

Welcome to WELLSTREAM ACUPUNCTURE

Feel Like Yourself Again!

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Confidential New Patient Information

Name _____ Date _____

Phone # _____ Email _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Birth Place _____

Age _____ Gender: M / F / T Ht _____ Wt _____ Marital Status _____

Occupation _____ Employer _____

Emergency Contact _____ Hm # _____

Relationship to Patient _____ Cel # _____

How did you hear about our clinic? _____

Primary Physician _____

Doctors Diagnosis _____

PRIVACY RIGHTS/HIPAA NOTICE

Our office is dedicated to providing health services with respect for privacy.

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. All health and general information discussed is private and confidential and will never go beyond Doctor and Patient. Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. We're happy to answer any questions you may have regarding HIPAA rules and regulations.

I hereby acknowledge that I have read WellStream Acupuncture's Notice of Privacy Practices.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released without patient permission pursuant to HIPAA regulations.

Primary Health Concern? _____

How long have you had this problem? _____ Have you had this previously? _____

How does this problem interfere with your daily activities? _____

What makes it better? _____ What makes it worse? _____

Is your condition: Constant Intermittent Pain Level: None Low Moderate Severe

Secondary Concerns you would like addressed? _____

Other concurrent therapies _____

How are you responding to your present course of treatment? Better _____ Worse _____ Same _____

Surgeries/Hospitalization *(please list dates also)*

Significant Trauma/Accidents _____

Do you have? Pacemaker Metal Implants Pregnant

Allergies _____

Medications (prescription drugs **AND** vitamins, supplements, herbs). Use back if you need more room...

Name _____ Dosage _____ To Treat? _____

Name _____ Dosage _____ To Treat? _____

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Name _____ Dosage _____ To Treat? _____

Name _____ Dosage _____ To Treat? _____

Name _____ Dosage _____ To Treat? _____

Name _____ Dosage _____ To Treat? _____

Name _____ Dosage _____ To Treat? _____

Stress None Low Moderate High Severe Please Explain Causes:

Exercise (type/frequency) _____

Habits: Cigarettes Coffee Tea Sodas Alcohol Drugs _____

Do you? skip meals snack eat large meals eat when rushed work and eat eat but not hungry

Average Daily Diet:

Morning _____

Afternoon _____

Evening _____

Snacks _____

Restrictions? (no gluten/dairy, vegan, etc...) _____

YOUR MEDICAL HISTORY

Cancer HIV+ Diabetes Heart Disease High Blood Pressure Low Blood Pressure Stroke
 Epilepsy Asthma Kidney Disease Anemia Bleeding Disorder STD Hepatitis Jaundice
 Thyroid Disease Chronic Fatigue Sudden Weight Loss Sudden Weight Gain

Other _____

Dates of Illness _____

FAMILY MEDICAL HISTORY

Cancer Diabetes Kidney Disease Heart Disease High Blood Pressure Stroke Epilepsy
 Low Blood Pressure Asthma Anemia Bleeding Disorder Hepatitis HIV+ Thyroid Disease

*For the following Sections on body systems function, please check X for any problems that are **new/acute OR chronic**. If you 'had it once' then skip checking that symptom. These questions help determine the energetic pattern of imbalance in your body to evaluate best treatment plan, and can be enlightening to you as well.*

MUSCULOSKELETAL PAIN

Neck Back Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes

Other area _____ Bones sore/painful Loss of Grip Swollen Joints Weakness

Leg cramps at night Tingling in feet Loss of feeling in hands/feet Muscle spasm/cramps

Stiffness all over Osteo Arthritis Rheumatoid Arthritis Tendinitis Sciatica

Onset of Pain: _____ Better with? _____ Worse with? _____

Describe the pain (ie: burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull)

HEAD, EYES, EARS, NOSE AND THROAT

Sinus Problems Mucus Nose Bleeds Runny Nose Congestion Frequent Colds Allergies

Sore Throat Dry Mouth Difficulty Swallowing Hoarseness/Loss of Voice Sensation of 'Lump' in Throat

Headaches (describe) _____

Dizziness Concussion Poor Memory Loss of Balance Head feels 'Heavy' Migraines

Eye Strain Eye Pain Floaters Blurred Vision Dry Eyes Watery Eyes Itchy Eyes

Ear Ache Ear Infections Hearing Loss Ringing/Buzzing in Ears Grinding Teeth TMJ

Tooth Pain Facial Pain Facial Paralysis Bells Palsy Other _____

LUNG SYSTEM

Shortness of Breath Difficulty Breathing Wheezing Cough Asthma Bronchitis

Pneumonia Difficulty Breathing When Lying Down Coughing Blood Coughing Phlegm

Sputum color? _____ Thick or Thin? _____ Other? _____

HEART SYSTEM

Insomnia Difficulty falling asleep Difficulty staying asleep Nightmares Restless. Sleep Apnea

Wake Easily Wakes frequently Wakes early : Time? _____ Heavy Sleep Snoring

Night sweating Cold Feet Cold Hands Swollen Hands/Feet Weakness in limbs

Fevers Chills Tremors Vertigo Dizziness Fainting Fatigue

High Blood Pressure Low Blood Pressure Pain/Pressure Chest Irregular Heart Beat Palpitations

SKIN/HAIR

Frequent Rashes Eczema Hives Itching Acne Dryness Clammy/Moist Oily
 Changes in Moles or Lumps Bleeds/Bruises Easily Varicose/Spider Veins Hair Loss Dry Scalp
 Change in Hair Texture Scars Other _____

DIGESTIVE SYSTEM

Poor Appetite Excess Hunger Feel tired if miss meal Cold Abdomen Weight Gain Weight Loss
 Strong Thirst: For cold? For hot? Crave Sweets Crave Salty Crave Sour
Specific food craving? _____ Weird food cravings? _____
 Heartburn Nausea Vomiting Belching Abdominal Bloating Foul Breath Stomach Pain

BOWEL MOVEMENT: Frequency(#/day) _____ Color _____ Quality (loose/firm) _____
 Diarrhea Constipation Flatulence Hemorrhoids Black Stools Bloody Stools Mucous Stools
 Pain/Cramps Sensitive Abdomen Foul Odor Colitis Irritable Bowel Chrohn's
 Sudden Energy Drop? At : _____(time) Fatigue Energetic Heavy Limbs Weak Limbs

URINARY SYSTEM

Pain/burning with Urination Pain before Urination Urgency to Urinate Incontinence Blood in Urine
 Kidney Stones Frequent Infections Strong urine smell Frequent Urination: Day Night
 Prostate Enlarged Elevated PSA Impotence Other _____
Urine color: _____ Amount:: (little/lots/not sure _____)

REPRODUCTIVE SYSTEM (for Women)

Pregnant? TTC? # of pregnancies _____ # of Deliveries _____ # Miscarriages _____ # of Abortions _____
Age Started menstrual cycle _____ Age Stopped _____ Last Monthly Period Date _____
Period Duration _____ Birth Control Method _____ Last PAP? _____
 Heavy Flow Light Flow Color (pale/dark/red/purple?) _____
 Irregular Periods Scanty Periods Missed Periods Dysmenorrhea Clots Cramps Spotting
 Vaginal Discharges: Yellow White Thick Thin Itching Odor
 Breast Lumps Breast Pain PMS Fibroids Endometriosis Low Backache Water Retention
 Hot Flashes. Menopause. Low Libido
Other _____

EMOTIONAL & NEUROLOGICAL

Nervousness Depressed Anxiety/Worry Easily Angered Easily Irritated Stressed
 Giddy Sadness/Grief Frequent Crying Mood Swings Suicidal Phobias/Fears Bi-Polar
 Panic Attacks Indecisive Other Emotional _____
 Seizures Tremors Numbness/Tingling Always Cold Always Hot Poor Coordination
 Neuralgia (pain) Shingles Other _____

Most Favorite:

Climate (dry/wet) _____
Season _____
Temperature _____
Taste _____
Food _____
Time of Day _____
Color _____

Least Favorite:

Climate (dry/wet) _____
Season _____
Temperature _____
Taste _____
Food _____
Time of Day _____
Color _____

*Thank you for completing this confidential health questionnaire.
Your honest, complete answers will assist me in providing you with the best possible health care.*

OUR PATIENT CARE FINANCIAL AGREEMENT POLICY

Effective January 1, 2019

Thank you for choosing Cindy Albon LAc, WellStream Acupuncture, as your healthcare provider. I am committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Missed Appointments and Cancellations

In order to prevent being charged a cancellation fee I agree to give at least 24 hrs notice of cancellation.

When we make an appointment, I am reserving time just for you. Sufficient cancellation notice allows us to offer your time to another patient who may be waiting for an appointment. **Last minute cancellations or missed appointments without 24 hr notice will be charged the full amount.** For patients arriving 10-15 minutes late or more, you may be able to have a shortened session. You may be asked to reschedule your appointment if there is not sufficient time to provide the best treatment to you, or to pay for the session in full.

Please help us provide the best care to you by keeping scheduled appointments in a timely manner. Late cancellations due to emergencies are understandable, in those cases the cancellation fee will be waived.

Rate Schedule

All sessions include AuriculoTherapy, Aromatherapy, Sound Therapy

Follow-up Acupuncture Treatment (established patient): 110 with E-stim: 120. with Cupping: 125

New Patient PAIN ONLY Consultation, Evaluation & Acupuncture Treatment: 145

New Patient Comprehensive General Health Consultation, Evaluation & Acupuncture Treatment: 175

New Patient Fertility, Cancer or Complex Health Consultation, Evaluation & Acupuncture Treatment: 225

Stop Smoking Program - Consultation, Counseling/Advice, and 6 Acupuncture sessions: 715

Cosmetic Facial Rejuvenation Acupuncture: 150 per session add on GuaSha Facial Massage: 35

Outcall Services to Patient's Home or Studio Lot: Please contact our clinic

Herbal Supplements: prices vary from \$10 - 45

Herbal capsules may be returned *unopened* for a full refund. No returns or refunds on custom herbal medicine extracts.

Rates are time based. Rates subject to change. The most current pricing may be on our website.

There is a \$45 fee for all bank returned (bounced) checks.

Regarding Insurance

We are In-Network providers for Cigna and will claim bill insurance for you. For all other insurances, we are out of network, and will provide you with a coded statement ("Super Bill") for submittal to your insurance carrier for direct reimbursement.

My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.

Payment is due in full at time of service. We accept cash, checks and cards.
In order to avoid a late cancellation fee, I agree to give at least 24 hrs notice.

X _____ Date _____
Signature of Patient or Responsible Party

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 REVERSE SIDE

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 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.

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

(Date)
OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE