

## Welcome,

Thank you so much for your interest in acupuncture and Oriental medicine. It is an exciting time in the field of Oriental medicine, and I am happy to share my skills and knowledge with you. I will do my best to assure that you receive the best care possible. It is important to me that your questions get answered and that you feel comfortable at all times during your visit. As a health care professional, I want to provide you with the most caring and efficient treatment. In an effort to do just that here are some guidelines.

**Appointments:** Please be on time for your scheduled appointments. This will help prevent delays. If you are more than 10 minutes late, you may have to reschedule your appointment.

**Cancellations:** It is understood that circumstances arise that may prevent you from keeping your appointment. However, to avoid charges, please honor the 24 hour advanced notice cancellation policy. Cancellations with more than 24 hours notice will not be charged. Cancellations with less than 24 hours notice will be subject to payment of 50% of the service price. Failure to show without notice will be subject to payment of 100% of the service price. Credit card details are required to secure an appointment.

**Payment Policy:** I require full payment at the “time-of service”. You will need to check with your insurance company prior to your first visit to see if you can be reimbursed for your treatment(s). I can furnish you with a superbill so that you can submit it to your insurance company for direct reimbursement.

### **Fee Schedule:**

General acupuncture initial evaluation and treatment- \$125

Follow-up 1 treatment per week- \$75

Follow-up 2 treatments per week- \$55 (Prepaid)

Follow-up 3 or more treatments per week- \$45 (Prepaid)

Herbal consult only \$50

Lifestyle/Diet consult- \$50

**Herbal Prescriptions:** I will keep some of the most popular herbal prescriptions on-hand at the spa. For those prescriptions you do not need to make an appointment for a refill. Simply call **at least 48 hours** before you would like to pick up your prescription and it will be ready for you. If you require a prescription that is mailed to you, please notify me **at least 72 hours** prior to your last anticipated dose to ensure that you receive your herbs in a timely manner.

**What I Offer:** The healing modalities that I make available to you may include any or all of the following:

acupuncture, electrical stimulation, acupressure/massage, moxibustion, cupping, Chinese herbal therapy, nutritional and lifestyle counseling.

**The Initial Visit:** The forms that you fill out are designed to gather detailed information and a description of your current health status. If you have any questions about these forms please let me know. I will discuss your concerns, take a very detailed history, and devise a treatment plan. An acupuncture treatment usually follows. You should allow approximately 1 hour and 45 minutes for your initial evaluation and treatment.

**My Goals**

- Make sure that customer service always meets the highest standards
- Make sure that any questions you have about your care are answered in a way that you understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Again, welcome and thank you. You have taken an important step on the path to more vibrant health. Please feel free to give me feedback on any aspect of my service, so that I may provide the best care possible. I look forward to serving you.

Best of Health,  
Elizabeth Wilson, RN, MSTOM, L.Ac.

## **Cancellation Policy**

It is understood that circumstances arise that may prevent you from keeping your appointment. However, to avoid charges, please honor the 24 hour advanced notice cancellation policy. Cancellations with more than 24 hours notice will not be charged. Cancellations with less than 24 hours notice will be subject to payment of 50% of the service price. Failure to show without notice will be subject to payment of 100% of the service price. Credit card details are required to secure an appointment.

By voluntarily signing below, I show that I have read, or have had read to me and agree to the above cancellation policy.

Patient Signature/Date X \_\_\_\_\_

## **Your Health Information and Privacy**

Dear Patient,

This notice describes our policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect, we may need to share limited personal medical and financial information with your insurance company or with other medical practitioners that you authorize.

### ***Safeguards in place to insure privacy:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

### ***Types of information that we gather and use:***

In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, and other third party administrators (e.g. requests for medical records).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 910-686-6440.

Best of Health,

Elizabeth Wilson RN, L.Ac.  
Natural Balance Acupuncture and Herbs, LLC

PATIENT NAME:

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

# ACUPUNCTURE INFORMED CONSENT TO TREAT

PATIENT NAME

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, Tiu-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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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.

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

	<input checked="" type="checkbox"/>	PATIENT SIGNATURE
	<input checked="" type="checkbox"/>	OFFICE SIGNATURE

**Natural Balance Acupuncture and Herbs, LLC**

Elizabeth Wilson, RN, L.Ac.

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ M / F Date of birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (work) \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_

Education (last grade completed) \_\_\_\_\_ Marital status \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Current healthcare provider, if any \_\_\_\_\_  
\_\_\_\_\_

Date of last complete physical \_\_\_\_\_

Weight \_\_\_\_\_ One year ago \_\_\_\_\_ Maximum \_\_\_\_\_ When? \_\_\_\_\_

Height \_\_\_\_\_

What is your normal blood pressure? \_\_\_\_\_

Primary health concern:

Other concerns (list as many as you like, in order of importance to you):

## FAMILY HISTORY

	Yourself	Mother	Father	Brother(s)	Sister(s)	Grandparents
Age (or age of death)						
Current Health (or cause of death)						
<b>MARK AN (X) FOR ALL CATEGORIES THAT ARE APPLICABLE PAST OR PRESENT</b>						
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness						
Asthma						
Allergies						
Skin diseases						
Anemia						
Kidney disease						
Glaucoma						
Tuberculosis						
Ulcer/colitis						
Thyroid disease						

**HOSPITALIZATIONS AND SURGERIES** (begin with the most recent; remember to include hysterectomies, vasectomies, etc) \_\_\_\_\_

**ABNORMAL LAB TESTS** (ultrasound, MRI, etc.) \_\_\_\_\_

**CURRENT MEDICAL DIAGNOSES** (if any) \_\_\_\_\_

**CURRENT MEDICATIONS**

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**TYPICAL DIET**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Cravings (sweet, salty, sour, bitter, spicy, other) \_\_\_\_\_

**EXERCISE** (type and amount)

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**LIFETIME REVIEW OF ILLNESSES** (list all serious physical or emotional complaints that you have suffered; it is helpful to begin with the most recent complaints first):

Psychological: \_\_\_\_\_

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*Musculoskeletal:* \_\_\_\_\_

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*Skin:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Lungs:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Heart and blood vessels:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Stomach and bowels:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Urinary:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Reproductive:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Other:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Please X any symptoms that apply to you now,  
check any that are significant from the past.

**Part A:**

- cough
- phlegm
- wheezing
- short of breath
- hoarseness
- sneezing
- loss of smell
- nasal congestion
- nasal discharge
- asthma
- allergies
- hay-fever
- itching eyes
- sinus headaches
- acne
- perspire easily
- itchy skin
- swollen glands
- vocal problems
- sore throats
- painful lymph nodes
- dry skin
- dry brittle hair
- smoker
- fatigues after perspiring
- catch colds easily
- grief
- melancholy- sadness
- crave spicy foods
- dislike dry weather
- dislike wind
- dislike damp weather

**Part B:**

- drooping eyelid
- prolapsed uterus
- prolapsed stomach
- gums bleed easily

- nose bleeds
- increased appetite
- decreased appetite
- diarrhea
- loose stool
- constipation
- # of bowel movements per day \_\_\_\_\_
- heartburn
- ulcers
- stomach pain
- intestinal rumbling
- alternating constipation & diarrhea
- butterfly sensation in stomach
- bad breath
- poor memory
- inability to concentrate
- known allergies
- please list allergies: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- loss of taste
- crave sweets
- list cravings: \_\_\_\_\_
- \_\_\_\_\_
- bruise easily
- slow wound healing
- poor digestion
- abdominal bloating
- fatigue after eating
- discomfort after eating
- nausea
- vomiting
- belching - burping
- flatulence
- hemorrhoids
- hernia

**Part C:**

- headache
- where on your head \_\_\_\_\_
- migraine
- tight or constricted chest
- anger easily
- pains increase with stress
- clear throat often
- high blood pressure
- last reading \_\_\_\_ / \_\_\_\_
- acid regurgitation
- vertigo
- eyes red
- yellow eyes/skin
- spots before eyes
- hiccups
- irritable
- lower rib pain
- bitter taste in mouth
- frustration
- sensation of something in throat
- premenstrual symptoms
- describe: \_\_\_\_\_
- \_\_\_\_\_
- dizziness
- eyes tired
- eyes sensitive
- blurred vision
- eyes sore
- high cholesterol
- high triglycerides
- history of hepatitis

**Part D: Women Only**

- age at first period
- age of menopause
- painful menses
- cycle (ie. every 28 days)
- irregular cycle
- length of flow (ie. 4-7 days) \_\_\_\_
- clots
- cramps later in flow
- recent change in cycle
- history of vaginal warts
- vaginal pain
- irregular pap test
- breast distension

- breasts painful
- fibroid tumors
- fibrocystic breast/ovary
- cramps early in flow
- color of flow: dark \_\_\_ light \_\_\_ bright \_\_\_
- # of pregnancy
- miscarriages
- infertility
- GYN surgeries
- please list: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Part E:**

- fatigue
- slump time of day \_\_\_\_ am/pm
- awakens fatigued
- cold feet
- cold hands
- urine color: dark \_\_\_ light \_\_\_ clear \_\_\_
- urination daily:
  - 4-6 times \_\_\_\_
  - 6-10 times \_\_\_\_
  - 10+ times \_\_\_\_
- night urination
- decreased stream or amount
- urgent urination
- painful urination
- ear ringing
- hearing loss
- dark circles
- weak/sore knees
- rheumatoid arthritis
- hair loss
- impotence
- chronic urinary infections
- intolerant of cold
- history of kidney infection
- joints stiff
- difficulty breathing
- fear
- anxiety
- morning diarrhea
- low energy
- sex drive: high \_\_\_ low \_\_\_ normal \_\_\_

**(Part E cont.)**

- incontinence
- difficult urination
- burning/painful urination
- swelling ankles
- puffy beneath eyes
- lower back pain
- loose teeth
- osteoarthritis
- infertility
- spermatorrhea
- abnormal thirst
- craves salt
- history of kidney stones
- joints painful
- pains get worse with exercise
- phobias
- asthma
- seminal emission
- memory loss

**Part F:**

- palpitations
- speech problems
- delirium
- jittery
- sweat at night
- hot palms
- insomnia
- pale skin
- missed pulse beats
- feeling of impending doom
- dry mouth
- chest pain
- restlessness
- irritability
- short of breath
- flushing in afternoon
- numb hands
- sore tongue
- mouth sores
- heart murmur
- chest congested
- scanty, yellow urine
- racing heart beat

**Part G:**

- sense of heaviness
- favor warm drinks
- physical labor
- muscle cramps
- fever/chills
- brittle nails
- favors cold drinks
- sedentary work
- regular exercise
- twitches/spasms
- weakness

**Part H: Please Check Medications that Apply to You**

- antacids
- antidepressants
- antibiotic/antifungal
- glucose regulator/insulin
- anti-inflammatory
- Aspirin/Tylenol/Advil
- chemotherapy
- heart medications
- blood pressure medications
- hormones
- laxatives
- oral contraceptives
- radiation
- recreational drugs
- thyroid medications
- relaxants/sleeping aids
- ulcer medications

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other: Please Check What Applies to You**

- alcohol
- coffee
- decaf
- candy
- cigarettes
- carbonated beverages
- diet sodas

**(Check Cont.)**

- distilled water
- fried foods
- fast foods (regularly)
- refined sugars
- red meat (regularly)
- margarine

**Check if You:**

- diet often
- exercise
- salt foods w/o tasting
- are under excessive stress
- exposed to chemicals
- work at a computer

**Check What Applies to You:**

- appendicitis
- scarlet fever
- typhoid fever
- HIV
- rheumatic fever
- nephritis
- malaria
- anemia
- mumps
- measles
- small pox
- eczema
- diabetes
- diptheria
- heart disease
- pneumonia
- polio
- jaundice
- hearing loss
- tuberculosis
- herpes
- tonsilectomy
- hepatitis
- epilepsy
- obesity
- asthma
- cancer
- heart attack
- goiter

- influenza
- pleurisy
- meningitis
- chemical poisoning
- drug reaction
- allergic reaction
- whooping cough
- alcoholism
- mental disorders
- eating disorders
- venereal infection

Anything else you would like us to be aware of:

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**Supplements:**

Vitmins/Minerals/Herbs/Homeopathics:

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**Other Comments:**

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