SYNERGY WELLNESS®

New Patient Form for Acupuncture Treatment

GENERAL INFORMATION

Name: _____ Date of Birth: ____/____/_____
First Name Middle Initial Last Name

Age: _____ Sex: ☐ F / ☐ M SSN: _____-_____-_____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Primary Physician: _____ Phone: _____-_____-_____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Name: _____	Insurance Name: _____
ID # / Group #: _____	ID # / Group #: _____
Subscriber Name: _____	Subscriber Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscriber Birth Date: _____	Subscriber Birth Date: _____

MAIN COMPLAINT

Reason for seeking acupuncture? _____

When did it begin, or what is the initial cause? _____

Have you been given a diagnosis? If so, what? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

MEDICAL HISTORY

Surgeries: _____

Significant Trauma (auto accidents, falls, emotional, etc): _____

Allergies: _____

Have you ever had an infectious disease? (HIV, TB, etc.) ☐ Yes ☐ No If so, please describe: _____

Medications: (Please list all OTC, prescription, vitamins, and supplements, and what they are taken for.)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY (Please check if any of the following applies to you or any family members)

☐ Alcoholism	☐ Asthma	☐ Hypertension	☐ Mental Illness	☐ Seizures
☐ Allergies	☐ Cancer	☐ Hypotension	☐ Multiple Sclerosis	☐ Strokes
☐ Alzheimer's	☐ Diabetes	☐ HIV / AIDS	☐ Pulmonary Disease	☐ Other: _____
☐ Arthritis	☐ Heart Disease	☐ Kidney	☐ Obesity	_____

If mother, father, or siblings are deceased, what was the cause? _____

_____

SOCIAL & LIFESTYLE

Do you exercise? ☐ Never ☐ Little ☐ Moderately ☐ Heavily What kind?: _____

Hours of sleep per night? _____ Do you wake rested? ☐ Yes ☐ No

☐ Awake easily ☐ Difficulty falling asleep ☐ Restless sleep ☐ Sleep too much

☐ Vivid dreams ☐ Bad dreams ☐ Other: _____

What is your stress level now on a scale from 1-10? _____

☐ Caffeine	How often? _____	☐ Alcohol	# of drinks per week: _____
☐ Tobacco	How often? _____	☐ Former alcohol use	# of years quit: _____
☐ Recreational Drugs	How often? _____	☐ Former tobacco use	# of years quit: _____

How many glasses of water do you drink per day? _____

Diet (please describe your typical daily diet):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

CURRENT SYMPTOMS (Check all that apply)

☐ High blood pressure ☐ Low blood pressure ☐ High cholesterol
☐ Hyperthyroid ☐ Hypothyroid ☐ History of blood clots
☐ Migraines ☐ Peculiar tastes or smells ☐ Metal implants: If so, where?_____

Liver / Gall Bladder

☐ Sigh often
☐ Feeling of lump in throat
☐ Depression
☐ Bitter taste in mouth
☐ Anger easily
☐ Dizziness / vertigo
☐ Irritability
☐ Stress
☐ Muscle twitching
☐ Muscle cramping
☐ High pitched ringing in ears
☐ Soft brittle nails
☐ Tingling / numbness of extremities
☐ Joint tightness / stiffness
☐ Headaches / migraines
☐ Visual problems
☐ Red eyes
☐ Dry / itching eyes
☐ Floaters in front of eyes
☐ Blurred vision
☐ Craving or avoiding sour foods

Heart

☐ Palpitations
☐ Anxiety
☐ Mental confusion
☐ Chest pain / tightness
☐ Frequent dreams
☐ Insomnia
☐ Forgetfulness
☐ Spontaneous sweating
☐ Restlessness / agitation
☐ Breathlessness
☐ Craving or avoiding bitter foods

Spleen / Stomach

☐ Poor appetite
☐ Excessive appetite
☐ Abrupt weight loss
☐ Abrupt weight gain
☐ Fatigue
☐ Easily bruised
☐ No thirst
☐ Loose stools
☐ Over thinking
☐ Worry often
☐ Hemorrhoids
☐ Bad breath
☐ Nausea / vomiting
☐ Gas / belching
☐ Bloating / pain
☐ Edema (swelling)
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer
☐ Craving or avoiding sweets

Digestion (SP, ST, LI, SI)

☐ Constipation
☐ Diarrhea
☐ Mucus in stool
☐ Blood in stool
☐ Undigested food in stool

Lung

☐ Nasal discharge
☐ Sinus congestion
☐ Dry cough
☐ Cough with sputum
☐ Nose bleeds

Lung

☐ Dry mouth
☐ Dry throat
☐ Dry nose
☐ Dry skin
☐ Skin rashes
☐ Itchy skin
☐ Alternating chills and fever
☐ Easily catch colds or flu
☐ Sore throat
☐ Difficulty breathing
☐ Shortness of breath
☐ Sadness
☐ Craving or avoiding spicy foods

Kidney / Urinary Bladder

☐ Weakness / pain in lower back
☐ Aching bones
☐ Feel cold easily / cold limbs
☐ Frequent urination
☐ Wake during night to urinate
☐ Incontinence
☐ Other urinary problems
☐ Night sweat
☐ Low sexual energy
☐ Excess sexual desire
☐ Low pitched ringing in ears
☐ Poor memory
☐ Early graying of hair
☐ Hair loss
☐ Hearing problems
☐ Fearful
☐ Easily startled
☐ Craving or avoiding salty foods

MEN'S HEALTH

☐ Prostate problems ☐ Erectile dysfunction ☐ History of testicular cancer
☐ Seminal emissions ☐ Genital pain ☐ Reduced sex drive
☐ Decreased urine flow ☐ Impotence ☐ Pain or burning during urination
☐ Other: _____

WOMEN'S HEALTH

Age at first menses: _____ Age at menopause: _____ Period between menses: ____ Duration of menses: _____

Number of pregnancies: ___ Number of births: _____ Miscarriages: _____ Abortions: _____

Last period: _____ Last PAP smear: _____ Pregnant: ☐ Yes ☐ No Form of birth control: _____

☐ Menstrual pain ☐ Low backache ☐ Irregular menses ☐ Vaginal dryness

☐ Mood changes ☐ Hot flashes ☐ Painful breasts ☐ Vaginal discharge

☐ Clots ☐ Heavy bleeding ☐ Fertility problems

FEMALE FERTILITY PATIENT ONLY

How long have you been trying to conceive? _____

Have you had fertility treatments? If yes, when, where, types, and by whom? _____

Have you taken medication for ovulation? ☐ Yes ☐ No When? _____ How long? _____

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No Results? _____

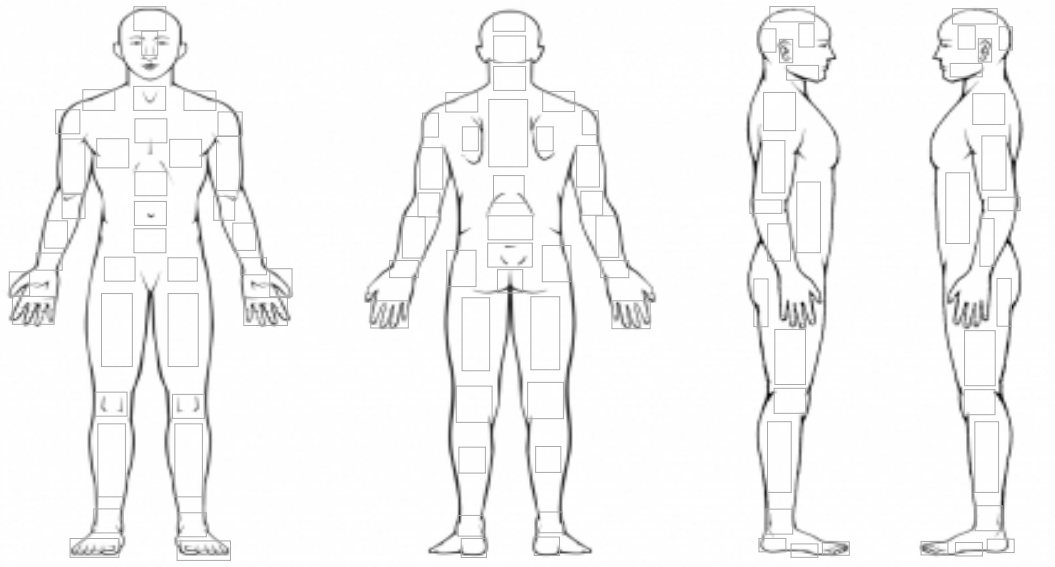
Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

Have you ever taken Depo Provera? ☐ Yes ☐ No When? _____ How long? _____

Has your spouse / partner had a fertility workup? ☐ Yes ☐ No If yes, what were his results? _____

PAIN AREAS

Please mark any areas of pain clearly.



My pain is:

☐ Sharp ☐ Cramping ☐ Fixed ☐ Burning ☐ Dull ☐ Aching ☐ Moving ☐ Other: _____

Do any of the following relieve the pain?

☐ Pressure ☐ Exercise ☐ Cold ☐ Heat ☐ Other: _____

Do any of the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Other: _____

HIPPA NOTICE OF PRIVACY PRACTICES

Your protected health information may be used and disclosed by Synergy Wellness for the purpose of providing health care services to you, to support the healthcare operation, and as required by law.

Treatment: to provide, coordinate, or manage your healthcare and related services. This includes the coordination of your healthcare with a third party. For example, to another healthcare professional to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Healthcare operations: in order to support the business activities of Synergy Wellness. These activities include, but are not limited to, quality assessment and review activities, licensing, and conducting or arranging for other business activities. For example, to contact you to remind you of your appointment or review your case to determine a continued course of treatment.

Use required by law: in the following situations without your authorization: communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; organ donation; research; national security; Worker's Compensation; inmate; required uses and disclosures. Under the law, disclosures must be made available to you and are required by the Secretary of the Department of Health and Human Services.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. You may ask Synergy Wellness not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care. Your request must state the specific restriction and to whom the restriction will apply.

You have the right to request to receive confidential communications by alternative means or at an alternative location.

You may have the right to amend your protected health information. If denied, you have the right to file a statement of disagreement with Synergy Wellness.

You have the right to receive an accounting of certain disclosures made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to Synergy Wellness or to the Secretary of Health and Human Services if you believe your privacy rights have been violated.

Synergy Wellness is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

I acknowledge that I have received the HIPPA Notice of Privacy Practices.

/ /201

Patient Signature Date

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 indicated 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, 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.

ACUPUNCTURIST NAME:

PATIENT SIGNATURE X Date: / /201

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

ALSO **SIGN** THE **ARBITRATION AGREEMENT**

AAC-FED **A2004**

PATIENT NAME:

ARBITRATION AGREEMENT

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 SIGNATURE **X** Date: / /201

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

OFFICE SIGNATURE **X** Date: / /201

ALSO **SIGN** THE **INFORMED CONSENT FORM**

AAC-FED **A2004**

FOR PATIENT REVIEW REGARDING DIAGNOSTIC EXAM

Please sign one of two options below:

Option 1: I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

/ /201

Patient Signature Date

Option 2: I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment. I understand this recommendation.

/ /201

Patient Signature Date

PAYMENT POLICY

All payments are due at the time of service. Appointments that are cancelled or missed with less than 24 hours advance notice may be charged a $25 fee. Thank you for understanding.

I have read, fully understand, and agree to all of the above-mentioned financial policies and terms of service.

/ /201

Patient Signature Date