INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the student interns and/or the licensed acupuncturists on staff at The Family Healing Spot, LLC who now or in the future treat me while employed by, working or associated with or substituting for The Family Healing Spot, including those working at this clinic or any other associated clinics: Acupuncture and other Oriental medical procedures including: diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advise; and, healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioners, and/or with other clinic personnel the nature and purpose of Acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that Acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at The Family Healing Spot, LLC.

_____	_____
Patient's name (please print)	Patient's signature
_____	_____
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
_____	_____
Signature of Patient's Representative (if applicable)	Date Signed

I, THE UNDERSIGNED, DO AFFIRM THAT _____(THE PATIENT) HAS BEEN ADVISED BY, KIMBERLY BOLDRINI-SENN, LICENSED ACUPUNCTURIST, TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ (PATIENT Signature) _____ Date

_____ (ACUPUNCTURIST Signature) _____ Date

The Family Healing Spot, LLC

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, as to whether this agreement is unconscionable, and any 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, preceptors, or 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. 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 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 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 Name _____

Patient Signature _____ Date _____

Office Signature _____ Date _____

The Family Healing Spot, LLC

Patient Financial Responsibility

What if I do not have insurance or you are not a participating provider for my carrier?

For patients who do not carry heath insurance and those for whom we do not accept their policy, payment will be expected in full at the time of the visit. Anyone who feels it is necessary to extend payments over a period of time is invited to discuss arrangements with us prior to their visit.

What are my financial responsibilities as a patient?

As a patient, it is in your best interest to know and understand your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. If you do not notify our office of a change in coverage at the time of you appointment and your claim is denied as a result, you will be responsible for the charges of the claim in full.

To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Make sure that your insurance company lists your physician as a participating provider. It is possible that only one of our physicians participate with your insurance plan. Benefit and coverage rules and policies differ among insurers and even between different plans of the same insurer. If you go to an out-of-network provider, you may have a greater financial responsibility for services provided from a physician that is not under contract with your health care plan. Your insurance company can assist you in finding an in-network provider to limit the amount of money you will have to pay for care. Contact your plan's Customer Service department for further assistance.

What should I do if my insurance changes?

You are responsible to notify us of all changes to your insurance coverage. Please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID or government issued ID.

IF WE ARE NOT NOTIFIED OF APPROPRIATE CHANGES AT THE TIME OF YOUR VISIT, WE CANNOT GUARANTEE INSURANCE PAYMENT. IF YOUR CLAIM IS DENIED BECAUSE WE WERE NOT NOTIFIED AT THE TIME OF YOUR VISIT YOU WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. INITIAL_____

Why are you asking for my deductible, co-insurance or co-payment at the time of my visit?

We ask that payments be made when you are at the physician office so you will not be bothered with an invoice sent to your home after your visit. It also helps us reduce our costs and saves you the trouble of mailing a payment back to our office.

What if my insurance plan requires a referral and/or a prior authorization?

If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior your appointment in our office.

If your insurance company requires a referral and/or prior authorization and you do not have one, you may not be seen for your scheduled appointment, or you will be responsible for full payment of your bill at the time of service. If you require more than one visit for treatment or if the referral has expired, you must contact your primary care physician for another referral and/or prior authorization.

When can I expect to receive a bill? Why was I sent a statement when my insurance company is supposed to pay my bill?

For patients with health insurance, once your insurance company has responded to our claim we will bill you accordingly. Payment will be due thirty (30) days after a bill is sent to you.

Whether you have insurance coverage or not, you as the patient are ultimately responsible to make sure your bill is paid. If you receive a statement showing that your insurance company has not paid, it may be helpful for you to contact your insurance company to ask why payment has not been made.

Where do I send payment? What methods of payment are accepted?

You can make payment in person or over the phone during our office hours, or you can mail payment to:

Kim Boldrini-Senn
The Family Healing Spot, LLC
1010 Park St, Suite 2W-3
Peekskill, NY 10566

Payment can be made with check, money order, cash, Visa or MasterCard. Checks should be made

to: The Family Healing Spot, LLC

There is a $35 fee for returned checks.

I _____ have read and thoroughly understand my financial responsibility for all services rendered. I am aware my insurance contract is between me and my insurance company and I will be billed by my provider for any services rendered not payable.

Signature _____ Date _____

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to The Family Healing Spot, LLC's "Notice of Privacy Practices. I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by Kim Boldrini-Senn or individuals authorized by The Family Healing Spot, LLC All information that can identify me personally will be removed. By signing this form, I am giving The Family Healing Spot, LLC authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment will be held confidential except in the instance where my safety or the safety of others may be at risk.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature The Family Healing Spot, LLC Privacy Rep/Date

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Authorization for Release of Health Information (Optional)

I, _____, hereby authorize The Family Healing Spot, LLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date

The Family Healing Spot, LLC

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Preferred title ☐ Mr. ☐ Mrs. ☐ Ms./Miss ☐ Dr.			Today's date
First name	Last name		Middle initial
Sex/Gender			
Date of birth	Age	Occupation	
Main phone #		Other phone #	
E-mail address		Allow email contact	Yes No
Address: Street		City State	Zip
Relationship status	# of children	Family physician	
Insurance company:	ID:	Group:	Copay:
Does your insurance cover Acupuncture? Yes No ?		Who is your employer?	
Emergency contact name		Phone	
How did you find out about our clinic? ☐ *Friends/Relatives(name)*_____ ☐ *Direct mail* ☐ *Location / Walk by* ☐ *Website* ☐ *Referred by*_____ ☐ *Health Fair/ Public Event* ☐ *Periodicals* ☐ *Other (please specify)*			

Main problem(s): _____

_____.

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Lifestyle Adjustments:

Anything I wish to have more freedom around (habits, mindset, chronic frustrations): _____

_____

Anything I wish to improve (mindset, activities, relationships, life changes): _____

_____

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Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Occupation: _____ Do you usually work ☐ indoors ☐ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits Do you smoke ? ☐ Yes ☐ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program: _____

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

Diet How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day

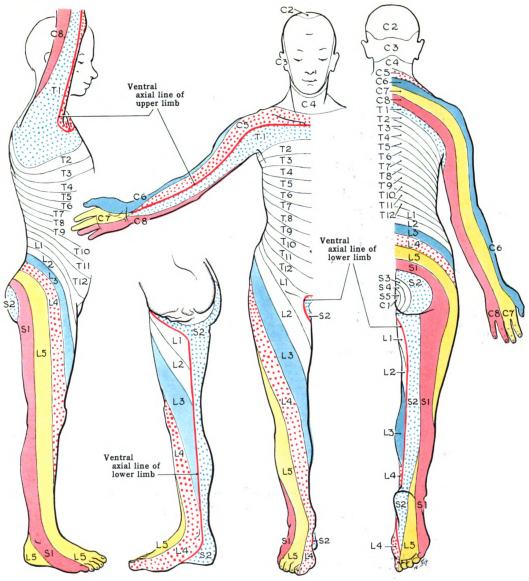
What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

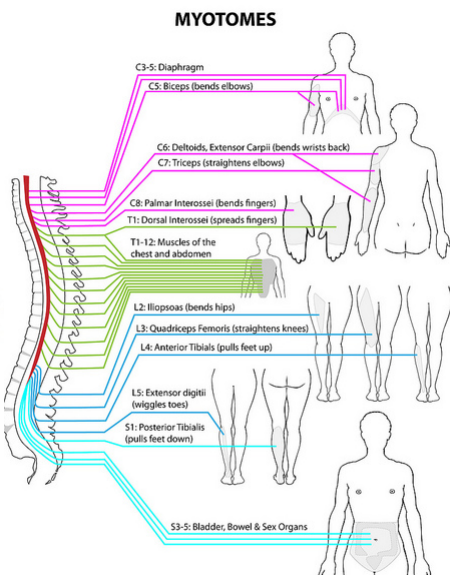
Water Intake per day: _____ Typical Breakfast:_____ Lunch: _____ Snack: _____

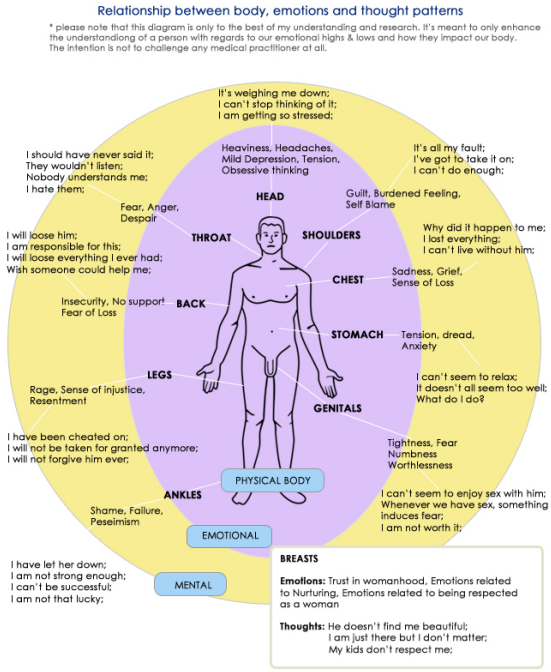
Are you a vegetarian/ Vegan? Yes No Crave: SWEET SALTY PUNGENT SPICY SOUR

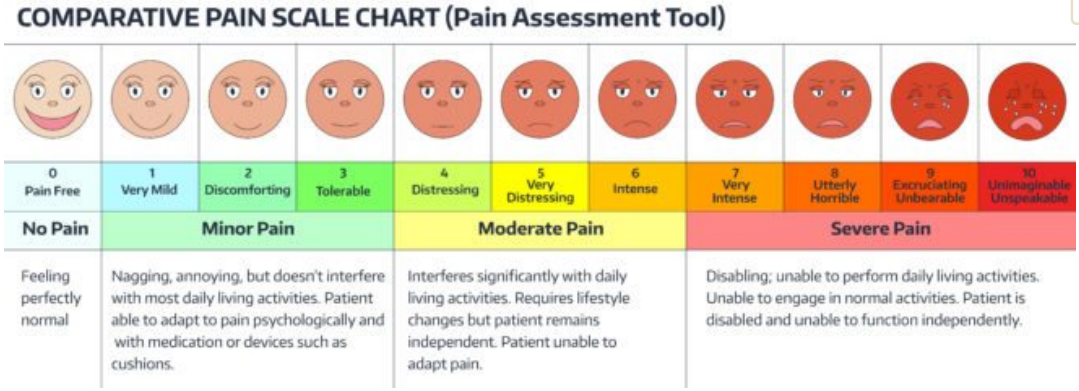
Dietary intolerance/ needs _____

Indicate pain level and/or painful or distressed areas: _____ /10









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Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General ☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite

☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema

☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair

☐ Purpura ☐ Change in hair or skin texture ☐ Other?

Musculoskeletal ☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Tremors

☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Back pain ☐ Hernia

☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain

☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Joint Sprain ☐ Other?

Head, eyes, ears, nose, and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens

☐ Eye strain ☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes

☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain

☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other?

Cardiovascular ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting

☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other?

Respiratory ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing

☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain

☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites ☐ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

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Neuro-psychological ☐ Loss of balance ☐ Lack of coordination ☐ Concussion

☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary ☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate

☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐Genital rashes ☐ STD ☐ Other?

Reproductive

Sex assigned at birth: ☐ Male ☐ Female Gender reassignment operation(s) _____

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-sections _____ Difficult deliveries

Date of last menstrual period _____ Are you currently, or could you possibly be, pregnant? ☐ Yes ☐ No

Age of first menstrual period _____ Duration of periods _____days Duration of cycle _____ days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? _____

If you're taking oral contraceptives, what are you taking and for how long? _____

☐ Prostate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems

☐ Frequent seminal emission ☐ Fertility problems ☐ Painful/swollen testicles ☐ Other

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Are there any other health issues you want to discuss with us? _____

_____

Signature: _____ **Date** _____

Representative: _____ Parent / Guardian / Spouse