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.

Insurance Information

Primary Insurance Company:

_____

Is this Insurance through your or your spouse's Employer? (If Spouse, Please write his/her Employer Name)

_____

Name of Policy Holder _____ Policy ID No. _____
Group No. _____ SSN: _____ Ins. Phone Number: _____

Secondary Insurance Company: _____

Is this Insurance through your or your spouse's Employer? (If Spouse, Please write his/Her Employer if Different then listed above): _____

Name of Policy Holder _____ Policy ID No. _____

Group No. _____ SSN: _____ Ins. Phone Number: _____

Check any illnesses which have occurred in any of <u>your blood relatives:</u>

☐ Alcoholism ☐ Allergies ☐ Bleed Easily
☐ Cancer/Type: _____ Radiation Treatments & Number: _____
☐ Chemotherapy Treatment & Number: _____
☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Low Blood Pressure
☐ Heart Attack ☐ Stroke ☐ High Cholesterol ☐ Kidney Disease ☐ Liver Disease
☐ Obesity
☐ Mental Illness(s)/ Type: _____
☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Multiple Sclerosis ☐ Vascular Disease

a healing point acupuncture center

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MIGUN™ THERAPY INFORMED CONSENT

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

If you have any of the following conditions, please inform us ***prior*** to your Migun™ therapy as you may be required to consult your physician for clearance prior to use or you may not be a candidate for Migun™ therapy. Your safety is our primary concern. Check the box for any conditions which may apply:

- ☐ Phlebitis/blood clots
- ☐ Diminished sensation/lack of feeling due to injury or illness (unable to properly feel heat or pressure) such as paralysis, diabetes, etc.
- ☐ Fused discs or implanted spinal/scoliosis rods or any other spinal hardware/implants that react to heat or which cannot tolerate pressure from massage
- ☐ Fractures or suspected fractures or other traumatic injuries that are not healed
- ☐ Malignant tumors or currently receiving cancer treatment
- ☐ Are currently pregnant (Can be allowed with MD Authorization)
- ☐ Reactive skin disorders such as prickly heat rash or photo allergic dermatitis
- ☐ Surgery with in the past 6 months
- ☐ Other condition: _____

I understand that Migun™ therapy is an FDA approved Class II medical device which may provide positive change in chronic pain and other conditions, and while generally considered a safe modality, there are potential side effects or adverse effects that I may experience including but not limited to possible muscle soreness, bruising or tender spots, reactions to the heat therapy such as red spots or rashes (do not place Migun™ handheld devices directly on skin, we have provided towels for barriers to protect your skin), dizziness upon rising from the therapy table, nausea, skin eruptions (pimples, boils, etc.), digestive changes (diarrhea), flu-like symptoms from detoxification, headache, tingling and tiredness. I have carefully read this Informed Consent, understand it and either do not have any of the conditions referenced above and/or have received clearance from a doctor to proceed with this therapy and/or have made an informed decision to assume the risk(s) and receive the therapies anyway because I believe the potential benefits outweigh the potential risks and wish to receive therapy using a Migun™ device.

Client/Patient name (Print): _____ Date: _____

I have been provided the opportunity to review the informed consent and question the and the use of the device(s), potential benefits, side effects, adverse effects and contraindications which were discussed with me and I have been provided an opportunity to address any questions or concerns in advance, during my treatment and have been advised that I may also discuss the therapy afterwards in person, via telephone or email should I have any questions or concerns. I have been informed that should I require assistance getting on/off treatment tables/devices, I must bring someone with them to assist me as East Lake Acupuncture's staff may not be trained in proper lifting/transfer techniques and are unable to assist me with these maneuvers for my safety and theirs.

_____	_____	_____
Printed Name	Signature	Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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

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

☐ ☐ ☐