Yan Acupuncture & Herbs, LLC

PATIENCT INFORMATION

Last Name	M.I.	First Name	Today's Date

Date of Birth:	Age	Biological Sex: ☐ M ☐ F Preferred Pronoun: _____	Status: ☐ Single ☐ Married ☐ Widowed ☐ Minor ☐ Student ☐ Veteran ☐ Separated

Address	City	State	Zip

How did you hear about us?
☐ Health Insurance ☐ Website ☐ Drive-by ☐ HealthProfs.com ☐ Social Media

Referred by

Cell Phone #

Permission to text you 24 hour Courtesy Reminder: Yes or No

Would you like to join our email newsletter to receive advices about holistic living, seasonal eating, and more? ☐ Yes ☐ No

Email

Height	Weight

Employer	Occupation	Job Duties

EMERGENCY CONTACT

Emergency Contact & relationship	Phone Number of Emergency Contact

12-hour Cancellation & "No Show" Fee Policy

- Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, our office reserves the right to charge a fee of $50.00 for all missed appointments ("no show"), or appointments cancelled without 12-hour advanced notice (unless due to sudden illness or an emergency).
- It is every patient's responsibility to remember their scheduled appointments. Reminder texts are an office courtesy and should not be solely relied on.
- "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. If no visit is schedule, a bill will be mailed to you.

Financial Responsibility

- I understand that estimated insurance coverage information and insurance billing are provided as a courtesy and all applicable copayments and deductibles are due at the time of service.
- I understand that it is my responsibility to notify Yan Acupuncture and Herbs LLC of any changes in my healthcare coverage. I understand that the insurance company has a disclaimer that the verification of benefits is not a guarantee of payment. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I agree to be financially responsible and make full payment for all charges not covered by my insurance company.
- I authorize my insurance benefits be paid directly to Yan Acupuncture and Herbs LLC for services rendered. I authorize representatives of Yan Acupuncture and Herbs to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.
- I understand that If I am a private patient without insurance, all charges are due at the time of visit.

Medical Record Release

For copies of chart pages, a minimum of ten working days and not more than thirty is required to process your request. A completed and signed record release must be done before any records are released. There will be a fee of $0.50 per page for the first 20 pages and $0.25 cents per page after that, payable prior to release of your copies.

By signing below, you acknowledge that you have received the notices and understand the policies listed above.

Patient's or Representative's 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? **Have you had Chinese herbal medicine?**

□ Yes □ No □ Yes □ No

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

_____

Physician name:_____

How was your childhood health?_____

Hospital visits/stays:_____

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:
□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_____

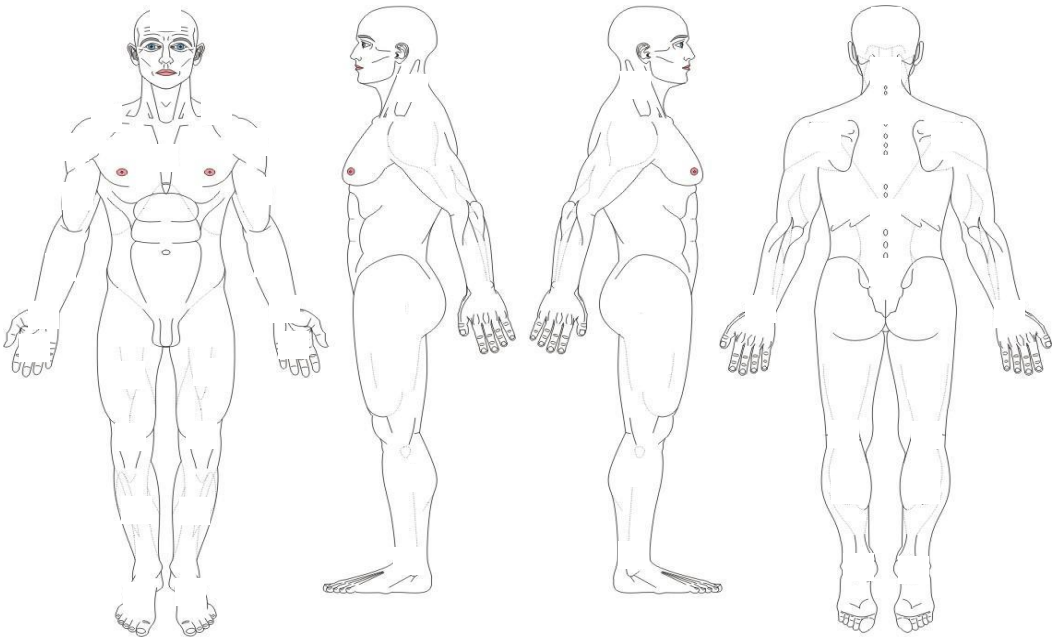
Current Medications/Supplements

(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_____			

Lifestyle

Describe a typical breakfast:
Lunch:
Dinner:
Snacks:

Crave foods:	Daily caffeine intake:
Water intake (per day):	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	

Stress 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	

Patient's or Representative's Signature:_____ **Date:** _____

WOMEN only:

Period	Age of first menses:	Color: □ bright red □ dark red □ purplish □ brown □ pink □ other	
	Menses cycle:	Clots: □ large □ small □ more □ less □ no	
	The day of last menses:	Period: □ regular □ irregular	
	Days of flowing period:	menstrual cramps:	□ before □ during □ after last days:
	Age of menopause:		□ pelvic area □ lower back □rectovaginal area □ thighs/legs
	following symptoms premenstrual	□ fluid retention □ breast tenderness □headache □ mood swings □ food cravings □insomnia □ anxiety □ depression □ Nausea □ vomiting □ irritability □ hot flashed □ constipation or irregular bowel movements □ other	
Pregnancy	Times of pregnancy:	Birth control	contraception method:
			any difficulties/side effects:
Births	Live births:	Any abortions:	
	Times of miscarriages:		
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) □ 2nd or 3rd day serum FSH/Estrogen/Prolactin test □ pelvic ultrasound □ laproscopy □ hysterosalpingography □ cervical conization □ D & C		
	Have you had any of the following fertility procedures? □ 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): Nipple discharge: □ Yes □ No Day of last mammogram:		
Genital		Genital itching: □ Yes □ No		Genital Herpes: □ Yes □ No

Patient's or Representative's Signature: _____ **Date:** _____

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

INFORMED CONSENT FOR TREATMENT

- The performance of Traditional Chinese Medicine procedures, which may include, but are not limited to acupuncture, moxibustion, cupping therapy & gua sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, tui na (Chinese massage), Chinese herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

- 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: _____

I _____ (Print Patient's Name) 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.

Patient's or Representative's Signature: _____ **Date:** _____

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HIPPA NOTICE OF PRIVACY PRACTICES

Yan Acupuncture & Herbs, LLC is required by law "the Health Insurance Portability & Accountability Act of 1996" 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:

- 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. However, such a revocation shall affect any disclosure we have already made in reliance on your prior consent.

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
3. The practice reserves the right to change the Notice of Privacy Policies
4. The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. The practice may condition treatment upon the execution of this consent.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis, including treatment, payment, and health care operation:

_____

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

Patient's or Representative's Signature: _____ **Date:** _____

FAINTING

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.

There are other causes of fainting, including, but not limited to, heart conditions; however, nervousness and dehydration are the most common in regard 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 name), 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.

Patient's or Representative's Signature: _____ **Date:** _____

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 whe ther 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). 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