Patient Intake

Date_____

Name_____

Date of Birth:_____ Age:_____

□Male □Female

Primary Address:_____

City:_____ State:_____ Zip:_____

For minors: Primary caregivers' name(s) – please list all and relationships:
Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

(Continue on back of page if needed)

Individual responsible for account:_____

Address of Individual responsible for account:

□Same as for patient, or

Address:_____

City:_____ State:_____ Zip:_____-_____

Best contact phone: _____ - _____ - _____

Secondary number: _____ - _____ - _____

Fax number: _____ - _____ - _____

May I/We contact you by Phone? □Yes □No

May I/We leave you a phone message? □Yes □No

Between what hours may I/We call: _____ to_____

Email:_____

Do you check email regularly? □Yes □No
May I/We contact you by email? □Yes □No

Whom can we thank for referring you to this office?_____

Have you / your child received any type of complementary/alternative therapy before?

□No
□Yes Type(s)_____

Primary Care Physician(s)_____

_____

Group:_____

Address:_____

_____

Phone:_____ Fax:_____

(continue on bottom or back of page if needed)

Are any specialists seen? □Yes □No

If yes, please list names, addresses, and phone numbers below, along with type of specialist and reason for specialist use:

•What is/are the primary condition(s) for which you are seeking care?

_____

_____

_____

Continued Information:

_____

_____

_____

_____

_____

_____

_____

Health History

Allergies
To Medications (Include type of reaction. E.g. "Penicillin – hives"):
To Foods (and reaction):
Environmental:

Prior Hospitalizations		
Dates (admit – discharge)	Hospital	Reason
Please continue on Back if necessary		

Current *Prescribed* Medications and Supplements (continue on back if needed)					
Medications	Dose (e.g. 25mg 2 times per day)	Prescribed by	For what condition	Started	Notes

Current Over the Counter Supplements and Herbs (continue on back if needed)					
Items	Dose (e.g. 25mg 2 times per day)	Heard about the remedy from?	For what condition	Started	Notes

Other Treatments, Folk Remedies, etc?

Emergency Room Visits (last 3 years)		
Dates (admit – discharge)	Hospital	Reason
Please continue on Back if necessary		

Studies Done (e.g. CT scans, MRI's, X-rays)		
Study Type	Date	Results

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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, but all my records will be kept confidential and will not be released without my written consent.

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.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

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, 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 the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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

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

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

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

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

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Acknowledgements of Office Policies and Procedures

Please initial each statement:

_____I have read all materials presented including the Disclosure of Malpractice Insurance Status, Scope of Services, Privacy Policy and Operations information, and have received a copy of the Privacy Policy.

_____I understand that call services are not available through this office, and that I am expected to have a primary physician for myself and/or my child for those services.

_____I understand that Dr. Miller does not carry Western medical malpractice insurance, and hence minimal if any remuneration is available for complications arising from Western medical care.

_____I understand that, while the therapies being used are well tried and believed to be effective by millions world-wide, the formal stance of the Western medical body of practitioners is that the non-biomedical therapies are unproven. Hence, no "gold-standard" of care has been established for these therapies.

_____I understand that for full efficacy of treatment, changes in diet and lifestyle may be recommended, and prescriptions for herbal formulas and/or Flower Essences may be given. If I do not take these medications as directed and/or do not adhere to these lifestyle and diet recommendations, the effectiveness of the treatments may be lessened and conclusions about the efficacy of the therapies cannot be drawn.

_____I understand that no type of medicine (including Biomedicine) can guarantee specific results, and that the role of the provider is to offer and apply the tools of medicine to the best of her or his ability. While the goal is always the improved health and well-being of the patient, specific results will vary from individual to individual.

_____I understand that I am allotted a specific amount of time for my appointment, and that if I am late for an appointment, the session length will not be increased to accommodate this lateness.

_____I understand that I am responsible for paying the full fee (up to $200) for the scheduled appointment if I cancel less than 24 hours prior to that appointment or if I do not show-up for the appointment. Further, I understand that reminder calls may not be made by the clinic or practitioner prior to the appointment.

_____I understand that this is a fee-for-service agreement, and payment for my session is due in full at the time of the meeting. I am responsible for submitting forms to my insurance company for reimbursement as allowed by my policy. No guarantees can be made on insurance reimbursement.

_____I understand that Biomedical services are very limited or may not be available, and will be used only at the discretion of the provider. In some cases, coordination of services with an internist will be required to maintain a therapeutic relationship with this clinic. (E.g. Adults who need management of their Western medications or who have an uncontrolled condition such as high blood pressure that needs a Biomedical work-up.) All children must be connected with a primary care pediatrician.

_____The treatment relationship established through this practice may be discontinued at any time by either party.

_____Prices for services are subject to change, but I am entitled to know the fee for service prior to my appointment.

_____	_____	_____
Signature	Printed Name	Date