7018 US Highway 301 North • Ellenton, Florida 34222 • Phone: 941-479-2937 • Fax: 941-460-4389 • www.DrVonador.com

Dear New Patient,

Welcome! Thank you so much for your interest in Acupuncture and Oriental medicine. At Acupuncture and Herbal Solutions, Inc. we do our best in every way possible to assure that you receive the best quality care. We want you to know that everyone on our staff is trained to:

- Make sure that our customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that we'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call us at (941) 479-2937 and any one of us will be happy to help you.

Again, welcome to Acupuncture and Herbal Solutions, Inc., you have taken an important step on the road to more vibrant health. We look forward to serving you.

Yours sincerely,

Dr. Dominique Vonador, AP, LAc

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Notice of Privacy Practices

I consent to the use or disclosure of my identifiable health information by Acupuncture and Herbal Solutions, Inc. for the purposes of diagnosis or providing treatment to obtain payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Acupuncture and Herbal Solutions, Inc.* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *ACUPUNCTURE AND HERBAL SOLUTIONS, INC.* is not required to agree to the restrictions that I may request. However, if ACUPUNCTURE AND HERBAL SOLUTIONS, INC. agrees to a restriction that I request, the restriction is binding upon *ACUPUNCTURE AND HERBAL SOLUTIONS, INC.*.

I have the right to revoke this consent, in writing, at any time except to the extent that *Acupuncture and Herbal Solutions, Inc.* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review ACUPUNCTURE AND HERBAL SOLUTIONS, INC.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Acupuncture and Herbal Solutions, Inc. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.DrVonador.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Acupuncture and Herbal Solutions, Inc. with respect to my identifiable health information.

Acupuncture and Herbal Solutions, Inc. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

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 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 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 proviser, including those working at the health care provider's clinic or office or any other office whether signatories 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 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 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 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 the 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 PRACTICE 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

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of 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, 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.

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.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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Medical Appointment Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another sick patient.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call.") A fee of **$50.00** will be charged to you for a missed appointment. This fee will not be billed to your insurance carrier. If you accumulate a total of three (3) missed appointments, you may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment will be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Printed Name of the Patient | Relationship to Patient (if patient is a minor)

_____ _____

Signature of Patient or Responsible Party if a Minor | Date

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PATIENT CONFIDENTIAL INFORMATION

1. Name _____ (First) _____ (Middle) _____ (Last)
2. Address _____ (Street) _____ (City) _____ (State) _____ (Zip)
3. Home Phone _____ 4. Cell Phone _____
5. Fax _____ 6. Email _____
7. Age _____ 8. Date of Birth _____ 9. Sex _____ 10. Marital: M S D W
11. Social Security No _____ 12. Driver's License No _____
13. Occupation _____ 14. Employer _____

Employer's Address _____ (Street) _____ (City) _____ (St.) _____ (Zip)

CASE HISTORY

16. Chief Complaint _____
17. Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other
18. Date of accident/Injury/Other ____/____/____
19. Have you seen any other doctor about this condition? _____ If yes, when? _____

Doctor's Name _____ Address _____

20. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____

23. In case of emergency, call _____ (Name) _____ (Street) _____ (City) _____ (Phone)

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses

_____

_____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Master Card ☐ Visa

INSURANCE INFORMATION

Insurance Name _____ Member ID _____

Subscriber Name _____ Group Number _____

Subscriber DOB _____ Insurance Phone # _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____

(parent's signature if patient is minor)

Referred by _____

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Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Acupuncture and Herbal Solutions, Inc. in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

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7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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13. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

14. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

15. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

17. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

18. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

19. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

20. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

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21. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____
2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____
3. Length of Cycle: _____ 6. # of Miscarriages: _____

22. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

23. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

24. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

26. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

27. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____
b. Exercise routine: _____
c. How many hours per night do you sleep? _____ Do you wake rested? Y N
d. Nicotine/Alcohol/Caffeine Use: _____
e. Have you experienced any major traumas? Y N Explain: _____
f. How many glasses of water do you drink per day? _____

How did you hear about us? _____

Would you like to receive our email newsletter? _____