Chiropractic Registration and History

1 Patient Information

Date: _____
Patient: _____
Address: _____
_____
City State Zip
Sex: M○ F○ Age: _____ Birth Date: ____/____/____
○Single ○Married ○Widowed ○Separated ○Divorced
Patient SS#: _____-_____-_____
Occupation: _____
Employer: _____
Employer Address: _____
_____
Employer Phone: _____
Spouse's Name: _____
Birth Date: ____/____/_____ -SS#: _____-_____-_____
-Occupation: _____
-Employer: _____
Whom may we thank for referring you? _____
_____

2 Insurance

Who is responsible for the account? _____
Relationship to patient: _____
Insurance Co.: _____
Group #: _____
Is patient covered by additional insurance? ○Yes ○No
Subscribers Name: _____
Birth Date: ____/____/_____ SS#: _____-_____-_____
Relationship to patient: _____
Insurance Co.: _____
Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Back in Line Chiropractic Center Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Back in Line Chiropractic Center Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Also, Payment Now fees are to be paid at time of service.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 Phone Numbers

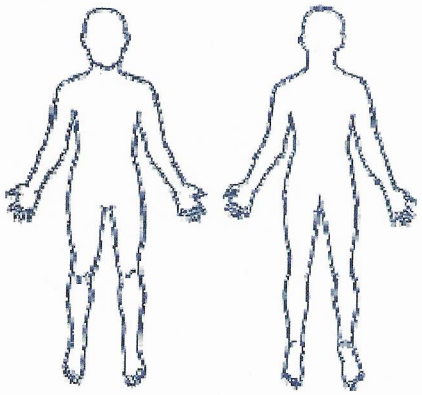
Home: _____ Work: _____
-Ext.: _____
Cell Phone: _____
IN CASE OF EMERGENCY CONTACT:
Name: _____ Relationship: _____
Phone Number: _____

4 Accident Information

Is condition due to an accident? ○Yes ○No
Date: ____/____/____
Type of Accident: Auto Work Home Other _____
To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp. Other _____
Attorney Name (if applicable) _____

5 Patient Condition

What is your major symptom/problem? _____
_____
When did the symptoms appear? _____
_____
Is this condition getting progressively worse? ○Yes ○No ○Unknown
Have you noticed any visceral or neurological problems since the condition occurred?
(For example: High blood pressure, loss of balance, numbness, etc. _____
_____



Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of the pain on a scale from 1 (least pain) to 10 (most pain) _____
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Radiating
☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling
Other _____
How Often do you have the pain? _____
Is it constant or does it come and go? _____
Does it Interfere with your? ☐Work ☐Sleep ☐Daily Routine ☐Recreation
What makes your condition better? _____
What makes your condition worse? _____
Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐ _____
Is there a particular time of day that your problem is better or worse? _____

Patient Medical History

Back in Line Chiropractic Center

Name: _____ Date: _____

List any surgery(s) and dates: _____

_____

List any falls or accidents: _____

_____

Broken bones, dislocations or fractures: _____

_____

Were you ever knocked unconscious? ○ Yes ○ No

Do you suffer from any condition(s) other than that for which you are consulting us? _____

_____

Are you presently taking any medication, prescription or over the counter? _____

_____

Do you have any allergies? _____

When did you last see a chiropractor? _____ Dr. _____

Please indicate conditions you have by marking below with (X), conditions you have had in the past with (O), and family history of conditions with (F):

( ) Aids	( ) Epilepsy	( ) Polio	( ) Parkinson's Disease
( ) Anemia	( ) Cancer	( ) Diabetes	( ) Rheumatic Fever
( ) Arthritis	( ) Tuberculosis	( ) Hypertension	( ) Multiple Sclerosis

PLEASE CHECK ALL PRESENT SYMPTOMS:

CARDIOVASCULAR

- ☐ general swelling
- ☐ loss of coordination
- ☐ swelling in face
- ☐ chest pain
- ☐ rapid heart beat
- ☐ blue or purple skin
- ☐ blue or purple nailbeds
- ☐ fainting
- ☐ ringing in ears
- ☐ heart attack
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ hardening of the arteries
- ☐ dizziness with nausea
- ☐ blurred vision
- ☐ fainting spells
- ☐ stroke
- ☐ diabetes
- ☐ cold hands and/or feet
- ☐ area of numbness
- ☐ arthritis of the neck
- ☐ previous neck or head injury
- ☐ loss of memory
- ☐ periods of blindness in one eye
- ☐ check if any of your family members have had a stroke

VERTEBROSILAR

- ☐ double vision
- ☐ pain across shoulders
- ☐ irregular muscle movement

MUSCULARSKELETAL SYSTEMS/HEAD

- ☐ unusually frequent headache
- ☐ unusually severe headache
- ☐ head feels heavy
- ☐ vertigo
- ☐ light-headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

NECK

- ☐ pain in neck
- ☐ neck pain with movement
- ☐ swelling in neck
- ☐ pinched nerve in neck
- ☐ neck out of place
- ☐ muscle spasms in neck
- ☐ grinding sounds in neck
- ☐ popping sounds in neck
- ☐ stiff neck
- ☐ limited neck movement

SHOULDERS

- ☐ pain in shoulders (right) (left)
- ☐ swelling in legs
- ☐ tension in shoulders
- ☐ muscle spasms in shoulder
- ☐ can't raise arm (right) (left)

ARM AND HANDS

- ☐ pain in upper arm
- ☐ pain in forearm
- ☐ pain in hands or fingers
- ☐ sensation of pins and needles in arms or fingers
- ☐ fingers fall asleep
- ☐ hands cold
- ☐ swollen joints in fingers
- ☐ sore joint in fingers
- ☐ loss of grip strength

MID BACK

- ☐ mid back pain
- ☐ pain between shoulder blades
- ☐ pain from front to back
- ☐ pain over kidney area
- ☐ muscle spasms in mid back

LOW BACK
- ☐ low back pain
- ☐ low back feels out of place
- ☐ muscle spasms in low back

HIPS, LEGS, AND FEET
- ☐ pain in buttocks
- ☐ pain down leg
- ☐ knee pain
- ☐ leg cramps
- ☐ pins and needles in legs
- ☐ numbness in leg or toes
- ☐ cold feet
- ☐ swollen ankles or feet

SKIN HAIR NAIL
- ☐ eczema
- ☐ itchy skin
- ☐ dry scalp
- ☐ oily scalp
- ☐ rough, scaly skin
- ☐ dry skin
- ☐ oily skin
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruise easily
- ☐ paper thin nails
- ☐ hair loss

EYES
- ☐ blurring of vision
- ☐ double vision
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes
- ☐ excessive itching
- ☐ pain in eyeball

EARS
- ☐ loss of hearing
- ☐ pain in ears
- ☐ discharge from ears
- ☐ vertigo
- ☐ ringing in ears

NOSE NASOPHARYNX
- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ pressure over eyes
- ☐ pressure under eyes
- ☐ obstruction in nose
- ☐ frequent colds
- ☐ sinusitis
- ☐ nasal allergies
- ☐ loss of sense of smell
- ☐ any trauma to nose

MOUTH AND THROAT
- ☐ cavities
- ☐ pain in mouth
- ☐ pain in throat
- ☐ bleeding gums
- ☐ difficulty swallowing
- ☐ changes in voice

RESPIRATORY
- ☐ shortness of breath
- ☐ dry cough
- ☐ productive cough
- ☐ coughing up blood
- ☐ wheezing

GASTROINTESTINAL
- ☐ poor appetite
- ☐ indigestion
- ☐ can't eat some foods
- ☐ nausea and vomiting
- ☐ abdominal pain
- ☐ change in bowel habits
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

WOMEN ONLY
- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ premenstrual symptoms
- ☐ irregular periods
- ☐ lumps in breast
- ☐ take birth control pills
- ☐ # of pregnancies: _____
- ☐ # of deliveries: _____

GENITOURINARY
- ☐ urination
- ☐ frequents
- ☐ normal
- ☐ infrequent
- ☐ low
- ☐ need to get up at night to urinate
- ☐ abnormal intense desire to urinate
- ☐ difficulty starting urination
- ☐ decreased output
- ☐ pain on urinating
- ☐ dribbling
- ☐ blood in urine
- ☐ cloudy urine
- ☐ lack of bladder control

VENERAL DISEASE
- ☐ AIDS
- ☐ syphilis
- ☐ gonorrhea

SOCIAL HISTORY
- ☐ smoking
- ☐ other tobacco use
- ☐ alcohol use
- ☐ drink coffee or tea

diet is:
- ○ balanced
- ○ not balanced

rest is:
- ○ sufficient
- ○ not sufficient

recreation is:
- ○ sufficient
- ○ not sufficient

my stress level is:
- ○ severe
- ○ moderate
- ○ minimal
- ○ none

GENERALLY FEEL
- ☐ nervousness
- ☐ irritability
- ☐ fatigue

Patient Consent for Use and Disclosure of Protected Health Information

Back in Line Chiropractic Center

I hereby give consent for Back in Line Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (TPO)

Back in Line Chiropractic Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Back in Line Chiropractic Center, 6991 W. Broward Blvd. #107, Plantation, FL 33317.

With this consent, Back in Line Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Back in Line Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as there marked Personal and Confidential.

With this consent, Back in Line Chiropractic Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Back in Line Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Back in Line Chiropractic Center's use and disclosures of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Back in Line Chiropractic Center may decline to provide treatment to me.

_____

Signature of Patient or Legal guardian

_____ _____

Patient's Name (print) Date

_____

Print Name of Patient or Legal Guardian

Informed Consent of Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

a) While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms.

Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose or chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____ 20_____

_____ _____
Patient Signature (or Legal Guardian) Signature of Witness

_____ _____
Patient Name (printed) Witness Name (printed)

Prior Chiropractic Treatment Information

Name of Chiropractor: _____

Location: _____

When was your last treatment? _____

Have you had X-rays? _____

Notice to Patients

Please note that all x-rays are analyzed for alignment and possible fractures at the time of the initial Report of Findings. A final analysis review will also be conducted by the physician upon their convenience; at which, the findings will be disclosed to the patient. Should the physician locate any matter which may be out of their scope of practice, the x-rays will be sent out to be analyzed and reported on by an independent radiologist for a service fee of $35.00. The patient will be responsible for this fee.

Additionally, if patient prefers to have the final analysis conducted sooner, the x-rays may be sent out to be analyzed and reported on by an independent radiologist for a service fee of $35.00. The patient will be responsible for this fee.

____ Yes, I would prefer my x-rays sent out immediately for final analysis for a fee of $35

_____ _____

Patient Signature Date

_____

Patient Name

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

PATIENT _____ CLINIC_____ FILM DATE _____

AGE_____ SEX M☐ F☐ SOCIAL SECURITY #_____/_____/_____ DATE OF BIRTH _____

PATIENT ADDRESS_____ CITY_____ STATE_____ ZIP_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____ DATE:_____

WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

_____

TRAUMA? YES☐ NO☐ EXPLAIN_____

PAST MEDICAL HISTORY_____

_____

MALIGNANCY? YES☐ NO☐ DETAILS_____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE]_____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

CASH (no insurance)_____ MEDICARE ONLY_____ MEDICAID ONLY_____

STANDARD NEED **NON-PARTICIPATING** PROVIDER INSURANCE NAME & BILLING ADDRESS

**PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).*

INSURANCE NAME & BILLING ADDRESS (PRIMARY)			**INSURANCE NAME & BILLING ADDRESS (SECONDARY)**		
CARRIER	TELEPHONE		CARRIER	TELEPHONE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____			**RELATIONSHIP TO INSURED** SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____		
INSURED NAME	INSURED DATE OF BIRTH		INSURED NAME	INSURED DATE OF BIRTH	
INSURED SOCIAL SECURITY #	INSURED ID #		INSURED SOCIAL SECURITY #	INSURED ID #	
INSURED GROUP #	BCBS 3 LTR PREFIX		INSURED GROUP #	BCBS 3 LTR PREFIX	
INSURED EMPLOYER	TELEPHONE		INSURED EMPLOYER	TELEPHONE	
IF W/C: EMPLOYER ADDRESS	CITY	ST ZIP	IF W/C: EMPLOYER ADDRESS	CITY	ST ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATIONSHIP TO EMPLOYMENT? YES ☐ NO ☐ AUTO ACCIDENT? YES ☐ NO ☐
OTHER? YES ☐ NO ☐

CLAIM # _____ **DATE OF INJURY** _____

W/C CARRIER or AUTO INSURANCE **NAME & BILLING ADDRESS** LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)			**ATTORNEY NAME & BILLING ADDRESS**	
CARRIER	TELEPHONE		ATTORNEY NAME	TELEPHONE
INSURANCE ADDRESS			ATTORNEY ADDRESS	
CITY	STATE	ZIP	CITY	STATE ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____			* PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY	
INSURED NAME	INSURED SOCIAL SECURITY #			
IF PI: ADJUSTER'S NAME	ADJ. TELEPHONE		IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES	

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

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

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE X

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE