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 licensed acupuncturists of Palouse Acupuncture, LLC 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 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. 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 Palouse Acupuncture, LLC 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 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.

PATIENT SIGNATURE	**X**

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

Acupuncture Guidelines:

Only single-use, sterile, disposable needles are used at this clinic.

To gain the most benefit from your acupuncture treatment, please follow the guidelines listed below:

1. Don’t engage in strenuous or vigorous activity, including sexual activity 8 hours before or after your treatment.
2. Avoid drinking alcohol and/or taking recreational drugs before and after your treatments.
3. If you feel light-headed after your acupuncture treatment, drink an extra glass of water and have a snack. Acupuncture has a tendency to lower your blood sugar and your blood pressure. To avoid this at your next treatment, have a light snack 15-20 minutes before arriving to your appointment.
4. Avoid excessively cold food, drink and cold physical environments. Cold food and drink damages the spleen and stomach energy and can cause upset stomachs and other digestive problems. Cold environments can discourage proper qi and blood flow in the body. For example, women should never submerge their bodies in cold water – the cold disrupts the qi flow in the uterus which can aggravate abdominal cramping and other pre-menstrual symptoms.
5. Drink 50% more water on days you are getting acupuncture. Acupuncture treatments are similar to a deep tissue massage; many of the built up toxins in your muscles and tissues are released. It is important to flush out the toxins before they re-settle.

It is not uncommon for patients to experience an increase in pain after a treatment for a few days; do not be alarmed. It is a positive and encouraging result if you experience any increase, decrease or change in pain patterns after an acupuncture treatment.

Typically, patients have quicker results if acupuncture is started as soon as a symptom occurs and definitely if acupuncture is started before two weeks have passed since the onset of symptoms.

Arbitration Agreement

Article1: 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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 of 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 AN 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)
PALOUSE ACUPUNCTURE, LLC SIGNATURE and DATE	X	

Palouse Acupuncture, LLC
619 S Washington Street, Suite 202
Moscow, Idaho 83843

Patient Name: _____Date of Birth: _____/_____/_____M/F:_____
Patient Address:_____City:_____State:_____Zip:_____
Phone Number:_____ Email Address:_____
Emergency Contact: _____Phone Number:_____
How did you hear about us? _____

Insurance information: If you do not have insurance please write "*self pay*" in the space below.
Insurance company name: _____ Policy number: _____
Note: In order to check eligibility and benefits, you will need to present your insurance card at the time of service.

Medical History: Please list the dates of any significant or relevant past medical diagnosis.
_____
_____

Surgical History: Please list the dates of all surgeries.
_____
_____

Family History: Please list any relevant health problems of members in your immediate family.
_____
_____

Current medications: Please list all current medications, supplements and/or herbal formulas + dosage.
_____
_____

Social History: Married / Single / Divorced / Widowed / Retired / Employed / Unemployed

Use of tobacco products: Y/N _____per day . Use of alcohol: Y/N ____drinks per week.

Exercise: _____x/week. Please circle the intensity that best describes your workouts: Mild / Moderate / High

Women's Health: (Men please skip this section.)

Age of first period: _____years old. Average days of bleeding: _____ Average days between periods: _____

What color is the blood? Check all that apply: _____ light red _____ red _____dark red _____purple _____brown

Circle any that apply: Clotting Breast tenderness Mood swings Abdominal pain

Painful periods Heavy periods Frequent yeast infections Abnormal discharge

Abnormal pap smear Abnormal mammogram Other:_____

Type of contraception: _____Number of pregnancies_____ Number of live births_____

Menopause: Please list any uncomfortable symptoms you would like to address with acupuncture:
_____

Purpose of today's visit:

_____

_____

Review of Systems: Please circle all that apply.

Dislikes heat/cold	Fever/chills	Abnormal sweating		Night sweats	Hot flashes
Poor energy	Insomnia	Headaches		Dizziness	Vertigo
Blurring of vision	Floaters	Eye pain		Redness	Excessive tearing
Eye dryness	Cataracts	Glaucoma		Tinnitus	Hearing loss
Ear infection	Earaches	Sinusitis		Hay fever	Nosebleeds
Nasal congestion	Sinus pain	Sinus pressure		Post nasal drip	Bleeding gums
Mouth dryness	Gingivitis	Sore tongue		Abnormal taste in mouth	
Heart trouble	Chest pain	Heart palpitations		High/low blood pressure	
High cholesterol	Edema	Wheezing	Chest pain	Coughing	Asthma
Shortness of breath	Dyspnea	Pleurisy	Bronchitis	Emphysema	Diarrhea
Constipation	IBS	Gas	Bloating	Indigestion	Heartburn
Acid reflux	Nausea	Vomiting	Belching	Hemorrhoids	Frequent urination
Incontinence	Increased urination at night		Kidney stones	Weakness of knees or low back	
Tingling	Numbness	Neuropathy	Neuralgia	High stress	Anxiety
Depression	SADD	ADHD	Diabetes	Thyroid trouble	HIV/AIDS
Hepatitis A / B / C	Other: _____				

Musculoskeletal Pain:		Neck	Thoracic	Low back	Shoulder	Hip	
Sciatic	Leg	Knee	Ankle	Foot	Elbow	Wrist	Hand
Joint	Fibromyalgia	Arthritis	Other:_____				

Pain scale: On a scale 0-10 (Ten is high), how high would you rate your pain today? _____ / 10

Policies

Appointments, Cancellations and Late arrival policy:

Appointments can be made by accessing our online scheduling system at www.palouseacupuncture.com. Click on the "Book Now" button to access the calendar of available appointments. You can also schedule by calling Palouse Acupuncture, LLC Tuesday thru Saturday 10:00am to 5:00 pm. The phone number is (208) 882-8534. If you are unable to speak to our receptionist, please leave your name and phone number and we will call you back.

We kindly request that you give 24 hours notice when cancelling an appointment. A fee of **$25.00** will be charged to your balance if you cancel or miss your appointment without **24 hours notice**.

Late arrivals result in delayed treatment for other patients. If you arrive more than 10 minutes past your appointment time, but still wish to be treated, you will receive an abbreviated treatment, but will be charged the full amount.

Payment Policy:

The patient is solely responsible for checking their medical plan for coverage. Please be sure to check if your plan covers acupuncture. Payment is due at the time of service. Payment is accepted in the form of cash, check and credit/debit. Any over-payment in cash will result in a positive credit to your account. If you wish to access that credit, please give 2 business days notice.

All patients are responsible for deductibles and/or any service not reimbursed by their insurance. This includes any service deemed "not medically necessary" by their insurance. All insurance payments belong to Palouse Acupuncture, LLC. Any insurance payments received by the patient for acupuncture services performed at Palouse Acupuncture, LLC must be turned over to Palouse Acupuncture, LLC. Any amounts not turned over will be billed to the patient and sent to collections if not paid within 30 days.

Primary Care Policy:

Palouse Acupuncture, LLC is not a Primary Care Facility. Patients seeking treatment at Palouse Acupuncture, LLC should have a separate Primary Care Provider.

Time of Service Payment Discount Program:

Palouse Acupuncture, LLC is committed to serving the healthcare needs of its patients and has established the Time of Service Payment Discount Program to assist both uninsured and under-insured patients.

Palouse Acupuncture, LLC considers a patient:

-Uninsured when a patient has no health insurance and
-Under-insured when a patient's primary, secondary and other health insurance will not cover acupuncture services. Insured patients must follow the rules of their insurance plan.

Under this Time of Service Payment Discount Program, all fees must be paid in full the day you receive treatment

Time of Service Payment Discount Fees:

$125 Initial consultation for Acupuncture
$85 Return visits for Acupuncture

By signing below, I authorize that I have read and agree to the terms and conditions contained in the above policies:

Patient Signature:		Date:	