Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: ☐ Female ☐ Male ☐ Other What is your preferred pronoun? _____

How were you referred to us? _____

Occupation: _____ Does your job require that you work outdoors? ❍ No ❍ Yes

What would you like to achieve from your treatment today? _____

_____

YOUR SKIN CARE

1) Have you ever had a facial treatment before? ❍ No ❍ Yes, when? _____

2) Have you ever had a body spa treatment before? ❍ No ❍ Yes

   If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

☐	Type I	Fair skin tones—Always burns, never tans
☐	Type II	Light skin tones—Burns easily, tans slightly
☐	Type III	Fair to olive skin tones—Burns moderately, tans moderately
☐	Type IV	Light brown skin tones—Burns slightly, tans easily
☐	Type V	Dark brown skin tones—Rarely burns, tans easily
☐	Type VI	Dark brown to black skin tones—Never burns, tans easily

4) Do you have any special skin problems or concerns pertaining to your face or body? ❍ No ❍ Yes

   If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? ❍ No ❍ Yes

   In the last month? ❍ No ❍ Yes

6) Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products? ❍ No ❍ Yes

   If yes, please specify what and when last used: _____

7) Have you used acne medication? ❍ No ❍ Yes, when? _____ Which medication? _____

8) Have you experienced Botox, Restylane, or collagen injections? ❍ No ❍ Yes

   If yes, please specify: _____

9) What skin care products are you currently using? (List brands if known)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products _____

Soap _____ Shower Gels _____

Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? ❍ No ❍ Yes (Check all that apply)

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing
☐ Stringing ☐ Depilatories ☐ Other: _____

11) Do you experience irritation from shaving? ❍ No ❍ Yes

If yes, please specify: _____

12) Do you experience ingrown hairs as a result of hair removal? ❍ No ❍ Yes

13) What areas of concern do you have regarding your: **Skin** (Check all that apply)

☐ Breakouts/acne ☐ Uneven skin tone ☐ Blackheads/whiteheads
☐ Sun damage ☐ Excessive oil/shine ☐ Wrinkles/fine lines
☐ Rosacea ☐ Dull/dry skin ☐ Broken capillaries
☐ Flaky skin ☐ Redness/ruddiness ☐ Dehydrated
☐ Sun/liver/brown spots ☐ Other: _____

Eyes (Check all that apply)

☐ Dehydrated ☐ Wrinkles ☐ Puffiness
☐ Dark circles ☐ Other: _____

Lips (Check all the apply)

☐ Dehydrated ☐ Cracked/chapped lips ☐ Other: _____

14) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____

☐ Cosmetics ☐ AHAs ☐ Medication
☐ Fragrance ☐ Food ☐ Shellfish
☐ Animals ☐ Latex ☐ Sunscreens
☐ Drugs ☐ Iodine ☐ Pollen
☐ Other: _____

15) What SPF do you use on your face? _____ How often/when? _____

16) Have you recently used any self-tanning lotions, creams, or treatments? ❍ No ❍ Yes

If yes, please specify: _____

17) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ❍ No ❍ Yes

If yes, please specify: _____

HEALTH HISTORY

18) Are you taking any oral contraceptives? ❍ No ❍ Yes

If yes, please specify: _____

19) Have you experienced any recent changes to or from your contraceptives? ❍ No ❍ Yes

If yes, please specify what and when: _____

20) Are you pregnant or trying to become pregnant? ❍ No ❍ Yes

21) Are you experiencing any menopausal symptoms? ❍ No ❍ Yes

If yes, please specify: _____

22) Are you currently undergoing any hormone therapy treatments? ❍ No ❍ Yes

If yes, please specify: _____

LIFESTYLE

23) How many glasses of water do you drink per day? (Please check one)
☐ <1 glass ☐ 1-3 glasses ☐ 4-7 glasses ☐ 8+ glasses

24) How many caffeinated beverages (coffee, tea, soda, etc.) do you consume per day? (Please check one)
☐ None ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6+ drinks

25) How many alcoholic beverages do you consume per week? (Please check one)
☐ I don't drink ☐ 1-3 drinks ☐ 4-7 drinks ☐ 8+ drinks

26) How many hours of sleep do you get per night? (Please check one)
☐ <3 hours ☐ 3-5 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10+ hours

27) Which foods do you consume on a regular basis?
☐ Fruits ☐ Vegetables ☐ Dairy/Eggs ☐ Cheese ☐ Poultry
☐ Fish ☐ Grains/Bread ☐ Processed Sugar ☐ Processed Meats

28) What does your daily commute look like?
☐ Car ☐ Bike ☐ Public Transport ☐ Walk ☐ I don't commute

29) How often do you travel on a plane?
☐ Never ☐ 1-2 times per year ☐ 1-2 times per quarter ☐ Every month ☐ Every week

30) How many hours do you spend in front of a screen or digital device?
☐ <3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ 10-12 hours ☐ 12+ hours

31) Do you exercise on a regular basis? ❍ No ❍ Yes

32) Do you smoke cigarettes, vape, or consume other tobacco products? ❍ No ❍ Yes

33) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)? _____

FUTURE APPOINTMENTS/CONTACT

May I call you at the provided phone number to confirm future appointments? ❍ No ❍ Yes

May I contact you via mail/email about future promotions and news? ❍ No ❍ Yes

Client Consultation—Continued

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client Name (Printed): _____

Client Name (Signature): _____ Date: _____

CONSENT TO ADVANCED or CLASSIC ESTHETICS TREATMENT

NAME _____ **DATE of BIRTH** _____

ADDRESS _____

CELL PHONE _____ **WORK PHONE** _____ **EMAIL** _____

SKIN TYPE: Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin; rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

TECHNICIAN: Yolanda M. Carroll

Procedure(s): This Informed Consent to Treat applies to two classifications of Esthetics care: Advanced Esthetics Services and Esthetic Classic Services. **Check the type of esthetic services below** applicable to you. Check both if you anticipate receiving treatment under both categories. Consult your technician if you have questions about the nature of treatment anticipated for you:

- ☐ **Advanced Esthetic Services:** Which includes Esthetic peels up to 40%, electrology, needling/collagen induction therapy, non-invasive ultrasound, and hand-held cryotherapy.
- ☐ **Esthetic Classic Services:** Which includes Body contouring, cellulite reduction, radio frequency, and high frequency treatments.

I elect to receive the esthetics procedure(s) indicated above. I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and am not an insulin-dependent Diabetic. I understand that if I am under the age of 18, Parental Consent is required for me to obtain these procedures. Under no circumstances may I have these services if I am under the age of 14. I represent that the stated date of birth is truthful on this form.

I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results. I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take. I understand that due to the nature of this treatment, results cannot be predicted, and I acknowledge that no guarantees have been made as to the results that may be obtained.

Warning: Treatment is not available to clients who are on *Accutane.* Clients using *anticoagulants* must disclose this to the Technician, as treatment may need to be modified to mitigate additional risk associated with the use of these drugs. Clients with a pacemaker, internal defibrillator, or metal implants must disclose this to the Technician as this may contraindicate them for treatment. For women of childbearing age: You confirm that you are not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, you must keep your technician informed should you become pregnant during the course of treatment.

Pre-Procedure and Aftercare Instructions: I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that for those with more color in the skin, it is advised to use a lightening agent leading up to the procedure to suppress the melanin in the skin. I understand there may be an extended period of recovery following the procedure(s), and that aftercare compliance is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation. I understand that particularly avoiding sun exposure after the procedure is crucial to reduce the risk of color change and will always apply a broad spectrum SPF 25 or higher, as recommended by my technician. I understand that initially, the skin treated may be red and swollen, that fine, thin scabs may form, and that the healing process typically takes anywhere from one to three weeks. However, I am aware that in rare cases, depending on my skin sensitivity and recovery capacity, healing could take as long as three to six months.

General Risks of Procedure(s): I understand there are risks associated with my procedure, including, but not limited to: minor burns, blistering, hypopigmentation (lightening of the area), hyperpigmentation (darkening of the area), swelling, allergic reactions, bruising, scarring, pin-point bleeding, pimple-like bumps, dry skin, tingling, and other similar side effects and/or reactions. I understand these risks also include, but are not limited to, the following:

1. **Scarring:** This treatment can create bruising and a moderate burn or blister to the skin. Depending on treatment received, more serious side effects may include, skin indentations or subcutaneous fat loss, and open sores that lead to infection.
2. **Pigmentation:** The treated area may become either lighter (hypo-pigmented) or darker (hyper-pigmented) in color. This is rare and is usually just temporary, however may become permanent.
3. **Infection:** Although infection following this treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes Simplex virus infections around the mouth can occur following a treatment, even if there is no past history of Herpes Simplex virus infections in the mouth area. Clients with a history of Herpes Simplex virus in the treated area are encouraged to seek preventative therapy. Should any type of skin infection occur, additional treatment, including antibiotics, may be necessary.
4. **Skin tissue pathology:** Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment. Treatment directed at abnormal lesions can cause malignant cells to develop and laboratory examination of the tissue specimen may not be possible.
5. **Allergic reactions:** Due to skin surface disruption, irritation and histamine reactions may occur resulting in itching, dermatitis, or other forms of sensitivity. In rare cases, local allergies to topical preparations have been reported.

I certify that this consent has been fully explained to me, that I have read the above paragraphs, and that I elect to receive the advanced esthetic procedure(s) indicated above. I understand the various risks associated with the procedure(s) and the importance of properly following pre-procedure and aftercare instructions to minimize those risks.

CLIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

TECHNICIAN SIGNATURE: Yolanda M. Smith **DATE:** _____

NOTICE: Occasionally, unforeseen problems may occur, and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

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: _____

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

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

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

Common symptoms that can occur after fainting

- Sweating stops
- Color begins to return
- Rapid pulse or "racing heart"
- 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 any procedure & or 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

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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

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Signature of Patient/ Guardian / Custodian

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