Date**

Print Name of Patient (Or Authorized Representative) **Relationship to Patient**

Consent for Treatment

Please read the following and confirm that you agree to and clearly understand them by signing below.

(1) Practitioner's License and Limitations: The practitioner performing the procedures is a Licensed Acupuncture Physician and a Doctor of Oriental Medicine ("DOM"). In the State of Florida, such a practitioner is a "Primary Health Care Provider" with limited prescriptive rights. However, this practitioner is not a Licensed Medical Doctor ("MD").

a) Authentic Oriental Healthcare ("AOH") dba Medical Acupuncture provides treatments based on traditional Chinese medical concepts and modern oriental medical techniques; therefore, we recommend that you consult with your primary care physician prior to treatment.

b) The practitioner has been certified by the Board of Acupuncture to perform Acupoint Injection Therapy, which means that the practitioner is allowed to administer the injection of herbs, homeopathic, and other nutritional supplements in the form of sterile substances. The practitioner only uses natural substances and does not use any synthetic drugs or medications.

c) The practitioner is licensed to use Adjunctive Therapies (such as Laser Acupuncture, Homeopathy, Thermal Therapy, Therapeutic Exercises, Lifestyle Counseling), and Herbal or Nutritional Therapies.

(2) Treatment: The practitioner will provide health care treatments, which may include Acupuncture, Herbal Formulas, Tui-Na, Cupping and Gua-Sha Therapy, Moxibustion, Therapeutic Exercises, and/or Nutritional Counseling. **I understand that Needling, Cupping, and Gua-Sha Therapy may cause bruising in some cases and are outside of the standard of care and are therefore considered unproven and experimental, with unknown and possibly dangerous and/or deadly outcome.**

(3) Financial Information: All fees are due in full at the time services are rendered unless prior arrangements have been made with AOH dba Medical Acupuncture. I hereby acknowledge and accept full responsibility for any costs incurred. Payment is made directly to AOH dba Medical Acupuncture or its affiliates for the amount due, as stated above. Payment can be made by major credit cards or cash.

(4) Authorization to Use and Disclose Protected Health Information ("PHI"): I authorize AOH dba Medical Acupuncture, its employees, representatives, and agents, to release of any of my information to my insurance company to obtain reimbursement. This information includes records of examination, diagnosis, treatment, and billing information during the duration of care.

(5) Fees Associated with Herbal Prescriptions: The cost of the "Customized Herbal Prescriptions" are not included in the pricing of any treatment(s), as these prescriptions are based on an individual's needs. Payment for any personalized prescriptions is additional, and such payment will be due the day the formula is received.

(6) Patient's Responsibilities: Results require full cooperation on the part of the patient. This cooperation includes and is not limited to the patient's agreement to remain active in the recommended program. Hence, compliance with recommended schedules is equally important, and the patient agrees to keep appointments to the best of their ability. The patient understands that additional treatments may be necessary due to lack of cooperation, failure to keep appointments, failure to follow diet or lifestyle recommendations, engaging in activities outlined to be injurious or which may cause additional trauma to the body and/or any unforeseen and therefore unpredictable problems and contingencies.

(7) Change to Patient Treatment Plan: If the need arises to change the patient's course of treatment, the patient must schedule an additional consultation with the practitioner before any changes in treatment plans occur.

(8) Expectations: By signing below, the patient recognizes that AOH dba Medical Acupuncture does not guarantee any results. Any balance due for services is regardless of results and treatment outcome.

I fully understand that by signing below, I am indicating that I have read and fully understood the information in this Patient Consent Form; that I have been verbally advised and that I have had an adequate and reasonable opportunity to ask questions concerning treatment; and I authorize the practitioners of AOH dba Medical Acupuncture to provide treatment.

Signature of Patient: _____ Date**:** _____
(Or Authorized Representative)

Print Name of Patient: _____
(Or Authorized Representative)

Relationship to Patient: _____

Financial Policy and Authorization to Bill Insurance

There are two billing options available for you. Please select the one that applies to your visits. If you choose to change your billing option at any time, you are required to let us know immediately and sign a new Financial Policy and Authorization to Bill Insurance form.

_____ **Veteran Community Care Network**
I understand I'm not responsible for co-payments during the period of authorization. Should I choose to have any service or products not authorized by VA or outside of the authorization period, I am responsible for those fees.

_____ **Private Pay/Uninsured Patients**
Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. The following estimates are guidelines only.

- **New patients** should be prepared to pay up to **$175 for the initial consultation.**
- **Established patients** should be prepared to pay **$125 for each follow-up visit.**
- **Additional services**, such as diagnostic testing, labs, and additional modalities, may be required during any visit. These additional services are not included in the estimates above and are rendered at an additional fee.

Additional Financial Responsibility

Request for Medical Records Fees: For copies of your records, AOH will charge you the lesser of: (i) the maximum amount allowed by Florida law, or (ii) $1.00 per page up to 25 pages and an additional $.25 per page thereafter.

Form Completion Fees: Our office charges a flat fee of $25.00 per form whenever you request a provider to complete a form requiring review of your chart. **Prepayment is required** before any form will be completed.

I authorize my insurance benefits to be paid directly to AOH. I also authorize the provider to release any information and records required by my insurance company. I understand that I may revoke this consent by written request at any time. No other records shall be released without my signed consent.

Signature of Responsible Party: _____ **Date:** _____

Print Name of Responsible Party: _____

CANCELLATION/NO SHOW POLICY

Please initial the following highlighted areas.

Cancellation/No Show Policy: Established Appointments

_____If you failed to cancel within 24 hours of your scheduled appointment, you will be charged a fifty-dollar ($50) fee – your insurance company will ***NOT*** cover this fee.

_____If you purchased a pre-paid series of treatments, and you failed to cancel within 24 hours of your scheduled appointment, you lose the treatment session which you missed.

Other Policies: Rescheduling

_____We allow a 15-minute grace period past the scheduled appointment time. If you arrive more than 15 minutes late, you can wait for an opening if there is one later that day **and** there will be a fifty-dollar ($50) rescheduling fee charged in your account – your insurance company will **not** cover this fee.

We appreciate your understanding. Thank you for being a patient of Medical Acupuncture.

_____

(Print Name)

_____ _____

(Signature) (Date)

VIDEO/PHOTOGRAPH RELEASE FORM

I hereby grant Authentic Oriental Healthcare LLC dba Medical Acupuncture the irrevocable right and permission to use photographs and/or video recordings of e on websites and in publication, promotional flyers, educational materials, derivative works or for any other similar purpose without compensation to me.

I understand and agree that such photographs and/or video recordings of me may be placed on the Internet. I also understand and agree that I may be identified by name and/or video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video and audio recordings, and any reproductions thereof and all plates, negatives, recording tape and digital files are and shall remain the property of Authentic Oriental Healthcare, LLC dba Medical Acupuncture.

I hereby release, acquit and forever discharge Authentic Oriental Healthcare, LLC dba Medical Acupuncture its current and former trustee, agents, officers and employees of the above-named entities from all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use or distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation.

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name or, if I am less than eighteen (18) years old that my parent or guardian has signed this release form below. This release is binding on me and my heirs, assigns and personal representatives.

_____

Signature of Individual Photographed/Recorded **Date**

_____

Printed Name of Individual Photographed/Recorded

_____

Signature of Witness **Date**