Northampton Community Acupuncture

160 Main St. Suite 23 & 24, Northampton, MA • (413) 586-8251 • nohocommunityacupuncture.com

A NOTE FROM NORTHAMPTON COMMUNITY ACUPUNCTURE:

Our malpractice insurance policy requires us to update patient records for new and returning patients, to include our updated Informed Consent to Treat policy, as well as an Arbitration Agreement.

Please note that Northampton Community Acupuncture does not dispense Chinese herbal medicine, nor do we currently employ the use of moxibustion, cupping, electrical stimulation or tui-na in our acupuncture practice.

Thank you very much for your cooperation.
Your staff of community acupuncturists at NCA June 2017

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:

(Date)

PATIENT SIGNATURE X

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

ALSO SIGN THE ARBITRATION AGREEMENT ON NEXT PAGE

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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 Mure 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.

(Date)

PATIENT SIGNATURE **X**

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

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON PREVIOUS PAGE

Northampton Community Acupuncture
160 Main Street, Suite 24
Northampton, MA 01060
413.586.8251
nohocommunityacupuncture.com

NOTICE OF RECEIPT OF PRIVACY POLICIES

As mandated by federal and state legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information.

By signing below you acknowledge that you have received and read a copy of our privacy policies information. (This is included on this clipboard, under the health history forms, for you to read, or you may request a copy to read at the clinic if you download paperwork online.)

Signature:_____
Patient or guardian

FINANCIAL AGREEMENT

Northampton Community Acupuncture makes every attempt to make acupuncture available to as many people as possible, at the most affordable rates.
In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged as if you attended, i.e., a $35 fee or one deduction from a package special.

We appreciate your understanding.

Printed Name: _____ Signature: _____

Patient Information

Date _____

Legal Name _____

Preferred Name _____

Address _____

Age _____ DOB_____

Gender Identity _____

Preferred Pronoun_____

Occupation_____Full or Part Time_____

Physician/phone _____

How did you hear about us? _____

Contact Information

Primary phone number_____

E-mail_____

Have you had acupuncture before? Y____ N____

Have you had acupuncture for your primary concern(s)? Y____ N____

Emergency Contact Information:

Name_____ Relationship_____

Primary phone number _____

Health History

What are your primary concerns for treatment and approximately how long have you had them?

Primary concern: Approximately how long:

_____

_____

Describe how your concern(s) negatively affect you:

_____

Please check the following that currently apply:

SLEEP:

(Difficulty) falling asleep____ staying asleep _____

Sleep apnea___ Racing thoughts inhibiting sleep_____

DIGESTION:

No. of bowel movements per week____ Gas_____

Diarrhea___ Constipation___ (Stool) Blood___ /Mucus ___/ Loose___ Bloating___ Reflux___ Hemorrhoids____

Vomit___ Nausea___ Pain___ Lack of appetite_____

Major dietary restrictions:

_____

Please list medications or supplements that you are taking on a daily basis and purpose for use:

Medication/Supplement: Purpose for use:

_____

_____

_____

Please list any serious illnesses, accidents or surgeries and estimated date(s), including childhood illnesses:

Incident: Estimated Date:

_____

_____

_____

Please check any conditions that you currently have or have had: Hepatitis B_____ HIV/AIDS_____

Are you pregnant? Y___ N___ Due Date (if known)____

Do you get regular medical exams? Y___ N___

Estimated date of last exam_____

PAIN CONDITIONS:

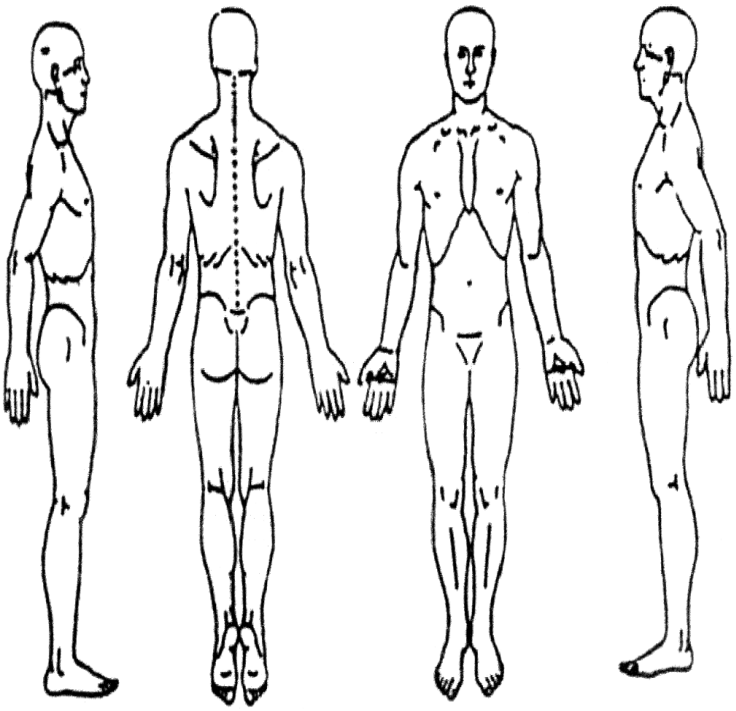
Please clearly circle any areas of pain that you are currently experiencing/ related to your primary concern(s):

List your pain conditions here:

1. _____

2. _____

R L



Please check the following traits that apply to the area of pain that is circled:

The following applies to pain condition #1:

Sharp___ Burning___ Aching___ Dull___ Crampy___

Fixed in one location? Y___ N___ Moving to various locations? Y___ N___

Does the pain feel *better* with the following: Pressure___ Cold__ Heat__ Excercise__ Other_____

Approximately how long have you been experiencing this pain?_____

Is this a flare-up of a chronic condition? Y____ N_____

The following applies to pain condition #2:

Sharp___ Burning___ Aching___ Dull___ Crampy____

Fixed in one location? Y___ N___ Moving to various locations? Y___ N___

Does the pain feel *better* with the following: Pressure___ Cold__ Heat__ Excercise__ Other_____

Approximately how long have you been experiencing this pain?_____

Is this a flare-up of a chronic condition? Y____ N_____

Do you have arthritis? Y___ N___

Do you have swelling/weakness/achiness anywhere in the body, and if so, where? _____

Do you experience cramping or tremors anywhere in your body, and if so, where?_____

The following information may or may not seem related to your primary concerns for acupuncture, however, the information is important in helping your practitioner gain an overall picture of your current health and well-being to best treat you.

Please check the following that currently apply:

BODY TEMPERATURE:

Tendency to feel (overall): Hot___ Cold___

Hands/Feet: Sweaty___ Cold___ Hot Flashes___

Night Sweats___ Dry/itchy skin___ Skin rashes___

ENERGY:

Shortness of breath___

General muscle weakness___

Poor Immunity___ General fatigue___ Tires easily___

MOOD:

Sadness___ Low motivation___ Depression___

Anxiety___ Mental confusion___ Foggy-thinking___

Excessive worry___ Excessive anger___ Irritability___

URINATION:

Burning___ Pain___ Blood___ Cloudy/dark___

Discharge___ Frequency___ Incontinence___

CARDIOVASCULAR:

Chest Pain__ Blood pressure: High___ Low_____

Poor circulation___ Swelling in hands/feet___

Rapid/irregular heartbeat___ History of heart attack___

EAR/NOSE/THROAT/EYE/RESPIRATORY:

(Ears) Achiness___ Loss of hearing___ Ringing___

(Sinuses) Congestion___ Pressure___

Dry mouth___

(Vision) Blurry___ Eye floaters___ Dry eyes___

(Cough) Dry___ Productive___

Difficulty breathing___ Asthma___

Do you smoke cigarettes Y___ N___ Have you smoked in the past? Y___ N___

Tension headaches ___ Migraines ___

(Do migraines include):Nausea___One-sided: R___L___

Light/sound sensitivity___

SEXUAL and REPRODUCTIVE HEALTH:

(Libido) Regular___ High___ Low___

Regular menstrual cycle: Y___ N___ Estimated age of first period___ Estimated age of menopause___

Average number of days in cycle___ Average number of days bleeding___

Estimated first day of last period_____

Blood clotting___ Spotting___ PMS___

Fertility issues___ Previous miscarriage___

Approximate date(s) _____

Erectile difficulties___ Prostate issues___

Low libido___

Testicular pain___ Fertility issues___

Signature

This information is correct to the best of my knowledge.

Signature:_____ Date:_____