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 ___________________ Work Phone ____________________________
Cell Phone ______ ________________ Is it okay to leave a **detailed** message at this number? Y/N

May we use email to communicate with you? Y / N Email Address: ________________________

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

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

☐ Smoker 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 accident cases are not being accepted at this time (01/2016 until further notice).

How did you hear about acupuncture? _________________________________

Who is your primary health care provider/MD? ____________________________

Gender: M / F Age _____ Date of Birth ____/____/____ SS# __________________
Current Weight _______ Current Height _________ Marital Status: Single ____ Married ____ Divorced ____
Separated ____

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
___ 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….) ____

____

____

____

____

____

Consent to Treat Form

I hereby request and consent to the provision of services rendered by Dr. Yolanda Carrillo, AP, DOM and/or other licensed providers at A Healing Point Acupuncture Center, PLLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, manual therapy, electrostimulation, ultrasound therapy, neuromuscular reeducation and/or other physical therapy modalities, cupping therapy, bleeding therapy, Gua- Sha, vitamin injections, liptropic injections, recommendations for herbs and supplements, kinesiology taping, ultrasound therapy, laser therapy, injections, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling and other modalities within the provider's scope of practice. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell and/or taste.

I understand that post treatment flare-ups (increased symptoms) are a normal and expected part of healing, however, I will immediately notify A Healing Point Acupuncture Center, PLLC of any increased pain or symptoms or if I am worried or concerned about any aspect of treatment or recommendations made by the provider. I understand the front desk and support staff and massage therapists
are not qualified to give me medical advice or treatment recommendations.

I have been informed that acupuncture and physical therapy are generally safe methods of treatment, but that it may have some side effects, including but not limited to, soreness, bruising, numbness or tingling near the needling sites of needle insertion or manual work, dizziness or fainting. Bruising and tenderness are common side effects of acupuncture, injections, and massage and physical medicine modalities.

Rare or 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 disposable sterile needles and maintains a clean and safe environment. Some potential risks of injections of any type are bruising, tenderness, allergic reaction to products or devices, numbness, muscle soreness or nerve damage. Some of our injections are manufactured with lidocaine. If you've ever had a reaction to lidocaine or any local anesthetic, please inform us. Burns and/or scarring are a potential risk of moxibustion and fire cupping.

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 Oriental Medicine, although some may be toxic in large doses. I agree to inform the provider at time of product recommendation if I am on blood thinners, have a heart condition, am breast feeding, have diabetes or am on any medications, though ultimately it is my responsibility to research herb-drug interaction before choosing to take any herbs, vitamins or supplements that are recommended. 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 clinician and or 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 and my records may be shared with my insurance company to facilitate payment 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.

______________________________ ______________________
OFFICE SIGNATURE Date

______________________________ ______________________
PATIENT SIGNATURE Date

(Relationship: Self / Guardian / Custodian)

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
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 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

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

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 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