AS YOU ARE
ACUPUNTURE

New Patient Intake

Today's Date: _____ Referred by: _____

First Name: _____ Last Name: _____

Address: _____ City/State/Zip code: _____

Cell phone: _____ Email: _____

Biological Sex: _____ Preferred Pronouns: _____

Birth Date: _____ Age: _____ Blood Type: _____

Occupation: _____ Employer: _____

Marital Status: _____ Children (number/age): _____

Height: _____ Weight: _____

Emergency Contact Name:_____ Contact Phone: _____

PCP Name: _____ PCP number: _____

Main Diet: Food Cravings (*what kind?*):
Family Medical Problems (what & who?):
Previous Surgeries/Hospitalizations:

Present Main Complaint(s) in order of significance to you:

1. _____
2. _____
3. _____

How do these affect your daily life?

Doctors seen for complaint:

Stress on a scale from 0-10 (low-high):

Where do you hold stress in your body?

When does your energy highest?

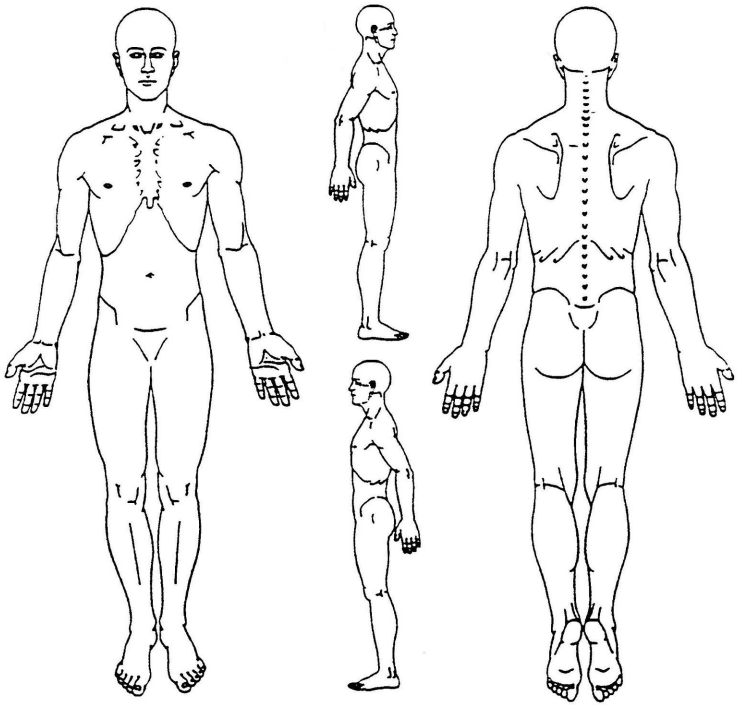
When is your energy lowest?

Medications + Supplements (dosage, what for, year started?):

Women only:
Date of last menstrual period: _____ Length of cycle: _____

PMS symptoms (if any): _____ Trying to conceive: YES NO

Pain profile: *Please circle any areas of pain (skip if no pain)*



Level of pain from (1-10):

_____

Frequency of pain (1-10):

_____

Is the pain:
☐ Sharp ☐ Burning ☐Aching
☐ Fixed ☐ Dull ☐Moving
☐ Cramping
☐Other: _____

What makes the pain better?	**What makes the pain worse?**
☐ Pressure ☐ Cold ☐ Heat ☐ Damp ☐ Rest ☐Other: _____	☐ Pressure ☐ Cold ☐ Heat ☐ Damp ☐ Wind ☐ Movement ☐Other: _____

Anything else you'd like to mention?

Constitutional checklist: *rate how much the follow conditions affect you by circling*

low energy	often	sometimes	not really
depression	often	sometimes	not really
anxiety	often	sometimes	not really
irritability	often	sometimes	not really
forgetfulness	often	sometimes	not really
insomnia	often	sometimes	not really
low appetite	often	sometimes	not really
heartburn	often	sometimes	not really
nausea	often	sometimes	not really
bloated abdomen	often	sometimes	not really
gassy	often	sometimes	not really
constipation	often	sometimes	not really
diarrhea	often	sometimes	not really
sweating easily	often	sometimes	not really
thirsty	often	sometimes	not really
frequent urination	often	sometimes	not really
incontinence	often	sometimes	not really
edema in legs	often	sometimes	not really
brain fog	often	sometimes	not really
headache	often	sometimes	not really
ear ringing	often	sometimes	not really
hard to hear	often	sometimes	not really
dizziness	often	sometimes	not really
eye strain	often	sometimes	not really
stuffy nose	often	sometimes	not really
sore throat	often	sometimes	not really
heart palpitations	often	sometimes	not really
chest pain	often	sometimes	not really
low libido	often	sometimes	not really
dry skin	often	sometimes	not really
itchy skin	often	sometimes	not really
cold hands/toes	often	sometimes	not really

Informed Consent to Traditional Chinese Medicine (TCM) Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the practitioners on staff at **As You Are Acupuncture** who now or in the future treat me while employed by, working or associated with or substituting for **As You Are Acupuncture**, including those working at this clinic, or any other associated clinics: acupuncture and other Traditional Chinese Medicine (TCM) procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing, modes of manual stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioners and/or with other clinic personnel the nature and purpose of acupuncture and other TCM procedures. Although I am aware that acupuncture and the other procedures used in TCM have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of TCM there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgement, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and TCM treatments may not have the desired therapeutic effect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at the **As You Are Acupuncture** clinic.

Patient's name (please print)	Patient's signature
Patient representative name/relationship	Patient Representative signature
Date	Date

AS YOU ARE ACUPUNTURE

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, We are required to have you respond affirmatively to at least one of the following statements before you may be treated. ***Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.*** (Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (*print name*) _____ am notifying **As You Are Acupuncture** of the following:

□ Yes □ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR □ Yes □ No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR I have NOT been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- □ Chronic Pain
- □ Smoking addiction
- □ Weight loss
- □ Alcoholism
- □ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

ACUPUNCTURIST'S SIGNATURE DATE

AS YOU ARE ACUPUNCTURE

New Patient Information

Please initial next to each paragraph and sign below:

____ **Cancellation Policy and Late Arrivals (15 minutes late or more)** - Treatments are by appointment, although walk-ins are often able to be accommodated. Life happens! If you find that you need to cancel an appointment, please call or email us as soon as you are aware you need to. We reserve the right to charge 75% of our fee if you cancel within 24 hours of your appointment. If the appointment is rescheduled for another time that same day and we can accommodate it, the fee is waived. You will receive a reminder text 2 days before as well as 1 day prior to your appointment. Payment is due at the time of booking for house calls and upon arrival in the clinic.

____ **Payment for Clinic Services Rendered** - Payment is due at the time of service at clinic and may be paid with a medical savings account card, flexible spending account card, health savings account card & all major credit cards. For house calls, payment is due upon booking. We are happy to provide you with a superbill so you may file with your insurance carrier.

____ **Use of Media** - We occasionally use pictures or video of patient progress on social media for marketing purposes. It is your choice as to whether or not you allow this. We will ask you for permission before taking pictures or video and you are encouraged consent or decline at that time, as well.

Allow **As You Are Acupuncture** to use photos or videos of my treatments & progress?

YES NO

_____ _____

PATIENT NAME (PRINT) DATE

_____

PATIENT SIGNATURE

AS YOU ARE
ACUPUNTURE

Notice of Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. We will only use and/or disclose your protected health information when the law allows us to do so. Any other use and disclosures will be made only with your authorization and, in those instances; you have the right to revoke that authorization. And if so, that authorization would be honored, where legal to do so, from that date forward.

> Treatment: For example, from time to time, our practitioners may decide that it is medically necessary to refer you to a specialist for additional care. That practitioner will need your medical information in order to be able to treat you and that is why we send out your records.
> Payment: Many of our patients utilize medical insurance that actually pays for their treatment. The insurers require your medical information to know how to pay us or your care and that is why we send out your records.
> Health Care Operations: We are allowed to disclose your medical information if that is necessary for our office to function efficiently. There are also times when we may need the help of a special vendor, such as a medical billing specialist, and we would then send your records to that vendor in order for us to carry on our business.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

This office has many practitioners. We reserve the right to share your file information within the confines of the professional and academic practices.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, holiday cards, thank you cards, newsletters and appointment reminders, by calls, postcards or letters.

Disclosure
This office may use or disclose your Protected Health Information when required by law. This includes but is not limited to Public Health needs, Health Oversight requirements, and issues of abuse or neglect, legal proceedings.

Patient Rights

- **Upon written request you have the right to access, review or receive copies of your healthcare records.** Exceptions are: 1) psychotherapy notes; 2) information we gather in preparation of an administrative action or proceeding; 3) data that is subject to certain provisions of the Clinical Laboratory Improvements Act. We may deny your request (in writing) under certain limited circumstances. Generally, if we agree to provide you with a copy of your records, we will do so within 15 days after you ask for it. We may charge you a reasonable, cost-based fee for the records.
- **Upon written request you have the right to receive a list of items this office disclosed about your healthcare information**. We are required to give you that data except for any use or disclosure: 1) for treatment, payment and/or health care operations; 2) made with your authorization; 3) that we make to you; 4) for any national security or intelligence purposes; 5) made before July 1, 2020; or 6) that does not require your authorization. We will provide this date for you (generally within 60 days) at no charge once each year, but after that, we will require that you pay a reasonable fee-based charge for the information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. You may ask that we limit the use and disclosure of your protected health information; we are not required to accept your request. If we do agree, however, we will do as you wish except in an emergency. You may submit your request to us in writing and tell us: 1) what information you want us to limit 2) how you want us to limit that data and 3) to whom we are to limit the access to this data.
- **You have the right to request that we amend your Protected Health Information; the request must be in writing.** We have the right to deny that request if you ask about medical information that 1) was not created by any of our practitioners; 2) the information is not part of the medical or billing records; 3) is not part of the records you may access or 4) the medical information is accurate and complete. We may ask that you tell us, in writing, why you want us to amend your medical information. Generally, we must act upon your request within 60 days after receipt of your request. If we agree to your request, we must make the appropriate amendment and follow the law regarding how and whom we inform about this amendment. If we do not agree, then we will tell you our reasons. You then have additional rights, including an appeal (by someone who did not participate in the decision not to allow you to amend your record) and you have the right to submit a written statement of disagreement.
- **You have a right to receive all notices in writing.**
- **You have the right to receive confidential communication by alternative means or at alternative locations**. Please make this request in writing to us. We will agree, so long as your request is reasonable, but you must tell us how to communicate with you and you must give us a complete address or contact information.

If you have questions, complaints or want more information contact:

NAME: Nicole Fillion-Robin, Owner
PHONE NUMBER: 512-549-5880
EMAIL: nicole@asyouareacu.com

You may also choose to send a written complaint to the U.S. Department of Health and Human Services.

This notice is effective as of May 25, 2020. From time to time, we may revise our Notice. If we do, we will post the most current version in our office, and you make ask for a copy of the Notice at any time.

HIPAA Acknowledgement and Appointment Reminders

I acknowledge that I have been provided access to the **As You Are Acupuncture** "Notice of Privacy Practices." I understand that I have a right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that **As You Are Acupuncture** staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by **As You Are Acupuncture** or individuals authorized by **As You Are Acupuncture.** All information that can identify me personally will be removed.

By signing this form, I am giving **As You Are Acupuncture** authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at **As You Are Acupuncture** clinics will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____ _____

PATIENT NAME (PRINT) DATE

_____

PATIENT SIGNATURE

Authorization for Release of Health Information - As You Are Acupuncture, PLLC

I, _____, hereby authorize **As You Are Acupuncture** the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

PATIENT'S SIGNATURE DATE

AS YOU ARE ACUPUNTURE

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, 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. 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.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) the patient should initial here. _____. Effective as 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, I acknowledge that I have received a copy.

_____ _____

PATIENT NAME (PRINT) DATE

_____

PATIENT SIGNATURE