COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature: _____	Parent / Guardian Signature _____	Witness Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____

A Healing Point
Acupuncture Center, PLLC
1329 Howland Blvd.
Deltona, FL 32738
Phone: 407-476-1818
E-mail: AHPAC1@gmail.com

Patient Intake Form

General Information

Patient Name (Print) _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____ Home#: _____ Phone#: _____
Cell#: _____ Is it okay to leave a detailed message at this number? Y ☐ / N ☐

May we use this email to send appointment reminders? Y ☐ / N ☐ Email Address: _____

**Please be advised that use of email does not guarantee privacy.*

☐ Pregnant Y ☐ /N ☐ ☐ Nursing Y ☐ /N ☐ ☐ Blood thinners Y ☐ / N ☐
☐ Smoker Y ☐ / N ☐ ☐ Diabetic Y ☐ / N ☐ ☐ Pacemaker Y ☐ / N ☐

☐ Communicable (contagious) conditions: Y ☐ / N ☐ : State Which:

_____

Occupation: _____ Employer: _____

Is your reason for being seen the result of an auto accident or workplace injury? Y ☐ / N ☐ *(If yes, please note, auto accidents/Workman's Comp cases are not being accepted at this time (01/2016 until further notice).*

How did you hear about acupuncture? _____

Gender: _____ Age _____ Date of Birth ____/____/____ Weight _____
SS# _____ Height _____ Marital Status: Single ☐ Married ☐
Divorced ☐ Seperated ☐ Widowed ☐

Who Is Your Primary Medical Doctor? _____ Date of Last Visit _____

Emergency Contact

Name _____ Relationship to you _____
Address _____ Phone _____

Name _____ Relationship to you _____
Address _____ Phone _____

Main Complaint

What is your primary reason for this visit? _____

_____

_____

This condition is due to _____
When did your symptoms begin? _____
Did your symptoms develop: ☐ Gradually ☐ Suddenly
How long do symptoms usually last? _____
Is there a pattern to your symptoms?
No Pattern ☐ In the morning ☐ In the evening ☐ All Day ☐ Occasionally ☐
Intermittently ☐ Constantly Constantly ☐ During Sleep ☐ Upon waking ☐
With movement ☐ With Rest ☐
Other _____

Patient Name (Print) :_____ **Date:**_____

What initiates your symptoms?

_____

What makes them worse? _____
What makes them better? _____
What other treatment/s have you received for this complaint?

_____

Did it help? Not at all ☐ Somewhat ☐ Very Effective ☐ Not Sure ☐

Other_____

Do you have specific questions you would like to discuss today?

_____

_____

_____

Have you received acupuncture/Chinese herbs in the past? Y ☐ N ☐
Name of Acupuncturist _____ Date of Visit _____ _____
Reason for treatments:

_____

_____

_____

List any illness for which you were hospitalized not requiring surgery

_____

_____

_____

List any illnesses requiring surgery including date

_____

_____

_____

List any other serious injuries (broken bones, scars, etc.)

_____

_____

_____

List allergies or sensitivities to any medications or substances (I.e. lotions, creams, ointments, aromas, Essential Oils, etc....) _____

_____

_____

_____

_____

_____

Patient Name (Print) :_____ **Date:**_____

Please list ALL medications and dosage including herbs, supplements, vitamins you are taking **and the reason each:**

Medication/Herb/Supplement	Dosage	Reason you are taking it

Allergies (Medications, herbs, foods, seasonal, etc.) **and the reaction you have from allergen** (hives, etc).

Allergic to:	Reaction (hives, etc.)	Severe/mild/moderate	Since: childhood, adulthood, etc.

PATIENT NAME: _____ **Date:** _____

ARBITRA TION 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, and 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 or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as 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 the 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 period C 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 the 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 (or Patient Representative)	X	(Date) (Indicate relationship if Signing for patient)

Copy of this document available upon request

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 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. 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.

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

a healing point acupuncture center

A Healing Point Acupuncture Center, PLLC
1329 Howland Blvd., Deltona, FL 32738
Ph:407-476-1818 Fax:321-275-4842
www.AHealingPointAcu.com
Dr. Yolanda M. Carrillo, AP, DOM
License#: AP3175

Cupping Consent Form

I hereby authorize Yolanda M. Carrillo, AP, DOM (Acupuncture Physician/Doctor of Oriental Medicine) and/or any other certified acupuncture physician or massage therapist, (hereinafter "Provider) to furnish vasopnuematic therapy also known as Fire Cupping, Vacuum Cupping, Silicon Cupping, or Manual Cupping.

Cupping Therapy

It has been explained to me, and I understand that cupping therapy will leave bruise-like ('hickey") marks that will last several days to several weeks depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear. These areas of bruising or discoloration are typically not painful, but can on occasion have soreness, itching and there may be soreness in the surrounding muscles. Cupping therapy is a medical treatment, not a novelty and should be treated accordingly. Your acupuncture physician will determine which areas are most appropriate for cupping, which type of cupping methods should be used and where how many cups should be applied, the length of time the cups should remain on and which cupping techniques (stationary, moving, etc.) to employ. This is not a service in which the patient should expect to dictate the terms of the service such as in a massage service.

Fire cupping - On rare occasions blisters my occur, either from the heat or from fluids being drawn to the surface by the cups and on occasion, however unlikely, a patient may experience a burn from the heated cups or heating implement. Small blisters should be left alone to heal on their own, while larger blister should be drained and dressed by the acupuncture physician.

I understand that cupping treatments can be a "detoxifying" treatment process and as a result, I may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to relieve these symptoms quickly. In some cases headaches and minor body aches may be experienced.

Contraindications

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patients or those who have been ill.
- Abdomen on pregnant women
- Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly.
- Those who are unable to experience heat or pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.

I_____, understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications. I further understand that there is a potential for burns and/or blisters due to the fire/heat aspect of the treatment. This is a rare but not unexpected occurrence.

_____ _____
Patient/Guardian **Date**

_____ _____
Witness or Practioner **Date**

OFFICE POLICIES

NO SHOW/LATE CANCELLATIONS If an appointment is missed or not cancelled with 24 hours prior notice to the scheduled time, a fee of $55.00 will be charged. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. Insurance will not reimburse the patient for this charge, nor will we bill the insurance for the visit. Our office staff makes appointment confirmation by phone as courtesy to our patient. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

AFTER-HOURS APPOINTMENTS All appointments made outside regular hours require staff to come in on their day off or after hours. Should you miss or cancel an after-hour appoint you may be charged for the entire visit there are no exceptions. A credit card may be required to hold your appointment and it will be charged the full amount of your visit should you not show or cancel outside a reasonable time.

MEDICAL RECORDS RELEASE Should you need copies of your records or other documents including receipts and income tax-related documentation, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. A completed and signed record release must be done before any records are released. If records are not being directly released to another physician's office, there will be a fee of $2.50 per page for the first 10 pages and 0.90 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of reproduction, payable prior to release.

AFTER HOURS AND EMERGENCIES In the event of an emergency situation, call 911 or go to the nearest Emergency Room. If you have an urgent concern that you need to discuss with the physician, please call our office to schedule your appointment. A" phone message left in the voicemail will be returned within 24 hours by the office Tuesday - Saturday. We are closed Sundays and Mondays and major holidays.

POLICY REGARDING SMALL CHILDREN. We love children at A Healing Point Acupuncture Center, PLLC; however, due to safety and noise issues we ask that all children under the age of nine (9) be left at home. The exception is children receiving treatment. Zen-like moments can be disturbed by fighting or crying children and parents will have a difficult time relaxing when worried about the little ones. For safety reasons children are prohibited from waiting in a treatment room while parents/guardians receive treatment.

TREATMENT OF MINOR CHILDREN. Children under twelve (12) being seen for treatment MUST be accompanied by a parent or guardian who is legally able to consent to treatment and make medical decisions on behalf of the minor child.

FAMILY & FRIENDS IN THE TREATMENT ROOM. With the exception of a parent accompanying a minor or a caretaker accompanying a disabled or unsteady individual. Family and friends are asked to wait in the lobby.

COMPLAINCE A treatment plan will be tailored to your condition. Missing appointments and otherwise not adhering to your treatment plan will interfere with your progress. Patients who deviate from the prescribed treatment plan may be discharged for non-compliance.

REFUNDS. Refunds on herbs will only be offered if they are returned within seven (days) of the date of purchase and are unopened, with the seal still intact. There are no refunds on services or opened products for any reason. Refunds on remaining package treatments will be refunded at the amount of the regular/full price service, not the discounted price as the package pricing would no longer apply.

TIMED SERVICES Massage and timed services are timed per industry standard. 50 minute hour and 25 minute half hour. Time to disrobe and conduct intake is factored in. To get the most time out of your service, please arrive at least 15 minutes prior to your service to allow time for check in. To get the most hands-on service time it is recommended you do not wait until your service is to start to arrive/check in and/or use the restroom. Services will not be extended to accommodate late arrivals as there is likely another service booked following yours. A timer is kept visible in each treatment room. Please monitor the time display on the timer as you may be required to sign for timed services (if we are billing your insurance.)

TURN OFF CELL PHONES. To help promote our relaxing atmosphere, we require phones be turned off or on vibrate while inside the clinic and no phone calls during treatment. Phone calls should be taken outside. Rest, relax, breathe and disconnect. Let the healing being.

FORMS AND REPORTS There will be a $50-$60 administrative fee for forms such as disability reports and letters of medical necessity. The fee will be determined based on the complexity of the document. Please allow seven (7) to ten (10) days for these reports to be completed. RECIPTS & TAX DOCUMENTS Please save your receipts. Each year we get dozens of requests from patients who lost or failed to save their copies. The forms and reports fees apply to compiling of copies of receipts and payment information.

CHECK POLICY. No personal checks will be accepted on NEW PATIENT visits. Any returned checks will incur a $50.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections agency, there will be a $95.00 fee for each account and you are responsible for any collection, court, or attorney fees. It is the responsibility of the patient to fully understand the rules and regulations of their insurance company and plan coverage.

I, _____ have read the above policies and understand my rights and agree to abide by said policies.

Printed Name _____ Signature _____ Date _____

Copy of this document available upon request

Financial Responsibility / Assignment of Benefits

I hereby authorize Dr. Yolanda Carrillo, AP, DOM and/or any other licensed provider at A Healing Point Acupuncture Center, PLLC (hereinafter "Provider) to furnish acupuncture, massage therapy, ultrasound therapy, kinesiology taping, neuromuscular or manual therapy, injection therapy as long as said method of treatment falls within said provider's scope of practice. Moxibustion, Gua Sha, cupping therapy and/or various other therapeutic treatments and any other therapies within the provider's scope of practice including but not limited to recommending herbs and supplements.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying time of service charges, my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say now, and that the Provider will bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the acupuncture treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pay all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. **I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider & or A Healing Point Acupuncture Center, PLLC.**

I understand that the Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I hereby request that my insurance carrier make payment directly to A Healing Point Acupuncture Center, PLLC or the rendering physician for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits and are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

_____ _____

Patient or if a minor, Patient's Guardian Date

Copy of this document available upon request

Fainting

Fainting during acupuncture

Acupuncture is a safe treatment; however, a *small* number of patients experience Light-headedness and some faint. This is a very rare occurrence. This is generally caused by nervousness, though dehydration and sudden changes in blood sugar can play role. To help prevent fainting, you should drink plenty of water and eat a light snack (not a heavy meal) prior to each treatment.

Fainting Causes

Fainting (syncope) is a sudden loss of consciousness from a lack of blood flow to the brain. Fainting victims usually wake up quickly after collapsing because once a person goes from vertical to horizontal, blood starts flowing back into the brain and they begin to wake up. It can be quick or it can take a while: everybody's different.

Most fainting is triggered by the Vagus nerve, which connects the digestive system to the brain, and its job is to manage blood flow to the gut. Unfortunately, the Vagus nerve can get a little too excited and pull too much blood from the brain, resulting in fainting.

Symptoms of fainting

Before fainting, a victim can exhibit or feel all or some of these signs and symptoms, depending on the cause of the fainting:

Dizziness or feeling Lightheaded	Tunnel vision or blurred Vision	Trembling or shaking
Confusion	Sweating	Eye Shifting/ shaking (nystagmus)
Nausea	Flushed or pale color	Headache
Sudden trouble hearing	Feeling hot & or Weakness	Shortness of breath

Common symptoms that can occur after fainting

Sweating stops	Rapid pulse or "racing heart"
Color begins to return	Loss of bowel or bladder control

Common fainting triggers during acupuncture

Psychological Triggers

Anxiety or nervousness and stress can stimulate the Vagus nerve in some people and lead to a loss of consciousness. In regards to acupuncture, those who faint are most often first-timers, experiencing some anxiety over the needles.

Dehydration

Too little water in the bloodstream lowers blood pressure, stimulating the vagus nerve. Dehydration coupled with nervousness over acupuncture creates a double-whammy. Toss in failing to eat a light snack prior to treatment and the odds of fainting or at least becoming light-headed are increased.

Fainting facts and general information

There are other causes of fainting, including, but not limited to, heart conditions; however, nervousness and dehydration are the most common in regards to acupuncture. All by itself, fainting is not life-threatening; however, sudden cardiac arrest looks a lot like fainting and requires immediate treatment.

If you feel suddenly flushed, hot, nauseated or break out in a cold sweat, don't try to stand up. Lie down until it passes. If it doesn't pass in a few minutes or you begin to experience chest pain or shortness of breath it is our policy to call 911.

Whenever someone passes out in our office and/or fails to become fully alert (recite day, month, year and name of president) within a few moments of fainting or feeling light-headed, it is our policy to call 911. Your safety is our primary concern.

I, _____ (please print), have read the above information on fainting and understand that eating a light snack and drinking plenty of water prior to acupuncture is important and failing to do so may cause light-headedness and in some cases, fainting.

_____ _____

Signature Date

Copy of this document available upon request

Privacy Policy

All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit **written** consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena. summons or other court order. Copies of our detailed Privacy Policy is attached and additional copies are available upon request, are posted online and are posted near the front desk and are on most intake clipboards.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of A Healing Point Acupuncture Center, PLLC Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in A Healing Point Acupuncture Center, PLLC Notice of Privacy Practices, please do not hesitate to contact a clinic representative of A Healing Point Acupuncture Center, PLLC Patient Privacy Officer as indicated on your Notice.

_____ _____

Patient Name/Patient Representative (Printed) Date

_____

Signature of Patient/ Guardian / Custodian

☐ ☐ ☐