VITAL
ACUPUNCTURE

10559 Crestwood Drive Manassas, VA 20109 Tel. 571-42-VITAL (571-428-4825) e-mail: info@vital-acupuncture.com

New Patient InFormation

Name_____ ☐ Female ☐ Male Date _____

What you prefer to be called_____Age_____ Date of birth _____

Preferred Language ☐ English ☐ Other_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone _____

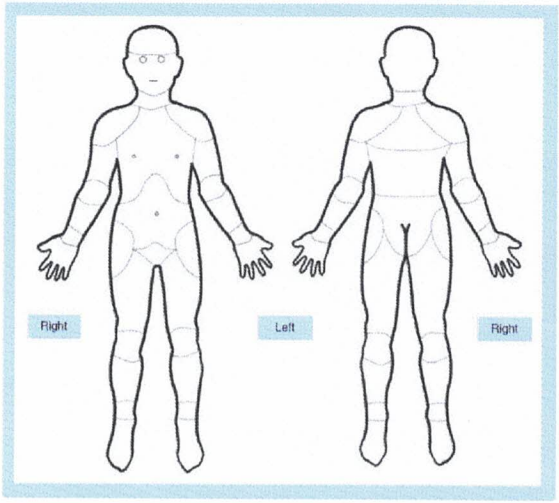
Email Address_____SS#(insurance only)_____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relation_____Phone_____

How did you hear about our office? _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

Other Doctors seen for this condition? _____

Have you had Acupuncture treatment before? ☐ Yes ☐ No

Family Physician/ PCP_____

May we forward our findings to your doctor? ☐ Yes ☐ No

Allergies (Medicine, Food, Environment)

_____

_____

Previous Surgeries _____

Other serious illnesses_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S M F		S M F		S M F	
__ __ __	Heart disease	__ __ __	Polio	__ __ __	Hepatitis
__ __ __	Anemia	__ __ __	Epilepsy	__ __ __	Cancer
__ __ __	Arthritis	__ __ __	Tuberculosis	__ __ __	Kidney Disorder
__ __ __	Asthma	__ __ __	Headaches	__ __ __	Rheumatic fever
__ __ __	Diabetes	__ __ __	Rheumatism	__ __ __	HIV/ARC
__ __ __	Scarlet fever	__ __ __	Multiple sclerosis	__ __ __	Stroke
__ __ __	High blood pressure	__ __ __	Muscular dystrophy		

__ __ __ Other (please explain) _____

ALLERGIES / DRUG REACTIONS

_____

_____

_____

_____

_____

	YES	NO
HIV:	☐	☐
AIDS:	☐	☐
TB:	☐	☐
HEPATITIS _____	☐	☐

OTHER_____

_____

_____

LIST OF MEDICATIONS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Vital Acupuncture Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or 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 working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping & gua-sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na, Chinese or western herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting.

I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous, nerve damage and organ puncture, including lung puncture (pneumothorax) and pregnancy. Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion.

I understand that the herbs and nutritional supplements (which are from plant, mineral, and animal 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 understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, in my best interest and understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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 or Patient Representative's Signature Date

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VITAL Acupuncture Notice of Patient Privacy Practices

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Our Responsibility: We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are require to maintain the privacy of your health information and how we may use it and disclose your health care information. We do not use your health information inside our office our outside without your written permission. In some limited cases, the law requires us to disclose your health care information without either a written or verbal consent.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Use and Disclose with Consent: We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. Treatment can be stopped with refusal to sign the form. We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

Use and Disclosure without Consent: In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:

- When state or federal law mandates certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
- Disclosures in response to subpoenas of orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
- Disclosure related to worker's compensation programs.

Your Rights Regarding Your Health Information: You have the following rights with respect to your protected health information, which you can exercise in writing to our office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to the request restriction. If we do agree the restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask to communicate with you in a confidential way, such as contacting you at work rather than at home. Please provide a written request. The right to see or get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a health care provider. Please complete our written records request for billing or medical records release.
- The right to receive an accounting disclosure of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice at your request.

You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated.

_____ _____

Patient's or Patient Representative's Signature Date

HEALTH CARE PROVIDER-PATIENT 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 binds 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) out of the patient in relation to all claims including loss of consortium. This agreement is also intended to binding any children of the patient whether born or unborn at the time of the occurrence giving rise to any claims. 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 ecide 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 loss, 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 statue 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**.** X_____.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.

_____

Health Care Provider's Signature (Date)

By: _____

Health Care Provider's Duly Authorized Representative (Date)

_____

Translated by (Date)

X _____

Print Patient's Name (Date)

X _____

Signature of Patient or Patient's Agent, Representative, or Parent (Date)

As: _____

Relationship to Patient

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Cancellation & No-Show Policy Agreement

As your appointment time is reserved specifically for you, Vital Acupuncture Clinic has a cancellation / no-show policy. Out of consideration for your acupuncturist's time, we ask that you notify us 24 hours in advance should you need to cancel or reschedule your appointment. **Vital Acupuncture will charge you 1 visit for late cancellations or missed appointments without 24-hour advanced notification.**

We do understand that unanticipated events happen occasionally; emergency cancellations are handled on an individual basis.

I have read and understand Vital Acupuncture Clinic's cancellation policy.
I consent to these terms.

Patient Signature _____

Date _____