# Yan Acupuncture & Herbs, LLC

4210 NW 37th PL STE 200 Gainesville, FL 32606

Phone: 352-872-5556

## Patient information sheet

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a significant role in your diagnosis and treatment. Please print clearly.

**PATIENCT INFORMATION**

| | | | | |
|---|---|---|---|---|
| Last Name | M.I. | First Name | | Date |
| Date of Birth: | Age | Gender M ☐ F ☐ | Status: ☐ Single ☐ Married ☐ Widowed ☐ Minor ☐ Student ☐ separated | |
| Address | | City | State | Zip |
| How did you hear about us? ☐ Search Engine □ Website □ Drive-by □ Other | | | | Referred by |
| Daytime Phone # (home, work, cell –circle one) | | | E-mail | |
| SSN # | Driver's License # | | Height | Weight |
| Employer | Occupation | | | Job Duties |

**EMERGENCY CONTACT**

| | |
|---|---|
| 1. Emergency Contact & relationship | Phone Number of Emergency Contact |
| 2. Emergency Contact & relationship | Phone Number of Emergency Contact |

**INSURANCE INFORMATION**

| | | |
|---|---|---|
| Insurance Carrier: | Insurance Plan: | Contact Number: |
| Group #: | Policy Number: | |
| Primary Care Physician: | Contact Number: | |
| Claims Address: | | |
| City | State | Zip Code |

| |
|---|
| If you will be filling a claim with your health insurance, ask the Front Desk Receptionist to include diagnosis codes on your receipt. Services rendered are to the patient, not to the insurance company. The insurance company is responsible to the patient; the patient is responsible to Yan Acupuncture & Herbs, LLC. |
| I hereby authorize the insurance carries listed above to make payments directly to the Health care Provider and understand that I am financially responsible for all charges incurred that are covered in full by my insurance. I further that if I enroll I another insurance plan, it is my responsibility to notify the Health Care Provider; otherwise I will be responsible for payment. |
| We provide 24 hour courtesy reminder calls for all upcoming patient appointments. We are asking permission to leave a message on an answering machine or with anyone who answers the phone at the phone # you provide. Initial here to give your consent _____<br>Phone #_____ |
| Chunling Yan is a Board Licensed Acupuncturist in the state of Florida. She received her oriental medicine education in Yang Zhou University, China and Florida College of Integrative Medicine in Orlando, Florida. She has a Master Degree in Oriental Medicine. She has 25+ years' experience in this field of medicine with no disciplinary actions. |

Please sign below stating that you have read the content of this page.

Patient/Guardian Signature: _____ Date: _____

# Yan Acupuncture & Herbs, LLC
## Medical conditions

**Chief Complain: (main reason for visit today: cough, headache, or lower back pain…)**

1. Major Complaint: _____

2. Secondary Complaint: _____

3. Other Complaint: _____

How long have you had major condition? _____

Do you know what could have caused it? How did it happen? _____

_____

What makes your condition better? What makes it worse? _____

_____

**Patient Medical History**

**Have you had acupuncture before**? □ Yes □ No

**Have you had Chinese herbal medicine?** □ Yes □ No

Are you under the care of a physician now? □ Yes □ No If yes, for what? _____

_____

Physician name: _____ Physician's phone: _____

**How was your childhood health**? _____

**Hospital visits/stays**: _____

**Recent tests**: (please indicate test results and date on following page)

□ Physical □ Cholesterol □ Blood □ Prostate □ HIV

□ STD □ Pap smear □ Mammography □ Other:

**Test Results and Date**: _____

**Check any you have had in the past:**

| | | | |
|---|---|---|---|
| □ Diabetes | □ Allergies | □ Rheumatic Fever | □ bleeding tendency |
| □ Heart Disease | □ Thyroid Disorder | □ Asthma | □ Multiple Sclerosis |
| □ CVA (stroke) | □ Tuberculosis | □ Jaundice | □ High Blood Pressure |
| □ Vein Condition | □ Gonorrhea | □ Mumps | □ Cancer |
| □ Measles | □ Chicken Pox | □ Nervous Disorder | □ Migraines |
| □ HIV/AIDs | □ Hepatitis | □ Epilepsy | □Appendicitis |
| □ Gout | □ Polio | □ Surgeries: | □ Seizures |
| □ Major trauma | □ Epilepsy | □ Birth trauma | □ Pacemaker. Date: |
| □ Asthma | □Other: | | |

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

**Family Medical History**

Check the following that have occurred in your blood relatives:

| | | | |
|---|---|---|---|
| □ Diabetes | □ Cancer | □ Heart Disease | □ High Blood Pressure |
| □ Allergies | □ Tuberculosis | □ Obesity | □ Bleeding Tendency |
| □ Kidney Disease | □ Alcoholism | □ Nervous Illness | □ Mental Illness |
| □ Stroke | □Asthma | □ Depression | □ Other_____ |

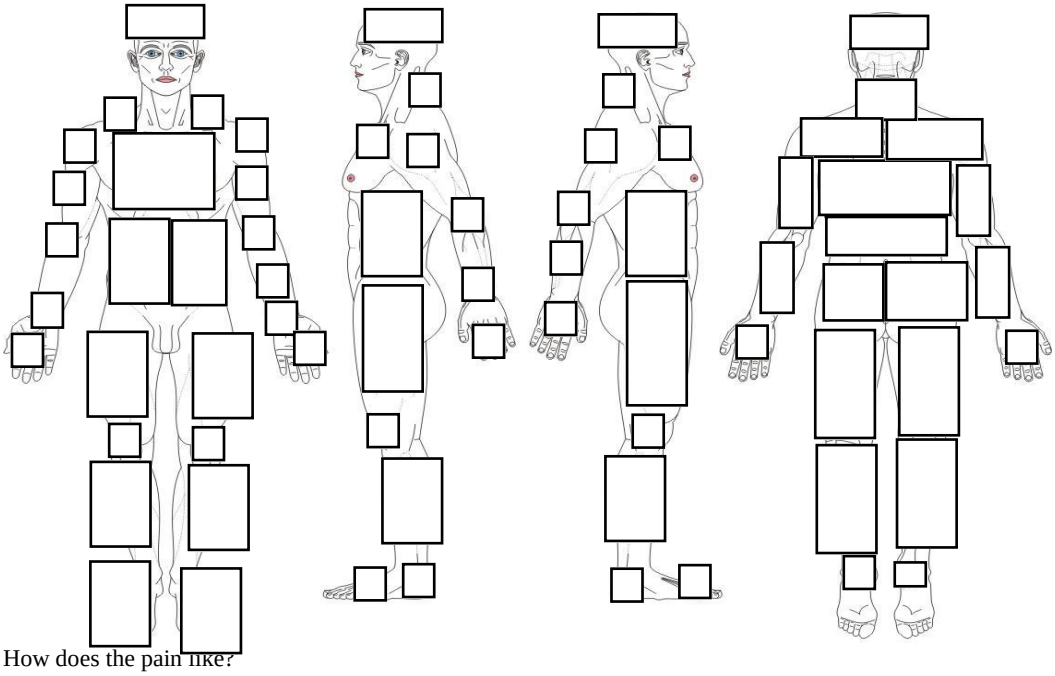
**Current Medications/Supplements**

(Please list all prescription medications and vitamins/supplements that you are currently taking)

| Medication/Herb/Supplement | Dosage | Reason you are taking it |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Patient Profile**

**PLEASE INDICATE YOUR AREAS OF DISCOMFORT OR PAIN**



How does the pain like?

□ Sharp □ Burning □ Aching □ Cramping □ Dull

□ Moving □ Fixed □ Numbness □ Tingling □ Other:

Which condition can make the pain better? □ Pressure □ Cold □ Heat □ Exercise □ other

Which condition can make the pain worse? □ Pressure □ Cold □ Heat □ Exercise □ other

**Specific problems in organs**

**Overall Temperature (Kidney function):**

□ Cold hands & feet □ sweaty hands & feet □ night sweats □ hot sensation
□ Afternoon flushes □ hot flushes □ lack of perspiration □ vaginal dryness
□ Cold sensation □ perspire easily □ thirsty □ low energy

**Heart function:**

□ Palpitations □ anxiety □ restlessness □ memory problem
□ mental confusion □ vivid dreams □ chest pain □ insomnia
□ mental fogginess □ mental sluggishness □ wake unrefreshed

**Lung function:**

□ Cough □ sinus congestion □ dry skin □ dry mouth
□ dry throat □ sore throat □ nose bleeds □ sneezing
□ difficult breathing □ dry nose □ stiff neck □ chills & fever
□ nasal discharge /color:_____ □ cough with sputum/color:_____

**Spleen function:**

□ low appetite □ bloating □ abrupt weight change □ mucous in stools
□ gurgling stomach □ gas □ fatigue after eating □ blood in stools
□ diarrhea □ constipation □ undigested food in stools □ nausea
□ loose stools □ hemorrhoids □ heavy body sensation □ incomplete stools
□ swollen hands □ swollen feet □ alternating diarrhea & constipation

**Stomach function:**

□ burning □ bad breath □ very large appetite □ canker sores
□ acid reflux □ belching □ stomach pain □ vomiting
□ bleeding or swollen gums

**Liver/Gallbladder function:**

□ over thinking □ anger easily □ tightness in chest □ bitter taste
□ frustration □ depression □ frequent headaches □ irritability
□ tingling □ numbness □ muscles spasms □ ringing in ears
□ drink alcohol □ lump in throat □ muscle tension

**Kidney/Bladder function:**

□ sore/weak knees □ low back pain □ high libido □ normal libido
□ low libido □ excessive hair loss □ fearful □ lack of bladder control

**Urination:**

□ frequent □ urgent □ painful □ burning
□ strong odor □ cloudy □ difficult □ scanty
□ dark yellow color

**Men only:**

□ testicular pain □ swollen testes □ premature ejaculation □ impotence
□ prostate trouble □ difficulty starting urine □ burning on urination □ nightly urination
□ prostate cancer □ dripping after urination □ coldness or numbness in genitalia
□ other_____

**Women only:**

<table>
<tr><td rowspan="6">Period</td><td>Age of first menses:</td><td colspan="3">Color: □ bright red □ dark red □ purplish<br>□ brown □ pink □ other</td></tr>
<tr><td>Menses cycle:</td><td colspan="3">Clots: □ large □ small □ more □ less □ no</td></tr>
<tr><td>The day of last menses:</td><td colspan="3">Period: □ regular □ irregular</td></tr>
<tr><td>Days of flowing period:</td><td rowspan="2">menstrual cramps:</td><td colspan="2">□ before □ during □ after last days:</td></tr>
<tr><td>Age of menopause:</td><td colspan="2">□ pelvic area □ lower back<br>□rectovaginal area □ thighs/legs</td></tr>
<tr><td>following symptoms premenstrual</td><td colspan="3">□ fluid retention □ breast tenderness □headache □ mood swings<br>□ food cravings □insomnia □ anxiety □ depression<br>□ Nausea □ vomiting □ irritability □ hot flashed<br>□ constipation or irregular bowel movements □ other</td></tr>
<tr><td rowspan="2">pregnant</td><td colspan="2" rowspan="2">Times of pregnancy:</td><td>contraception method:</td></tr>
<tr><td>Birth control</td><td>any difficulties/side effects:</td></tr>
<tr><td rowspan="2">Births</td><td colspan="2">Live births:</td><td colspan="2">Any abortions:</td></tr>
<tr><td colspan="4">Times of miscarriages:</td></tr>
</table>

| | |
|---|---|
| Infertility | □ Yes □ No ( if so, answer below) |
| | See a fertility clinic or Reproductive Endocrinologist? (please list) |
| | Have you had any following procedures/tests? (check all that apply)<br><br>□ 2nd or 3rd day serum FSH/Estrogen/Prolactin test □ pelvic ultrasound □ laproscopy<br>□ hysterosalpingography □ cervical conization □ D & C |
| | Have you had any of the following fertility procedures?<br>□ non-stimulated IUI □ stimulated IUI □ stimulated cycle w/o IUI □ IVF □ IVF w/ donor eggs |
| | Your partner semen analysis? □ Yes □ No results (if so, describe): |
| | Are you exposed to toxic fumes/chemicals on a regular basis in the workplace or home? (describe) |

| | | | | |
|---|---|---|---|---|
| Vagina | discharge | color: | □ thin □ thick: | strong odor: □ Yes □ No |
| | | Abnormal pap smear: □ Yes □ No ( If so, Describe) | | |
| | others | Pain/infection: □ Yes □ NO | Vaginal dryness: □ Yes □ NO | |
| Breast | | Lump: □ Yes □ No (if yes, describe it):<br><br>Nipple discharge: □ Yes □ No<br>Day of last mammogram: | | |
| Genital | | Genital itching: □ Yes □ No | Genital Herpes: □ Yes □ No | |
| Other: | | | | |

**Lifestyle**

| |
|---|
| Describe a typical breakfast: |
| Lunch: |
| Dinner: |
| Snacks: |

| | |
|---|---|
| Crave foods: | Daily caffeine intake: |
| Water intake (day/per): | Alcohol (how often & how many drinks): |
| Exercise: | Recreational drug use? (type and amount): |

| | | |
|---|---|---|
| Sleep | Hours/per night: | rested in the morning: □ Yes □ No |
| | Wake up in the night: □ Yes □ No | How often: |
| | Hard going back to sleep: □ Yes □ No | |

| | |
|---|---|
| Energy level (0=no stress, 10=most stress): 1 2 3 4 5 6 7 8 9 10 | |
| Enjoy your work? □ Yes □ No | How many hours/week do you work? |
| Happy in home environment: □ Yes □ No | |

**Print Patient's Name_____ Signature of Patient _____ Date Signed_____**

**Yan Acupuncture & Herbs, LLC**
4210 NW 37th Place, STE 200
Gainesville, FL, 32606
(352) 872-5556

# INFORMED CONSENT FOR TREATMENT

**PLEASE READ BEFORE SIGNING**

I _____hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling based on traditional Chinese medical theory within the scope of the practice of acupuncture on me( or one of the patient named below, for whom I am legally responsible) by a the acupuncturist named below and/ or other Licensed and Board Certified 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 office listed below or any other office or clinic, whether signatories to this form or not in the state of Florida. If wish to decline any form of treatment/procedure recommended by the physician, I have the right to do so.

**Acupuncture** is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

**Moxibustion** is the application of indirect heat by burning a stick of compressed Folium Artemisiae vulgaris, commonly known as Mugwort over acupuncture points. (At our clinic we may use an infrared heat lamp instead of compressed Folium Artemisiae vulgaris).

**Cupping** utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

**Tui-Na** is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

I understand that the herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditional Chinese considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. The herbs may need to be prepared and 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 safe method of treatment and only pre-sterilized, disposable needles will be used. 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 maintain a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risk may occur, including but not limited to bruising, bleeding, redness, bump, pain or other strong sensation at or near the needling sites, nerve pain, and aggravation of current symptoms, or appearance of new symptoms or light headaches, or nausea, Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand that I should not move while the needles are being inserted, retained, or removed. Bruising and redness is a common side effect of cupping. If I feel uncomfortable at any time during the treatment session, I will inform the physician immediately.

I accept the fact that **NO GUARANTEE** is made concerning the outcome of my acupuncture treatments and/or herbal medicines or other treatment methods.

I accept the fact that each combination of herbs is designed for my needs and my needs only, ***and therefore I cannot receive a refund on any herbs or any services rendered.*** I also understand that I may stop treatment at any time.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I have the right to refuse treatment; however, I must communicate this to the acupuncturist before any herbal prescription has been filled for me; otherwise I will be obligated to pay for the herbs prescribed.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants. If I have any of the above conditions, I have listed them here:

_____

_____

By voluntarily signing below I, _____ hereby certify that I have read, or have had read to me, the above consent, have been told about the risks and benefits of acupuncture and other procedures, I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

## I am declining the following treatment/procedure:

_____

*To be completed by patient:*

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

*To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:*

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

_____
As: Relationship or authority of Patient's Representative

_____
Date Signed

**Yan Acupuncture & Herbs, LLC**
4210 NW 37th PL STE 200
Gainesville, FL, 32606
352-872-5556

# HIPPA NOTICE OF PRIVACY PRACTICES

Yan Acupuncture & Herbs, LLC is required by law to maintain the privacy of your Protected Health Information (PHI). This Notice of Privacy Practices tells you how your PHI may be used and disclosed and how you can access this information. Please review it carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPAA," it is our legal duty to safeguard your PHI. Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office. You may also request a copy of this Notice from us, or you can view a copy of it in our office. This Notice will remain in effect until it is replaced or amended.

During the course of our relationship with you, your PHI may be used or disclosed for treatment, payment, and healthcare operations within our office. You may specifically authorize us to use PHI for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI. This authorization will have an expiration date that can be revoked by you in writing.

**Marketing**
This office will not use or disclose your PHI for marketing communications without your written authorization. This office may send greeting cards, notice of clinic events, newsletters, and/or appointment reminders.

**Disclosure**
This office may use or disclose your PHI without your consent or authorization when required by law.

**Treatment**
We may disclose your health information to other health care professional within our practice for the purpose of treatment, payment or health care operations.

**Payment**
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

**Emergencies**
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health**
As required by law, we may disclose your information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Law Enforcement**
We may disclose your health information to a law enforcement official for purposes such s identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons**
We may disclose your health information to coroners or medical examiners.

**Organ Donation**
We may disclose your health information to organizations involved in procuring, banking, transplanting organs and tissues.

**Research**
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Patient Rights**

1. Upon written request, you have the right to review and receive copies of your PHI.
2. Upon written request, you have the right to receive a list of disclosures about your PHI.
3. You have the right to request additional restrictions on the use and disclosure of your PHI, as permitted by law.
4. You have the right to receive all notices in writing.
5. Upon written request, and as permitted by law, you have the right to request that we amend your PHI.

If you have any questions about this Notice or any complaints about our privacy practices, please contact our office.
Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201.

This Notice went into effect on **August 22, 2016**

**I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices.**

_____
Signature of patient or patient's Guardian Date

_____
Printed name of patient or patient's Guardian Relationship to Patient Date

_____
Witness Date

**OFFICE USE ONLY**

I attempted to obtain the patient's signature on this HIPPA Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, including 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide to a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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, as to whether this agreement is unconscionable, 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 preceptors, or 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.

This agreement is intended to create an open book account unless and until revoked.

**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 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 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 | Date |
|---|---|
| (Or Patient Representative) | (Indicate relationship if signing for patient) |

| OFFICE SIGNATURE | Date |
|---|---|

# OFFICE POLICIES

To help serve you better, I've listed some guidelines and office policies. Please sign the Client Acknowledgement on the reverse side and bring this form with you to your first treatment, which is scheduled for:

- Please eat 1 to 2 hours prior to your appointment time.
- Please arrive at least 30 minutes prior to your first appointment to fill out some forms
- Please wear loose-fitting clothes if possible.

**NO SHOW/LATE CANCELLATIONS** If an appointment is missed or not cancelled with **6 hours** prior notice to the scheduled time, a fee of $20.00 will be charged if that time slot cannot be filled. If you are 20 or more minutes late, your appointment will be cancelled and you will be charged a $20.00 fee for the reserved appointment time. We are closed Sunday. Monday appointments **MUST** be cancelled no later than 2pm on Saturday as we will be unable to fill the spot if it's cancelled while we are closed. 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.

**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 $0.50 cent per page for the first 20 pages and 0.25 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. All phone message left in the voicemail will be returned within 24 hours by the office Monday – Saturday. We are closed Sundays and major holidays.

**POLICY REGARDING SMALL CHILDREN**. We love children at Yan Acupuncture & herbs; 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 or waiting room.

**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 herbal pills 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. Each combination of herbs is designed for individual only, and therefore no refund on any herbs or any services rendered.

**TIMED SERVICES** Your initial visit will last approximately 90 minutes. Return visits are typically 45-60 minutes. This time will be spent interviewing you regarding your medical history and primary complaint, conducting a physical examination based on Traditional Chinese Medicine (TCM), and treatment.

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.

**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.

**PROHIBIT SMOKING.** Smoking should not be permitted in the office nor within 25 feet of the building.

**FORMS AND REPORTS** There will be a $20-$40 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.

**PAYMENT POLICY** Payment for services is due in full at the tie services are rendered. We accept **cash, check, Visa, MasterCard, American Express, and Discover only**. Please note that if you wish to file a claim with your health insurance provider, this is the patient's responsibility. (Filing a claim does not guarantee that you will be compensated.) We will provide any necessary paperwork to enable you to file a claim. However, you are still responsible to Yan Acupuncture & Herbs for the full payment of services provided. **No personal checks will be accepted on NEW PATIENT visits.** When a check is returned by the bank for insufficient funds we are charged $35 by the bank and only one occurrence is permitted. If a second check bounces, I will require cash-only payment from then on. We will contact you by mail to alert you to this problem for payment due plus the bank charge. Payment must be made to us within 20 days from date of the letter. At that time, we will file a written complaint with the Gainesville Police Department who will proceed with prosecution in a Court of Law. Patient needs to pay balance BEFORE any more services are rendered and must pay BEFORE they are seen by the doctor. No write-offs accepted.

**CLIENT ACKNOWLEDGEMENT:**

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

Printed Name _____Signature _____Date_____

I am pleased to have you as a client and hope you will soon share my enthusiasm for the health-enhancing benefits of acupuncture. My goal is to support your body's natural healing process and assist you in improving your health and vitality.

# 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 a 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
- ☐ Weakness
- ☐ trembling or shaking
- ☐ Eye 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 triggers fainting during acupuncture**

**Psychological Triggers**

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

**Dehydration**

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

**Fainting facts and general information**

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

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

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

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

_____ **Signature**

_____ **Date**

Copy of this document available upon request