

# SERENITY ACUPUNCTURE, INC. – JENNIFER FREY, L.Ac., EAMP, AP

520 NORTH 5<sup>TH</sup> AVENUE \* SEQUIM, WA 98382 \* 360-683-8550 \* [JFREYLAC@GMAIL.COM](mailto:JFREYLAC@GMAIL.COM)  
WWW.SERENITYACUPUNCTURECLINIC.COM

## Confidential Patient Intake Form

Today's Date: \_\_\_\_\_

Information contained in this form is considered strictly confidential. Your responses are important to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

What would you like to be called in our office? \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_ Phone #3 \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact – Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

\*\*\*\*\*

Give a brief detailed description of the primary issue(s) you are currently experiencing:

\_\_\_\_\_  
\_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_ Is this condition:  Getting Worse  Better  Same

When did the condition begin? \_\_\_\_\_

Is the condition interfering with:  Work  Sleep  Daily Routine  Other: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No - Comments: \_\_\_\_\_

What seems to make this issue better? \_\_\_\_\_ worse? \_\_\_\_\_

Other issues you would like addressed: \_\_\_\_\_

\*\*\*\*\*

Please indicate your area(s) and type(s) of pain on the figures below:

numbness

-----

pins & needles

oooooooo

burning

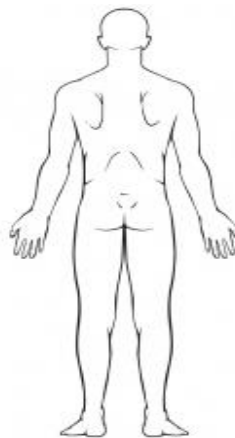
xxxxxxxx

aching

\*\*\*\*\*

stabbing

////////



Please a mark at the level of your pain on the scale below:

No pain \_\_\_\_\_ worst possible pain

Other doctors/therapists that have treated this condition: \_\_\_\_\_

Have you been given a diagnosis?  Yes  No – If yes what was it? \_\_\_\_\_

Family physician's name (if you have one): \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Was this the result of a work or auto injury?  Yes  No – Comments: \_\_\_\_\_

# Review of Health History

Name: \_\_\_\_\_

Please check the corresponding boxes if you have the condition now or have had it in the past.

<u>General</u>	<u>Now</u>	<u>Past</u>	<u>Neck</u>	<u>Now</u>	<u>Past</u>	<u>Genitourinary</u>	<u>Now</u>	<u>Past</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Lumps / Masses	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Cough Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women Only</b>		
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiovascular</b>			Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
<b>Head</b>			Rapid Pulse	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Itching	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Spotting	<input type="checkbox"/>	<input type="checkbox"/>
TMJ Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Menses: _____		
<b>Eyes</b>			Blue Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>	Length of Cycle: _____		
Last Eye Exam:			High BP	<input type="checkbox"/>	<input type="checkbox"/>	Days of Flow: _____		
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Low BP	<input type="checkbox"/>	<input type="checkbox"/>	Color: bright red/ dark red/ pale red/ Clots: <input type="checkbox"/> yes <input type="checkbox"/> no		
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<b>Blood</b>			Birth Control Type: _____		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	# of Pregnancies: _____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Low Iron	<input type="checkbox"/>	<input type="checkbox"/>	# of Births: ___ Miscarriages: _____		
Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Period: _____		
<b>Ears</b>			Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no		
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to get pregnant? _____		
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Tender Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Date of Last PAP: _____		
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Mammogram: _____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Men Only</b>	<u>Now</u>	<u>Past</u>
<b>Nose</b>			Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Mass	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Prostate Exam: _____		
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological</b>	<u>Now</u>	<u>Past</u>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Undigested Food	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mouth</b>			Gas	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Black/ Tarry Stool	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
<b>Throat</b>			Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/ Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>						

# Review of Health History (continued)

Name: \_\_\_\_\_

Please check the corresponding boxes if you have the condition now or have had it in the past.

Musculoskeletal	Now	Past	Musculoskeletal	Now	Past	Psychiatric	Now	Past
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Joint	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
			Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
			Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
			Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

Please check the corresponding box if you have had any of the following conditions.

<input type="checkbox"/> Measles	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<u>Blood Type:</u>	<u>Immunizations/ Vaccinations:</u>
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> A+	<input type="checkbox"/> DPT
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> A-	<input type="checkbox"/> MMR
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> B+	<input type="checkbox"/> Smallpox
<input type="checkbox"/> Tumor	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> B-	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Angina	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> AB+	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Parasites	<input type="checkbox"/> Migraine	<input type="checkbox"/> AB-	<input type="checkbox"/> Influenza
<input type="checkbox"/> Stroke	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> STD	<input type="checkbox"/> O+	<input type="checkbox"/> Polio
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Herpes	<input type="checkbox"/> O-	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Goiter	<input type="checkbox"/> HIV / AIDS		

**Surgeries/ Injuries/ Serious Illnesses:**

\_\_\_\_\_

**Medications/ Vitamins/ Supplements:**

\_\_\_\_\_

**Allergies:**

\_\_\_\_\_

**Social History: please check the box that most accurately represents you or fill in the blanks.**

<b>Mental Work:</b> <input type="checkbox"/> none <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy <b>Physical Work:</b> <input type="checkbox"/> none <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy <b>Exercise:</b> - Days per week: _____ Types: _____	<b>Sleep:</b> _____ hours per night: Quality: <input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> good <input type="checkbox"/> excellent Difficulty Falling Asleep? <input type="checkbox"/> yes <input type="checkbox"/> no Frequent Waking? <input type="checkbox"/> yes <input type="checkbox"/> no - if so what times? Dream-Disturbed? <input type="checkbox"/> yes <input type="checkbox"/> no
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**Past Occupational History:** \_\_\_\_\_

**Please indicate usage per day or per week of the following:**

Water: _____ glasses per day - <input type="checkbox"/> room temp. <input type="checkbox"/> cold	Soft Drinks: _____ per day/week - <input type="checkbox"/> regular <input type="checkbox"/> diet
Coffee: _____ cups per day/week (circle)	Juice: _____ per day/week (circle)
Tea: _____ cups per day/week (circle)	Sweets: _____ per day/week (circle)
Alcohol: _____ drinks per day/week (circle)	Cigarettes: _____ packs/day for _____ years
Type: <input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> liquor	

**Please describe your energy levels:**

How is your energy? (Please circle)	Low - 0 1 2 3 4 5 6 7 8 9 10 - High
What time of day is your energy highest?	<input type="checkbox"/> 6am - 12pm <input type="checkbox"/> 1 pm - 5pm <input type="checkbox"/> 6pm - 12am
What time of day is your energy lowest?	<input type="checkbox"/> 6am - 12pm <input type="checkbox"/> 1 pm - 5pm <input type="checkbox"/> 6pm - 12am

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## **Patient Notification of Qualifications and Scope of Practice and Informed Consent**

East Asian Medicine means a healthcare service using East Asian Medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. Qualifications for Jennifer L. Frey, L.Ac., EAMP, AP include the following education and license information:
  - Master's degree in Traditional Oriental Medicine  
Emperor's College - Santa Monica, CA (1/99 – 12/02)
  - WA ST Lic. # AC00002119, 1/14/03
  - FL ST Lic. # AP 2873
2. The scope of practice for an East Asian Medicine Practitioner in the state of Washington includes the following:
  - Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; and
  - Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); and
  - Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; and
  - Breathing; Relaxation; East Asian exercise techniques; Qi gong; East Asian massage and Tui Na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
  - Superficial heat and cold therapies.
3. Acupuncture is a generally safe method of treatment, but it may have side effects. These include, but are not limited to:
  - Pain following treatment; minor bruising, numbness or tingling near the needle sight and dizziness. Unusual and rare risks of acupuncture include fainting, spontaneous miscarriage, nerve damage and organ puncture (such as pneumothorax).
  - Burns and/or scarring are a potential risk of moxibustion and cupping.
  - Infection is a possible side-effect, however, this clinic uses disposable needles and maintains a clean and safe environment.
4. I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I choose to rely on the practitioner to exercise judgment for the best course of treatment for my best interest, based on the facts known at the time. I understand that results are not guaranteed.
5. I agree to inform the East Asian Medicine Practitioner if I have a severe bleeding disorder, pace maker or any potentially serious conditions prior to any treatment.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Terms and Conditions of Service**

### **Cancellation Policy**

We request that all cancellations be made with a minimum of 24-hour notice. Failure to provide 24-hour notice or a failure to show may result in your account being charged for the visitation at our standard fee. Thank you for your understanding.

### **Financial Agreement**

The patient or patient's representative shall pay Serenity Acupuncture – Jennifer Frey, LAc for services rendered in accordance with the regular rates and terms of the clinic. When this agreement is executed by the patient or patient's representative all shall be jointly and individually liable.

The patient or patient's representative hereby agrees to the above stated terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat 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. 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 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)

(date)

(Indicate relationship if signing for patient)

## NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from healthcare providers.
- Information we receive from third party payers.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. This office may use or disclose your *protected health information* when required by law. You may specifically authorize us to use *protected health information* for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to share your information with.

This office may send correspondence, such as, birthday cards, newsletters and appointment reminders, by phone calls, post cards, letters, emails or text.

Patient Rights:

**Upon written request –**

- You have the right to access, review or receive copies of your healthcare files.
- You have the right to receive a list of items this office has disclosed about your health information.
- You have the right to request that this office place additional restrictions on disclosure of your *protected health information*.
- You have the right to request that we amend your *protected health information*.
- You have a right to receive all notices in writing.

Complaints:

Complaints about your privacy rights or how your privacy is handled at this office can be submitted to our office directly. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)  
200 Independence Avenue, S.W.  
Room 509F B Building  
Washington, D.C. 20201

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I have read, understand and agree to the Notice of Privacy Policies from this office.

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that I have the right to request a restriction of how my protected health information is used. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_