NEW PATIENT INFORMATION

ORLANDO ACUPUNCTURE

POST OFFICE BOX 4171, WINTER PARK, FL 32793 PH. 407-673-6700

PATIENTS NAME:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WORK / CELL PHONE:

DATE OF BIRTH: OCCUPATION:

MARITAL STATUS: CHILDREN / AGES:

HOBBIES, RELAXATION: HOW DID YOU HEAR ABOUT US:

E-MAIL ADDRESS:

EMERGENCY CONTACT: PHONE: RELATION:

MEDICAL DOCTOR:

OTHER HEALTHCARE PROVIDER(S):

IS THERE ANYTHING LIMITING YOU FROM CARE: NO YES

CONTACT ME FOR APPOINTMENT CONFIRMATIONS VIA: TEXT MSG – PHONE CALL – EMAIL

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

□ PACEMAKER □ SEIZURE DISORDER □ METAL IN BODY (other than fillings) □ BLEEDING DISORDER
□ HYPOGLYCEMIA or DIABETES □ BELIEVE YOU ARE OR MAY BE PREGNANT □ CANCER

LIST ALL HERBS, VITAMINS OR ANY OTHER SUPPLEMENTS THAT YOU ARE CURENTLY TAKING:

MAJOR COMPLAINT IN ORDER OF SIGNIFICANCE TO YOU:

HOW DO THESE CONDITIONS IMPAIR OR LIMIT YOUR DAILY ACTIVITIES?

FAMILY MEDICAL HISTORY: ALLERGIES ASTHMA CANCER DIABETES

HIGH BLOOD PRESSURE HEART DISEASE SEIZURES STROKE

DO YOU HAVE A REGULAR EXERCISE PROGRAM? PLEASE DESCRIBE:

HAVE YOU EVER BEEN ON A RESTRICTED DIET? WHAT KIND:

PLEASE DESCRIBE YOU AVERAGE DAILY DIET:

MORNING AFTERNOON SNACKS EVENING

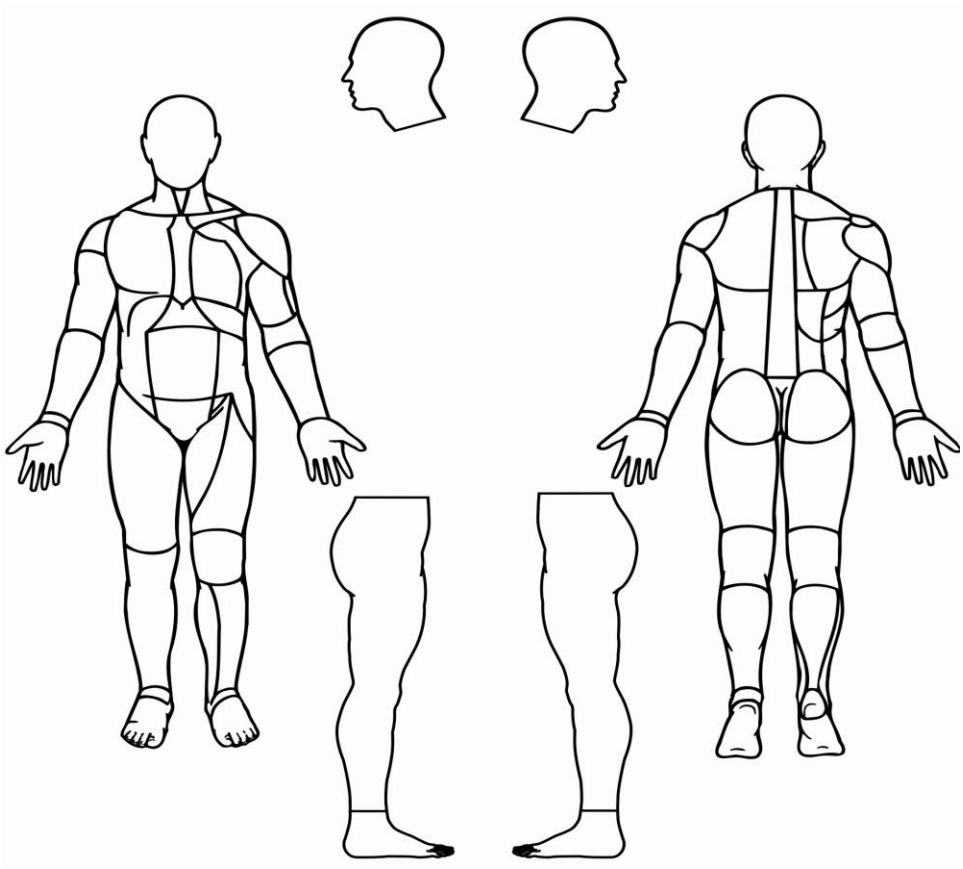
DO YOU CONSUME: CIGARETTES ALCOHOL COFFEE SODA TEA

IF SO HOW MUCH:

INDICATE ANY MEDICATIONS YOU ARE TAKING:

NAME OF MEDICATION	CONDITION PRESCRIBED FOR
Result:	
Result:	
Result:	
Result:	
Result:	
Result:	
Result:	
Result:	

PLEASE POINT OUT ANY PAINFUL OR DISTRESSED AREA(S):



PAYMENT FOR SERVICE

The best care can be provided with open communication and mutual understanding. We invite early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. Patients are expected to pay at the time services are rendered. Because most Insurance plans will cover your treatment we encourage you to let us verify your eligibility and benefits.

INSURANCE: Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. *WE CANNOT GUARANTEE PAYMENT FOR YOUR CLAIMS.* If your insurance company pays only a portion of the bill, or rejects your claim, or applies it toward your deductible you are responsible for any unpaid balance. An explanation of benefits will be sent to you the policyholder. When you receive this information please advise the office if you have any questions or concerns about it.

- Patients having PPO and Company benefits will be required to pay the normal co-payment, which typically ranges from $5 to $35**.**
- ***PATIENTS ARE REQUIRED TO REIMBURSE ORLANDO ACUPUNCTURE, INC (JOHN BARNETT, AP) ANY AMOUNT PAID DIRECTLY TO THE PATIENT.***

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PRIVATE, GROUP, ACCIDENT, AND HEALTH INSURANCE AND AGREEMENT TO BE FINANCIALLY RESPONSIBLE FOR FEES

PATIENT/ GUARANTOR: _____ Date of Birth: _____

INSURANCE COMPANY: _____

CLAIM/GROUP: _____ ID#:_____

SS#:_____

I hereby instruct and direct that the above Insurance Company pay by check made out and mailed to: ***ORLANDO ACUPUNCTURE, INC ., PO Box 4171, Winter Park, FL 32793***

Or:

If my current policy prohibits direct payment to physician, then I hereby also instruct and direct you to make out the check to me and mail it as follows: ***Orlando Acupuncture, Inc., PO Box 4171, Winter Park, FL 32793***

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY.***

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I understand that I am financially responsible for all charges and that some or perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1% will be applied to any unpaid balance over 30 days.

Signature of Policyholder:_____ Date:_____

Office Signature_____

ORLANDO ACUPUNCTURE

PATIENT POLICIES

ACUPUNCTURIST – PATIENT AGREEMENTS

Welcome to Orlando Acupuncture

The purpose of these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following policies get the best results.

1. PATIENT POLICY: CLOTHING

The acupuncture points used for your condition will determine the areas of your body that need to be exposed. Please wear clothing that is loose fitting (e.g.: pants that can be moved above the knee) or bring shorts. You will be notified if a gown is necessary. If you need to change clothing, you may use one of the treatment rooms.

2. PATIENT POLICY: NO-WAIT CLINIC PROCEDURES

Please arrive 5 minutes before your designated time (for example, if you have an appointment at 9:00, arrive at 8:55). This will help to insure that patients are treated in a timely manner.

Please finish any cell phone calls before your appointment time. Patients on a cell phone will <u>not</u> be taken back for treatment.

3. PATIENT POLICY: PAYMENT OF BILLS

We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. It is not our policy to bill patients. Our policy is that patients not maintain a personal balance due.

4. PATIENT POLICY: MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

1. If you need to change the time of your appointment, plan to come at another time on the same day.

2. If the same day is not possible, be sure to make up the missed appointment within 7 days.

3. If you miss or cancel an appointment without at least a 24 hour notice you will be charged a $35 missed appointment fee unless you schedule a make-up appointment within 7 days.

5. PATIENT POLICY: RE-EXAMINATIONS

During your treatment series, Re-Examinations may take place approximately once a month. The purpose of these visits will be to review your progress and make any adjustments necessary. It will also give us time to determine if any new condition needs to be treated and how you are progressing so far. It is important to arrive 10 minutes early for the Re-Exam since forms have to be filled out by the patient, and the Re-Exam will take approximately 15 – 20 minutes.

6. PATIENT POLICY: DIETARY SUGGESTIONS, LINIMENTS, FOOD SUPPLEMENTS, AND HERBS

If applicable, dietary suggestions should be followed, herbs and food supplements taken, and liniments used. Any problems you may have with these recommendations should be communicated to your Acupuncturist.

7. PATIENT POLICY: NOTIFY THE OFFICE IF YOU BECOME SICK

Infections and illnesses, such as colds, flu's, ear infections, and allergies (known as wind invasions in Oriental Medicine), are, often times, easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization, and second, it could be complicated by your current herbal formula. It is essential to let your acupuncturist know of such illnesses.

8. PHARMACEUTICAL DRUGS: ALWAYS CONSULT YOUR DOCTOR

An Acupuncturist in the State of Florida is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency condition. **If the patient decides they want to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so.**

I agree (Initial)_____

9. PATIENT POLICY: UPSETS

We are here to serve you. Please speak with your acupuncturist, the Clinic Director, or our Case Manager about any upsetting matter. We see your comments as allowing us to help you and others. Thank you

I have read the above and I understand and accept these policies.

_____ _____

Patient's Signature Date

_____

Patient's Name (Print)

ORLANDO ACUPUNCTURE

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

A.) Please read and fill in all the information that pertains to you.
B.) On following pages, under each category, check all the symptoms that you experience either acutely or chronically. Mark the column on the left hand side only. The big charts to the right are reserved for future appointments and re-evaluations.
C.) Add and total all the boxes that you checked.
D.) Date today's date

	TEST	DATE	TEST RESULTS
	Physical		
	Cholesterol		
	Prostate		
	Mammography		
	Pap Smear		
	Blood (Which Test)		
	HIV/STD		
	Other		

PLEASE INDICATE IF YOU HAVE (OR HAVE HAD) ANY OF THE FOLLOWING:							
	Diabetes		Allergies		Rheumatic Fever		Vein Condition
	Heart Disease		CVA (Stroke)		Thyroid Disorder		Tuberculosis
	Asthma		Pneumonia		Emphysema		Chicken Pox
	High Blood Pressure		Gonorrhea		Bleeding Tendency		Polio
	Syphilis		Measles		Nervous Disorder		Migraines
	Meningitis		HIV		Mononucleosis		Other Liver Illnesses
	Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
	Paralysis		Cancer		Jaundice		Other Kidney Illnesses
	Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

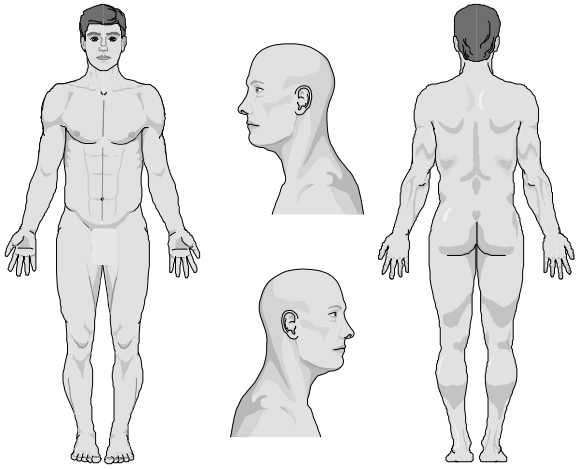
IMMUNIZATIONS

SURGERIES

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

1. PAIN

On the figures below, please mark clearly any areas of pain and indicate any scars.



WHAT MAKES THE PAIN BETTER?	
	Soft Pressure
	Hard Pressure
	Cold
	Heat
	Exercise
	Rest
	Other
WHAT MAKES THE PAIN WORSE?	
	Soft Pressure
	Hard Pressure
	Cold
	Heat
	Exercise
	Other

2. DESCRIBE YOUR PAIN

Under each category, check all of the symptoms that you have experienced in the last 6 months. Mark the column on the left hand side only. The numbered columns to the right are reserved for future re-evaluations. Please total and date the boxes at the bottom.

	Sharp
	Fixed
	Burning
	Moving
	Cramping
	Aching
	Dull
	Other
	TOTAL BOXES CHECKED
/	Date

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
/	/	/	/	/	/	/	/	/	/

3. KIDNEY FUNCTION
(Overall Temperature)

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Cold Hands										
	Cold Fingers										
	Cold Toes										
	Cold Feet										
	Sweaty Hands										
	Sweaty Feet										
	Hot Body Temp Sensation										
	Cold Body Temp Sensation										
	Afternoon Flushes										
	Night Sweats										
	Heat in hands, feet, & chest										
	Hot Flashes (any time of day)										
	Thirsty										
	Perspire easily										
	Lack of perspiration										
	Do you take water to bed										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

4. LUNG, KIDNEY FUNCTION
(Overall Energy)

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Shortness of Breath										
	Difficulty keeping eyes open										
	General Weakness										
	Easily Catch Colds										
	Low Energy										
	Feel Worse After Exercise										
	Chronic Fatigue & Malaise										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

5. LIVER, SPLEEN, HEART FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Dizziness										
	See Floating Black Spots										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

6. HEART FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Anxiety										
	Sores on tip of tongue										
	Restlessness										
	Mental confusion										
	Chest Pain traveling to shoulder										
	Frequent dreams										
	Wake un-refreshed										
	Coffee? How much per week? __										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

7. SPLEEN FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Low Appetite										
	Abrupt Weight Gain										
	Abrupt Weight Loss										
	Abdominal Bloating										
	Abdominal Gas										
	Gurgling Noise in Stomach										
	Fatigue after eating										
	Prolapsed Organs? _____										
	Bruise easily										
	Over Think										
	Worry										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

8. SPLEEN, STOMACH, SMALL/LARGE INTESTINE FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Loose Stools										
	Constipated										
	Incomplete Stools										
	Diarrhea										
	Blood in Stools										
	Mucous in Stools										
	Undigested food in the Stools										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

9. STOMACH FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Burning sensation after eating										
	Large appetite										
	Bad Breath										
	Canker Sores (mouth)										
	Bleeding, swollen, painful gums										
	Heartburn										
	Acid Regurgitation										
	Ulcer (Diagnosed? Y/N)										
	Belching										
	Hiccups										
	Stomach Pain										
	Vomiting										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

10. DAMPNESS TRAPPED IN THE BODY

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Bodily sensation of heaviness										
	Mental Heaviness										
	Mental Sluggishness										
	Mental Fogginess										
	Swollen Hands										
	Swollen Feet										
	Swollen Joints										
	Chest Congestion										
	Nausea										
	Snoring										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

11. LIVER FUNCTION (EYES)

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Itchy										
	Bloodshot										
	Hot										
	Dry										
	Watery										
	Gritty										
	Blurry Vision										
	Decreased Night Vision										
	Near-sighted										
	Far-sighted										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

12. URINATION (BLADDER FUNCTION)

Please Select a Color		Pale Urine		Dark Yellow Urine		Clear Urine

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Reddish										
	Cloudy										
	Scanty										
	Profuse										
	Strong Odor										
	Burning										
	Painful										
	Discharge										
	Difficult										
	Urgent										
	Frequency										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

13. LUNG FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Nasal Discharge (color_____)										
	Cough										
	Nose Bleeds										
	Sinus Congestion										
	Dry mouth										
	Dry Throat										
	Dry Nose										
	Dry Skin										
	Allergies (to _____)										
	Alternating Chills / Fever										
	Sneezing										
	Headache (location _____)										
	Overall Achy Feeling in Body										
	Stiff Neck										
	Stiff Shoulders										
	Sore Throat										
	Difficulty Breathing										
	Smoke Cigarettes (__ per day)										
	Sadness										
	Melancholy										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

14. LIBIDO

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	High										
	Normal										
	Low										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

15. LIVER, GALL BLADDER FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Alternating Diarrhea/Constipation										
	Chest Pain										
	Tight Sensation in the Chest										
	Bitter taste in the mouth										
	Anger Easily										
	Depression										
	Frustration										
	Irritability										
	Skin Rashes										
	Headache at the top of the head										
	Tingling Sensation										
	Numbness										
	Muscle Twitching										
	Muscle Cramping										
	Muscle Spasms										
	Seizures										
	Convulsions										
	Lump in the Throat										
	Neck Tension										
	Shoulder Tension										
	Limited Range of Motion (neck)										
	Limited Range of Motion (shoulders)										
	Alcohol/day _____										
	Recreational Drugs _____										
	High-Pitched Ringing in Ears										
	Gallstones (history or current)										
	STD's (list _____)										
	Unable to Adapt to Stress										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

16. KIDNEY, URINARY BLADDER FUNCTION

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Frequent Cavities, Teeth Problems										
	Easily Broken Bones										
	Sore Knees										
	Weak Knees										
	Cold Sensation in the Knees										
	Low Back Pain										
	Memory Problems										
	Excessive Hair Loss										
	Low-Pitched Ringing in the Ears										
	Kidney Stones										
	Bladder Infections										
	Lack of Bladder Control										
	Wake during the night to urinate (2+)										
	Fear										
	Easily Startled										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

MEN ONLY

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Swollen Testes										
	Testicular Pain										
	Impotence										
	Premature Ejaculation										
	Coldness/Numbness in Genitalia										
	Other _____										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

WOMEN ONLY

FOR LONG TERM CARE PATIENTS ONLY: On the day of your RE-EVALUATION(S), CHECK OFF the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
	Nausea										
	Vomiting										
	Food Cravings										
	Water Retention										
	Breast Swelling										
	Breast Tenderness										
	Headaches										
	Migraines										
	Dull Pain (where _____)										
	Sharp Pain (where _____)										
	Depression										
	Irritability										
	Anxiety										
	Other (explain _____)										
	TOTAL BOXES CHECKED										
/	Date	/	/	/	/	/	/	/	/	/	/

Do you have regular menstrual cycles?	**Y / N**
Are you pregnant?	Y / N
Do you have bleeding between periods?	Y / N
Do you have vaginal discharge?	Y / N
Age of first menstruation	
Average Number of days in Flow	
Average Number of days in Entire Cycle	
Number of Children	
Number of Pregnancies	
Age of menopause	

Please fill in the menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): pale, bright red, brown rust, dark purple, other							
Amount of Flow: normal, heavy, light							
Pain Cramps: dull, sharp, other							
Vomiting (check if yes)							
Nausea (check if yes)							

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

ORLANDO ACUPUNCTURE

1890 State Road 436 • Suite 237 • Winter Park, FL 32792

(407) 673-6700

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to other unless you direct us to do so or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Officer at the number above.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

_____ _____

Patient or legally authorized individual signature — Date / Time

_____ _____

Printed name and signed on behalf of the patient — Relationship
Parent, legal guardian, representative.

_____

Witness/Staff Member

To promote communication and improve patient care we would like to send your medical doctor a report of your treatments. Please let us know your Primary Care Doctor's (Or Doctor that referred you) name and address or phone number, if you know it so that we can keep them apprised of your progress. (Optional)

_____

_____

_____

_____

Notice of Privacy Practices for
Orlando Acupuncture, Inc.
(HIPAA Notice)

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Your Health Information Rights

Although your health record is the physical property of the healthcare organization that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information obtain a paper copy of the notice of information practices upon request inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment purposes.
For example: Information obtained by an, acupuncturist, massage therapist, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. The acupuncturist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the acupuncturist will know how you are responding to treatment.

We will also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment purposes. **For example**: A bill may be sent to you or a third-party payer such as an insurance company, the Medicare program or any other organization, person or program that may be responsible for paying for services. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. **For example**: Health care providers within the organization, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes In your case and others like it. This Information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. An example is insurance billing done through a separate billing company who is an independent contractor. There may be additional independent contractors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to

notify or assist in notifying a family member, personal representative, or another person responsible for your care,
your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or otherwise provide information about additional services or health care products you may find useful.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance to enable product recalls, repairs, or replacement.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Legal Matters: In the event of' a claim,
litigation or other legal proceeding or contemplated legal matter, we may disclose health information to our attorneys and individuals or organizations working for them.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem
If have questions and would like additional information, you may contact John Barnett, the HIPAA Privacy Official, for Orlando Acupuncture, Inc. at Po Box 4171, Winter Park. FL 32793 or (407) 491-6411.

If you believe your privacy rights have been violated, you can file a complaint with the HIPAA Privacy Official for Orlando Acupuncture, Inc. or with the secretary of Health and Human Services.

There will be no retaliation for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ORLANDO ACUPUNCTURE

1890 Semoran Blvd., Suite 237, Winter Park, Florida 32792

INFORMED CONSENT

I voluntarily request and consent to be treated by Orlando Acupuncture, Inc. and its staff. The Clinic offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

All of the Orlando Acupuncture Acupuncturists are licensed by the State of Florida to practice acupuncture and Chinese Medicine, and are nationally board certified by the NCCAOM. In addition, they have all graduated with Masters Degrees from accredited Acupuncture schools.

The treatments may consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and channels
2. Use of electrical, mechanical, or magnetic devises to stimulate acupuncture points and channels
3. Moxibustion
4. Acupressure
5. Cupping
6. Chinese Massage ("Tui-Na"), Manual Therapy, or Dermal friction techniques
7. Infra-red heat
8. Use of Laser therapy
9. Use of Chinese Herbal Medicine or other nutritional supplements
10. Dietary advice based on traditional Chinese medical theory
11. Point injection therapy

I have been informed that acupuncture is a generally safe method of treatment, and acknowledge that there are some risks. Side effects may include, but are not limited to the following; Some pain, numbness, tingling, or bruising following treatment in or around the insertion area.
Unusual, but possible risks of acupuncture include but are not limited to the following; nerve damage, organ puncture, and Fainting. Infection is another possible risk, although the clinic uses single-use, sterile disposable needles to minimize this risk.

I will notify a clinical staff member who is caring for me if I am or become pregnant, if I have a severe bleeding disorder, have a history of seizures, or a pace maker prior to any treatment.

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 generally considered safe. 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 if I experience any of these symptoms. 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 there is neither an implied nor stated guarantee of success or effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding these procedures will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.
I hereby authorize Orlando Acupuncture, Inc. to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim. I also authorize Orlando Acupuncture, Inc. to obtain my medical records from other physicians or medical centers.

Patient Signature_____ Date_____

Patients Representative or Parent_____

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 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: 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_____ (Date)_____
(Or Patient Representative, indicate relationship if signing for patient)

OFFICE SIGNATURE_____