COMMUNITY ACUPUNCTURE TIPS, for first time visitors

First, when you come into the clinic, you'll notice it's very QUIET, that's because some people are already resting and we shut off our phones and keep voices to a whisper.

At your first visit, we will take the time to sit in a private office and have a quick chat about why you're here, but that conversation shouldn't happen in the waiting room.

There are baskets by the front door for your stuff, you can take the baskets with you to your chair.

If you have jingly keys, a popping plastic water bottle, or a lovely, crinkly, plastic publix bag, please, please, quietly place it in a basket for the duration of your stay.

Please leave your shoes on until you get to your chair, no bare feet walking around please. When you arrive in your chair, then remove socks and shoes please.

We invite you to be respectful of other people and their treatments when you're here, please refrain from talking excessively in the treatment room.

PAYMENT should be done BEFORE entering the treatment room. There is a payment station right up front, when you come in the door.

CASH - fill out a payslip and paperclip it to your money and drop it in the box.
Check - just drop it in the box
Charge - it's at the payment station on the tablet, I can help you with it but cash and check are preferred.

FIRST TIME VISIT - $30-55 ($20-45 plus the $10 administration fee)
ALL RETURN VISITS - $20-45

YOU PAY WHATEVER YOU CAN, IT'S UP TO YOU, no questions asked. We all have a different story.

After you've paid, filled out your paperwork, put your things in a basket, you're ready. You'll wait for me in the waiting and then I'll take you back. I see a patient every 10 minutes, so we don't have a lot of time. Tell me the basic reason that you're here and any concerns you have. Then, I will direct you to the treatment room and do the treatment. You'll rest, with the needles in for at least 30 minutes, most patients learn after a few treatments when they feel "done." This can take anywhere from 30 minutes to over an hour! Many people fall asleep and wake feeling refreshed…the best healing occurs when you are sleeping…

801 2nd Street North, Suite C, Safety Harbor FL, 34695
www.CalmCommunityAcupuncture.com
(727) 744-4245

Financial Policy

Calm Community Acupuncture makes every attempt to make this treatment affordable and available to those who need it! Out of respect for our intentions and other patients who need to make an appointment, understand that when you schedule an appointment, it takes up a spot on our very busy calender, UNLESS THERE IS AN EMERGENCY, I ask you PLEASE, give 24 hrs. notice if you have to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with LESS than a 24 hr. notice, and of course, appointments missed without notice, will be charged $20.

Thank you for understanding,
Calm Community Acupuncture

Signature_____Date_____
Printed Name _____

Contact Authorization

Please check the box and place your initials in the space provided if Calm Community Acupuncture is authorized to:

_____ Email newsletters or announcements
_____ Leave voicemail messages on your telephone(s)

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Notice of Privacy Practices (HIPAA requirement)

This notice summarizes how YOUR health data may be used and shared. It will also tell you how to get access to this information.

I. How I might use or share your health information:

A. Treatment - to give you medical treatment or other types of health services

B. Payment - to bill you for your services

C. Health Care Operations - For our own operations, such as quality control, compliance monitoring, audit, marketing, newsletters and thank you cards.

II. Disclosures where I do not have to give you a chance to agree or object.

A. As required by law

B. Public Health Risks

C. Communicable diseases

D. Health Oversight (Government Agencies that oversee the health care system)

E. If child abuse or neglect is suspected

F. Legal Proceedings

G. Law Enforcement

H. Workers Compensation

III. Disclosures that may be made with your written authorization.

A. Persons involved in your care or payment for your care - we may share your health information with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. You have the following rights relating to the health data that I keep in my records about you.

A. Right to confidential communications about your personal health information

B. Right to ask for limits on the health information that we give out about you

C. Right to inspect your health record and to receive a copy upon request.

D. Right to amend data in your health record that you believe is inaccurate or incomplete

E. Right to know to whom we have disclosed your health information

F. Right to a paper copy of the complete Privacy Policy

G. Right to file a complaint if you feel that your privacy rights have been violated

H. Right to provide and/or revoke an authorization for other uses and disclosures.

I acknowledge that I have read this NOTICE OF PRIVACY PRACTICES. I understand that I may ask for a copy of this at any time.

Signature_____Date_____

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.

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 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 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 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 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)
(Or Patient Representative)		(Indicate relationship if signing for patient)
PATIENT SIGNATURE	**X**	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED

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 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, Tiu-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 be 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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.

PATIENT SIGNATURE	(Date)
X	

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

AAC-FED

Patient Information

Date _____.
Name_____.
Address _____.
City State Zip_____.
Age_____Birthdate_____.
Occupation _____.
Company Name _____.
Primary Care Physician_____.
Physician Phone Number_____.

How did you hear about SHCA?
_____.

Contact Information

Home Phone _____.
Cell Phone _____.
Email _____.

Please give the name of an authorized person that I may give medical information to if needed, this will also act as your emergency contact.

Name _____.
Relationship_____.
Contact Phone Number_____.

Health History

What is your main reason for coming in for treatment today?
_____.
_____.
_____.
How is your sleep?_____.
_____.
How is your digestion?_____.
_____.
List all Medications and supplements you are currently taking.
_____.
_____.
List serious illnesses, accidents or surgeries._____.
_____.
_____.
Circle illnesses that have occurred in blood relatives.
Diabetes High Blood Pressure
Cancer Stroke Heart Disease
Kidney Disease Obesity
Auto Immune Disease

Check Symptoms you have or have had in the past year:
- ☐ Depression
- ☐ Difficulty Focusing
- ☐ Dizziness
- ☐ Excessive Fear
- ☐ Fatigue/tiredness
- ☐ Chronic headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed my life

Check conditions you have or have had in the past:
- ☐ AIDS
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Diabetes type 1
- ☐ Diabetes type 2

How Long has it been since you've had a complete medical exam?_____.

Health History ... Continued

Check any symptoms you have had in the last year:

MUSCLE/JOINT/BONES
- ☐ Tremors
- ☐ Swollen Joints

Pain, weakness,numbness in:
- ☐ Arms or Hips
- ☐ Back Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other_____.

EYES/EARS/THROAT/RESPIRATORY
- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged Glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose Bleeds
- ☐ Loss of Hearing
- ☐ Persistent Cough
- ☐ Ringing in the Ears
- ☐ Sinus Problems

SKIN
- ☐ Boils
- ☐ Bruise Easily
- ☐ Dry Skin
- ☐ Itching
- ☐ Chronic Hives
- ☐ Psoriasis/Eczema
- ☐ Unusual or Spontaneous Sweating

GENITAL/URINARY
- ☐ Chronic UTI
- ☐ Frequent urination
- ☐ Incontinance
- ☐ Kidney Stones

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Cholesteral
- ☐ High or Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Previous Heart Attack
- ☐ Rapid/ Irregular Heart Beat
- ☐ Swelling of Ankles

GASTROINTESTINAL
- ☐ Bloating
- ☐ IBS
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Cholitis
- ☐ Chronic Constipation
- ☐ Diarrhea
- ☐ Always Hungry
- ☐ Gall Bladder Disease or Removal
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Celiac's Disease

FOR WOMEN ONLY
- ☐ Bleeding between periods
- ☐ Clots in period
- ☐ Excessive Menstrual Flow
- ☐ Severe/debilitating Cramps
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Severe PMS
- ☐ Previous or Chronic Miscarriage
- ☐ Scanty Menstrual Flow
- ☐ Infertility

Is there any chance that you could be pregnant?
- ☐ Yes
- ☐ No

THE INFORMATION ON THIS FORM IS CORRECT, TO THE BEST OF MY KNOWLEDGE

Signature _____.

Date _____.