Corvallis Acupuncture & Wellness Center, LLC
107 SW 2nd St. Corvallis, OR 97333
corvallisacupuncture.com
(541) 602-8172

Patient Confidential Information

Date_____ Name_____

Date of birth_____

Age____ Sex M F Marital status M S D W

Occupation_____ Do you enjoy your work_____

Email_____Phone (hm)_____ (cell)_____

Street address_____ city/state/zip_____

If we need to get in contact with you, may we contact you by phone____ email_____ by mail_____

Emergency contact_____ phone number_____

How did you hear about Corvallis Acupuncture and Wellness Center_____

Case History

What are your primary health concerns_____
_____
_____

Please list secondary health concerns you may have:_____
_____
_____

Is your health concern(s) a result of auto accident____ injury____ job related_____other_____

Date of accident/injury_____

Have you seen any other health care providers about this/these conditions_____ If so, who_____ may we contact them_____

Who is your current primary health care provider_____ what clinic_____ May we contact your health care provider_____

Date of last physical_____ Height_____ weight_____ weight 1 year ago_____

For Females: Are you pregnant_____ If yes, how far along_____

Please note that if you do become pregnant, it is important to tell me at your next appointment

For minors: both parents' names and address_____

Insurance Information

Do you have a personal, group health or accident insurance_____ if yes, please give:

Health Insurance Company_____

Address_____ phone number for providers_____

Subscriber Name_____ Group number_____ ID number_____

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

Date_____

Signature_____

Personal health history

Check the appropriate line if you have experienced any of the following:

__ Adverse reaction to medical treatment
__ Allergies seasonal __ environmental __ food
__ anemia
__arthritis
__ bleeding disorder
__ cancer or tumor
__ chemical dependency
__diabetes
__eating disorder
__ eye disorder
__ gout
__ headaches
__ heart disease
__ hepatitis, or liver disorder
__ herpes
__ high blood pressure
__ immune disorder
__ hernia
__ kidney disorder
__ low blood pressure
__ musculo-skeletal disorder
__ organ transplant
__ pacemaker
__ respiratory disorder
__ sciatica
__ seizures/epilepsy
__ skin disorder
__ specialized diet
__ intestinal disorder
__ stroke
__ thyroid disease
__ tuberculosis
__ ulcer
__ urinary tract disorder
__ venereal disease
__ other:_____

Is there anything else we should know about your medical history:_____
_____
_____

Major hospitalizations: If you have been hospitalized for any serious medical illness or surgery, please describe below. Do not include normal pregnancies.

Medication and Supplements:

Please list all over the counter medications, prescriptions, vitamins, herbs, etc. that you are currently taking.

Please list any allergies to medication:

_____

Previous Pregnancies:

	Year	length of pregnancy	labor hours	type of delivery
1.				
Complications				
2.				
Complications				
3.				
Complications				
4.				
Complications				

Lifestyle:

use of tobacco: __ yes __no If yes, # of cigarettes/day_____ age started_____

use of alcohol: __yes __no If yes, # of drinks a day/week_____ age started

use of caffeine: __ yes __no # colas/day____ # coffee/day____ #tea/day____

What sort of diet do you have? (please check)

__ standard American __ weight loss type __ fast/quick prep

__ vegetarian __ vegan __ raw food

__ low fat __ low carbs __ muscle building diet

__ balanced food groups

Please list foods and beverages that you consume in a normal week

Breakfast:	Snack	Lunch	Snack	Dinner	snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is nutrition or diet something you'd like to improve or be evaluated for? __ yes __no

Activity/Exercise:

What type of exercise do you do?_____ for how long_____

How many times/well_____

Activity level at work:_____

Activity level at home:_____

Would you like evaluation for the best form of exercise for your body and health __ yes __ no

How would you characterize your life in terms of stress?

__ high stress __ much stress __ fairly stressed __ mild stress

__ periodic stress __ no stress

Would you like to be handling stress better, or reduce the effects of stress? __ yes __ no

Do you currently experience any of the following moods often?

__ depression __ Anxiety __ insecurity __ anger __ irritability __ phobias

__ nervous __ sadness __mood swing __short temper __ obsessive thinking

__ isolated __ hopelessness __ thoughts of suicide

Would you like to be evaluated for possible treatment solutions for these states __yes __no

Please check off symptoms you have had in the <u>past 3 months.</u>

Part A:

__ Cough
__ Sore throat
__ hoarseness
__frequent colds/flu
__ swollen glands
__ painful lymph nodes
__ skin rashes
__ spontaneous sweating
__ Allergies
__ Itchy eyes
__ sneezing
__ nasal discharge
__ wheezing
__ grief/sadness
__ acne
__nasal congestion
__ sinus congestion
__ sinus pain
__Shortness of breath
__ chest tightness
__ crave spicy foods
__ fever/chills

Part B:

For following symptoms indicate if daily, weekly, or monthly:

__ Nausea_____
__ Vomiting_____
__ bloating_____
__ gas_____
__ belching_____
__ Acid regurgitation_____
__ stomach pain
__ ulcers
__bad breath
__ gum bleeding
__ excessive hunger
__ poor appetite
__bruise easily
__ # of bowel movements/day
__ loose
__hard
__painful
__ blood or mucus
__difficult to pass
__ odorous
__ burning
__ alt diarrhea/constipation
__ hemorrhoids
__Fatigue after eating
__ recent weight gain
__recent weight loss
__ slow wound healing
__frequently fatigued
Time of day_____
__ organ prolapse
__loss of taste
__ crave sweets
__ crave carbohydrates
__ heavy limbs
__ weak muscles
__ easily worried
__ foggy-headed
__edema/retain water
__varicose/spider veins

Part C:

__ irritability
__ frustration
__easily stressed
__ freq. angry outbursts
__rib side pain
__ frequent sighing
__ Dizziness
__Vertigo
__dry hair, skin, nails
__ dry eyes, floaters
__ red eyes
__ bitter taste in mouth
__ Eye pain/strain
__ neck/shoulder pain
__ tremors
__ blurry vision
__hiccups
__ sensation of Something in throat

Part D:

__ low back pain
__ poor hearing
__ear ringing
__ hair loss
__ premature graying
__ cold hands and feet
__ generalized cold feeling
__ warm body temperature
__knee pain

__scanty urination
__ urgent urination
__ profuse urination
__ color or urination_____
__ dribbling urination
__ frequent urination
__ nighttime urination
__ dark circles under eyes
__ high or low libido

__ fear/phobias_____
__ lack of will/drive
__ crave salt
__ swollen ankles
__ birth defects
__ developmental problems in childhood
__ osteoporosis
__ puffy under eyes

Part E:

__ palpitations
__ difficult falling asleep
__ wake during the night
__ disturbing dreams
__ jittery/easily startled

__ thirst
__ dry mouth/throat
__ sore tongue
__ poor memory

__ Anxiety
__ Depression
__ restless
__ night sweats

Men:

Last prostate exam_____
PSA results_____
__ prostatitis/ BPH
__low sperm count
__poor sperm mobility

__ low sperm progression
__difficult achieving erection

__ premature ejaculation

Women:

First day of last period____
# of days of bleeding_____
# of total days of cycle_____
pads/tampons per day_____
Color of blood:
__pale __purple
__bright red __ dark red
__ brown
__infertility
__ fibroids
__ age of menarche
pregnancies____
of live births_____

__ Cramping
__ mood swings
__ breast tenderness
__food cravings
__ Headaches w/ period
__ bleeding b/t periods
Clots __ large __ small
__purple __ red __ brown
__regular breast exam
__ breast lump/ fibrocystic
__ age of menopause

type of birth control
_____
__ pregnant
__ nursing
__ Abnormal pap test
__history of vaginal wart
__ pain with intercourse
__ abnormal vaginal discharge
__ hot flashes
__ GYN surgeries (date/type)_____
_____

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 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

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 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

AAC-FED

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____ _____
BIRTHDATE _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations -- and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient:
X_____ _____
Patient Signature or Legal Representative **Date**

Office Use Only:
Accepted
Denied _____ _____ _____
Signature Title Date

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& WELLNESS CENTER

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24 Hour Cancellation & “No Show” Fee Policy

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Corvallis Acupuncture & Wellness Center reserves the right to charge a fee of $45.00 for each missed (”*No Show*”) appointment, which is not absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. We will send you a text and email reminder of each appointment (*when we have your phone or email address*) but it is still your responsibility to check emails, junk mail and text messages.

Thank you for your cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed, Last Name, First Name Date

_____

Signature

Policy Effective: January 2019