AcuMeridian Wellness, LLC
242 Rt 79, Suite 11, Morganville, NJ 07751 *(732)858-1322* *http://www.acumeridianwellness.com*

Patient Intake Form - Initial Visit

Name Last-_____First_____Middle_____SS#_____/_____/_____

Date of Birth_____ /_____ /_____ **Gender** F ____M _____ **Email**_____

Address _____City _____

State_____ Zip Code_____

Telephone: Home (_____)_____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Marital Status: S ☐ M ☐ D ☐ Other:_____ **Occupation** _____

Height _____ **Weight** _____ **Blood Pressure**_____**Pulse**_____

How did you hear about our clinic?_____

Have you been treated by Acupuncture or Oriental medicine before? Y ☐ N ☐

Name of your physician:_____Phone:_____

Address of your physician: _____City _____State ____Zip_____

In an Emergency Notify: Name_____ Relationship to patient_____

Home Phone : (_____)_____-_____Cell Phone:(_____)_____-_____Work Phone:(_____)_____-_____

PATIENT INSURANCE INFORMATION (See attached Insurance Information & Check List)

Insured's ID Number _____ Insured's Policy Number _____

Insurance Plan Name or Program Name _____

Patient Relationship to Insured Self ☐ Spouse ☐ Child ☐

If insured is other than "Self", what is Insured's name ? _____and DOB?_____ _____

and Insured's SS#_____/_____/_____

FINANCIAL AGREEMENT

Payment for Clinic Services Rendered: Payment is **due at the time of service** and may be paid by cash or check. **All credit card payments will be charged an additional 3% fee.** Any checks returned due to insufficient funds will be charged an additional $30.

Assignment of Benefits for Insurance (For patient with verified insurance coverage):
I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Cancellation Policy:
Please be respectful of the time set aside for your treatment. All scheduled appointments require a 24 hour cancellation notice or the patient will be charged for a FULL office visit fee.

Herbal Prescriptions:
I understand that **all herb sales are final** as herbal prescriptions are intended only for the patient for whom they have been prescribed.

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Patient/Guardian's Signature _____ **Date**_____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____

2. When did this problem begin? _____

3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? What were the results?_____

5. Are you currently receiving treatment for your problem? _____If so, please describe:
_____

6. To what extent does this problem interfere with your daily activities (e.g. work, sleep, eat, sex, etc):
_____

PAST MEDICAL HISTORY
Illnesses(with dates):

_____

_____

Surgeries(with dates):

_____

Significant Trauma (Auto accidents, falls, etc., with dates) :

_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes □ No □ If so, please describe:

_____

CURRENT MEDICATIONS: (prescription and over-the-counter drugs, vitamins, herbs, etc.)

_____

_____

ALLERGIES:

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)
Mother's Side

_____

Father's Side

_____

Siblings

_____

If any of the above is deceased, what was the cause?

_____

PERSONAL HISTORY
Birth History (Prolonged labor, pre-term birth, forceps delivery, etc.) _____
Childhood Illnesses _____
Current Predominant Emotions (Stress, depression, etc.) _____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes □ No □ If so, please describe:

_____

Have you traveled abroad in the past year? Yes □ No □ Where?

_____

Smoking? Yes □ No □ Alcohol? Yes □ No □

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST SIX MONTHS)

□ Fevers □ Chills □ Poor Appetite □ Poor Balance

□ Fatigue □ Night Sweats □ Day Sweating □ Tremors

□ Poor Sleep/Insomnia □ Dream Disturbed Sleep □ Strong thirst for Hot or Cold drinks?

□ Weight Loss □ Weight Gain □ Sudden energy drops? What time of Day? _____

□ Joint Pain □ Localized Weakness □ Bleeding or Bruising

NEUROPSYCHOLOGICAL

□ Seizures □ Areas of Numbness □ Anxiety □ Concussion □ Lack of Coordination □ Poor Memory

□ Dizziness □ Loss of Balance □ Easily Angered □ Headaches □ Fainting □ Depression

□ Migraines □ Disorientation □ Mania □ Easily Susceptible to Stress

Have you ever been treated for emotional problems? If so, please describe:

_____

PREGNANCY & GYNECOLOGY

_____Age at First Menses _____ Number of Pregnancies □Birth Control?

□ Period between Menses _____ Number of Births What type? _____

_____Duration of Menses _____ Miscarriages How long?_____

□ Abortions □ Fertility Problems □ Heavy or □ Light Periods □ Difficult Births □ Vaginal Discharge

□ Irregular Periods □ Breast Lumps □ Vaginal Sores □ Painful Periods □Clots □ PMS

First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/ _____/ _____

CARDIOVASCULAR

□ High blood pressure □ Dizziness □ Swelling of Hands □ Blood Clots □ Irregular heartbeat □ Fainting

□ Difficulty in Breathing □ Palpitations □ Low blood pressure □ Cold Sweats □ Cold Hands/Feet

□ Chest pain □ Swelling of Feet □ Phlebitis

RESPIRATORY

□ Cough □ Pain w/ Deep Breaths □ Difficulty in Breathing □ Asthma □ Bronchitis □ Shortness of Breath

□ Easily Winded w/ Exertion when laying down □ Coughing Blood □ Production of phlegm What Color? _____

GASTROINTESTINAL

□ Nausea □ Abdominal Pain/ Cramps □ Digestive Disorders □ Vomiting □ Parasites □ Constipation

□ Indigestion □ Belching □ Diarrhea □ Ulcers □ Bad Breath □ Blood in Stools □ Hernia □ Hemorrhoids

GENITO-URINARY

□ Pain on Urination □ Decrease in Urine □ Kidney stones □ Urgent Urination □ Blood in Urine □ Frequent Urination

□ Waking up to Urinate □ Unable to Hold Urine □ Genital Sores

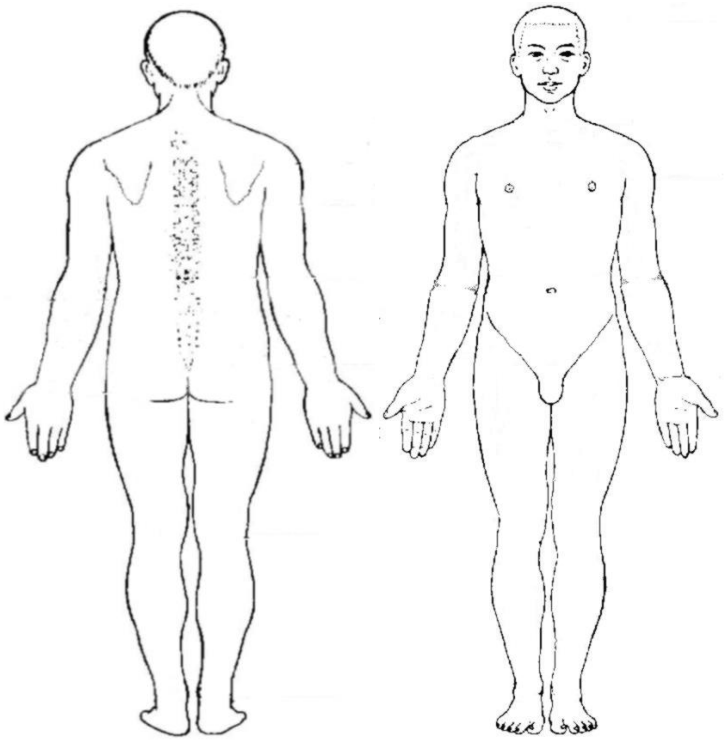
Men Only: □ Impotency □ Difficulty in or Erection or Ejaculation □ Testicle Pain or Swelling

MUSCULOSKELETAL

□ Muscular Weakness □ Arthritis □ Recent Sprains □ Muscle Cramps □ Spasms

□ Injuries or Falls □ Muscular Atrophy □ General Aches □ Joint Instability

Please circle on the diagram any areas of any type of pain or injury



Please try to describe the type and quality of the pain (sharp, dull, achy, etc)

_____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10
No pain The most intense pain

A Message to Our Patients About Arbitration

The attached 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 New Jersey courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide you with quality medical care which fully meets your health care needs. We know that most problems begin with communication. Therefore, if you have any questions about your care, please contact us.

Answering Questions about Arbitration

Q. What is an arbitration agreement?

A. By signing an arbitration agreement, a patient and a healthcare practitioner agree to use a private, confidential, and expedited arbitration, rather than a public, lengthy and costly courtroom trial, to settle any future malpractice claims. In arbitration, a neutral arbitrator (quite often a retired judge) decides the case. By agreeing to arbitrate, the parties preserve their right to present their claims fully; however, they choose a specific forum for dispute resolution: an arbitration hearing rather than a judge or jury trial.

Q. Why does arbitration provide a speedier resolution than civil litigation?

A. With the huge backlog in our civil courts, there is often a three- to five-year wait for an available courtroom and judge. In arbitration, the wait is usually less than one year. In addition, simplified procedural rules used in arbitration hearings reduce the number of motions made by attorneys, so a decision can be expedited. That means less worry time for both the patient and health practitioner.

Q. Are arbitration agreements legal?

A. Yes. In an effort to improve the court system, the federal, and most state laws have been modified to incorporate arbitration as a standard system of dispute resolution. Our paperwork has been specifically designed and updated to meet these requirements.

Q. Is arbitration cheaper than a trial?

A. Yes. Attorney's fees in arbitration hearings are, on average, 60% less than in judge and jury trials. Thus, savings can be substantial, as attorneys' fees in a typical judge or jury trial range between $50,000 and $150,000.

Q. What if a patient won't sign an arbitration agreement?

A. While most patients sign willingly, some (statistically less than 1%) will refuse to sign and will go elsewhere for treatment. That may be to the health practitioner's advantage. That small minority of patients who won't sign is comprised of "professional plaintiffs" (people who make a living out of forcing settlements in nuisance suits) or patients who approach the doctor-patient relationship with the mind-set that they will file suit the minute they think anything has gone wrong.

Most patients see the mutual benefit of arbitration in time and cost savings. In addition, patients understand that a malpractice insurance company may require its insured health practitioners to use arbitration forms. Patients appreciate that such a practitioner really cares and has taken the proper business attitude of getting malpractice insurance in case that practitioner should inadvertently injure a patient. And, with arbitration rather than civil litigation, that injured patient won't have to wait five years to get a settlement or judgment.

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ARBITRATION ARGEEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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

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

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

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

_____ _____
Patient's Name Signature of Patient or Guardian Date

_____
Practitioner's Signature Date

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Informed Consent

I,_____, have sought acupuncture services from Dr. Carrie M. Koo, L.Ac/Dr. Jaclyn Reich, L.Ac. and acknowledge that **I HAVE BEEN ADVISED TO SEEK MEDICAL SERVICES FROM AN M.D. FOR THE CONDITION(S) FOR WHICH I SEEK TREATMENT. I UNDERSTAND THAT UNDER NJS LAW, THE PRACTITIONER IS REQUIRED TO ADVISE ME TO CONSULT A PHYSICIAN.**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above 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 above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

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

I 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that 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's Name Signature of Patient or Guardian Date

_____
Practitioner's Signature Date

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Privacy Notice

This Notice together with our Practices Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. They also describe how you can gain access to your health information. **Please review this information carefully.**

Understanding Your Health Record:

A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

Your Health Information Rights:

Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

Our Responsibilities:

We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of

privacy practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient name: _____ (Please print)

Patient/Guardian Signature: _____

Date: _____

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Standard and Practices

Privacy of Patient Information

Date:

Standard

AcuMeridian Wellness is committed to treating all of its patients with appropriate care and respect. Information which our patients provide to use in connection with their treatment, Protected Health Information (PHI), is subject to standards of security and confidentiality as defined under Federal Law, the Health Information Portability and Accountability Act (HIPAA). These standards and Practices set forth our procedures to insure compliance with the requirements of HIPAA.

Practices

1. Written or electronic files containing PHI must be stored in secure facilities. Written files will be maintained in locked file cabinets and electronic files will be stored in secure databases only accessible through password protected codes. Computer screens will be positioned so that they are not viewable by persons other than our personnel authorized to access that information. All personnel shall use discretion when discussing PHI in conversations.

2. A Notice of Privacy Practices together with the statement of Practices Regarding Disclosure of PHI will be provided to all patients at the time of their initial visit. All patients will be requested to sign a statement acknowledging receipt of this information. The acknowledgement will be kept on file for 6 years.

3. Patients will be requested to advise us whether we may contact them by phone or in writing regarding their care. It is our practice to call to remind patients of their appointments and to send billing and relating information to patients homes.

4. PHI may be routinely be used for treatment, billing, payment and quality control purposes. PHI may also be used without the patients consent for the following purposes:

    a. Uses and disclosures required by law
    b. Uses and disclosures for public health activities
    c. Disclosures about victims of abuse, neglect or domestic violence
    d. Disclosures for judicial an administrative proceedings
    e. Disclosures for law enforcement purposes
    f. Uses and disclosures about decedents
    g. Uses and disclosures for cadaver or organ donation purposes
    h. Uses and disclosures to avert a serious threat to health or safety
    i. Disclosures for workers compensation
    j. Disclosures to a State Licensing Board or other professional oversight entity.

5. Patients have the right to request restrictions on the use of their PHI, although we are not always able to abide by such requests. All such requests must be submitted in writing on our Restriction Request Form. We will take all such requests under advisement and notify

the patient in writing of our determination. A copy of the determination will be maintained in our files. If the request is granted then it will be observed, except in the event of an emergency or in the event we terminate the agreement.

6. State law pertaining to parent/guardian authorization will apply in the case of a minor. When state law is silent, we reserve the right to use our professional judgment.

7. Non-routine requests for PHI will be reviewed in the normal course and may require specific patient authorization.

8. Patients may request an account of all PHI disclosures made by use in the prior six years. Such an accounting will not include disclosures:

   a. For treatment, payment and healthcare operations
   b. To the patient
   c. To persons involved in the patients care
   d. For national security or intelligence purposes
   e. To correctional institutions of law enforcement agencies
   f. Disclosures made prior to the enactment of HIPAA

In some instances PHI may be used once it has been stripped of all elements of personally identify information. Identifiers that may be stripped include:

   a. Name
   b. All address information
   c. E-mail address
   d. Dates (other than the year)
   e. Social Security number
   f. Medical Record numbers
   g. Health Plan beneficiary numbers
   h. Account numbers
   i. Certificate numbers
   j. License numbers
   k. Vehicle identification numbers
   l. Facial Photo's
   m. Telephone numbers
   n. Device Identifiers
   o. URL's
   p. IP addresses
   q. Biometric Identifiers
   r. Zip code, if the geographic unit includes less than 20,000 persons
   s. Any other unique data which when used alone or in combination with other information might identify the individual who is the subject of the information

9. We are required to act on written requests for onsite review of PHI within thirty days of our receipt of the request. If copies are requested, we may charge a reasonable copying fee. Patients do not have the right to access:

   a. psychotherapy notes
   b. information relating to criminal, civil or administrative procedures
   c. PHI lawfully prohibited from release because it is subject to or exempted from Clinical Laboratory Improvements Amendments (CLIC)

d. Information created by someone other than us or given to use under a promise not to release.

10. Patients have a right to request amendments to their PHI. Requests to amend must be made in writing, clearly stating the requested amendment and the reason for the request. We will provide a written response within 60 days. If unamended information had previously been provided to third parties, we will undertake to advise any such person of the amendment. If the request is denied we will provide a written statement setting forth the basis for the denial.

11. Amendments Rights do not apply in the following circumstances:

    a. The information is not part of the patient file
    b. The information is accurate and complete
    c. The information was not created by us

12. We shall designate a person who shall be responsible for developing and implementing our HIPAA policies and procedures. This person shall also be responsible for training all staff in these policies and procedures. All employees will be required to sign an Employee Agreement Form acknowledging that they have been trained and that they understand their obligations. Employee infractions of HIPAA will result in discipline and may result in termination of employment. Similarly, any third party vendor who has access to PHI will be requirement to acknowledge that they are HIPAA compliant in all services provided to our business.

13. Any patient who exercises his/her rights under HIPAA shall not be adversely treated by us. The staff is expressly prohibited from intimidating, threatening, coercing, discriminating, or retaliating against any patient who exercises their HIPAA rights.

14. Any patient wishing to appeal as determination or to file a complaint regarding HIPAA should contact the Secretary of DHHS within 180 days of the alleged violation. All personnel shall fully cooperate with any resulting investigation. Complaints are to be filed:

    Office for Civil Rights

    U.S. Dept of Health and Human Services

    200 Independence Ave, S.W.

    Washington, D.C. 20201

    HOTLINE 1-800-368-1019

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