WESTSIDE FAMILY ACUPUNCTURE

5115 Coors Blvd NW, Suite A * Albuquerque NM 87120 * (505) 897-6560

PERSONAL INFORMATION

Name: Last_____ First _____ MI _____

Date of Birth_____ Gender (M) (F) (Single) (Married) (Partner)

Address _____

City_____ State _____Zip+4_____

Home #_____ Cell # (if preferred)_____

E-mail _____

Occupation _____ Employer _____ Student (F/T) (P/T)

Emergency Contact: Name_____ Relationship to Patient _____

Emergency Contact Home # _____ Cell # (If preferred)_____

Referred by (Person's Name)_____

(Saw Location) (Healthfair) (Our Website) (Insurance Website) (Other Website) (Google Search) (Other Search Engine)

ADDITIONAL BILLING INFORMATION

Are we billing your medical insurance? (Y) (N) If yes, is there a secondary policy? (Y) (N)

Is treatment related to an on -the- job injury? (Y) (N) If yes, are we billing Workman's Compensation? (Y) (N)

Is this visit related to a legal case such as an auto accident? (Y) (N) If yes, are we billing a 3rd party for your case? (Y) (N)

MEDICAL INSURANCE PATIENTS ONLY

Primary on the medical policy (Myself) (My Spouse) (My Parent) Employed by_____

Primary's Name _____ Primary *DOB*_____ *Primary's Phone#*_____

*Primary's Address*_____

WORKMAN'S COMPENSATION CASES ONLY

Claim # _____ Referral Diagnosis _____

Referred by Dr. _____ at (Clinic Name) _____

Workman's Comp Contact _____ Phone # _____

3rd PARTY PAYER LEGAL (AUTO/ MED PAY/ ATTORNEY ETC.) CASES ONLY

Claim # _____ Date Of Accident or Injury _____

Location of Accident or Injury_____ Is there med pay on your auto insurance? (Y) (N)

Handled by (Your Attorney) (Claims Adjuster) Name _____

at (Law Firm) (Auto Insurance) Name _____

Phone # _____ Fax # _____

Signature of Patient _____ Today's Date_____

Name of Patient (Printed)_____Chart# _____

Signature of Witness_____ Name of Witness (Printed)_____

Westside Family Acupuncture

Medical - Personal - Family History

Name: _____ Date:_____

Primary Care Doctor/Referring Provider_____ Office Location_____

*Main health issue(s) for which you are seeking treatment?*_____

*When did the issue start?*_____

Have you been treated or are you now being treated for this by another healthcare provider? (Y) (N)

Do you bruise or bleed easily? (Y) (N) Do you have a Pacemaker (Heart)? (Y) (N)

How do you feel about receiving acupuncture? (I've had it before) (Fine) (Fearful) (I don't know)

Do you have any infectious diseases? (ex. AIDS/Hepatitis/Staph) **(Y) (N) List** _____

Females only: Are you pregnant or is it possible that you could be pregnant? (Y) (N)

Medical Status / History

☐ High / Low Blood Pressure	☐ Arthritis OA - RA	☐ Insomnia
☐ Diabetes	☐ Thyroid Hypo - Hyper	☐ Sleep Apnea
☐ High Cholesterol	☐ Kidney Disease	☐ Chronic Fatigue
☐ Heart Attack / Stroke	☐ COPD - Asthma	☐ Chronic Pain
☐ ED (Erectile Dysfunction)	☐ COPD - Chronic Bronchitis	☐ Allergies / Sinuses
☐ Liver / Gall Bladder Disease	☐ COPD - Emphysema	☐ Smoker
☐ Emotional Issues	☐ Cancer	☐ Alcoholism

Family History

☐ Heart Disease	☐ Obesity	☐ Allergies
☐ Diabetes	☐ Stroke	☐ Heart Attack
☐ Cancer	☐ High Blood Pressure	☐ COPD
☐ Other_____	☐ Other_____	☐ Other_____

List any past traumas (ex. Car accidents/Falls)

_____

_____

_____

List surgery/hospitalizations w/approx. dates

_____

_____

_____

_____

List Other Medical Conditions / Allergies

_____

_____

_____

☐ **Provide a list of your current Medications**

WORK & SOCIAL SUPPORT

Occupation:_____

Retired ____ Student ____ Unemployed_____

Employed by:_____

Do you enjoy your work?
☐ Always ☐ Usually ☐Rarely ☐ No

My family/social support network is:
☐ Non-existent ☐ Adequate ☐Good ☐Great

My stress level is:
☐ Overwhelming ☐ High ☐ Mild ☐Low

I feel my life is:
☐ Significant /Meaningful ☐ Stagnant ☐ Fine
☐ In need of direction/support

DRUG LIST & FURTHER MEDICAL HISTORY

Please list prescription and over-the-counter medications you are taking (Or Provide a list)

Drug Name	Taking it for (what condition)	For How Long	Dosage (how much)	Frequency (how often)

Please Check Any Recent Symptoms Within the Past 6 weeks

Head - Ears -Eyes Nose - Throat	Respiratory	Cardiovascular	Gastrointestinal
☐ Headaches	☐ Frequent Colds	☐ High Blood Pressure	☐ Heart Burn
☐ Impaired vision	☐ Persistent Cough	☐ High Cholesterol	☐ Abdominal Pain
☐ Dry or Tearing Eyes	☐ Difficult Breathing	☐ Low Blood Pressure	☐ Nausea/Vomiting
☐ Hearing Loss	☐ Shortness of Breath	☐ Heart Disease	☐ Ulcers
☐ Ear Ringing	☐ Asthma	☐ Chest Pain	☐ Poor Appetite
☐ Sinus Problems	☐ Pneumonia	☐ Palpitations	☐ Strong Appetite
☐ Nose Bleeds	☐ Emphysema	☐ Edema	☐ Passing Gas
☐ Sore Throat	☐ Heavy Chest	☐ Stroke	☐ Gall Bladder Stones
☐ Dry Throat	☐ Tight Chest	☐ Heart Attack	☐ Hemorrhoids
☐ TMJ or Grinding Teeth	☐ Congested Chest		☐ Change in Bowels
	☐ COPD		

Genito-Urinary Track	Neurological	Musculo-Skeletal	Psychiatric
☐ Kidney Disease	☐ Vertigo/Dizziness	☐ Neck/Shoulder Pain	☐ Clinical Depression
☐ Kidney Stones	☐ Paralysis	☐ Upper Back Pain	☐ Mood Swings
☐ Painful Urination	☐ Numbness/Tingling	☐ Mid Back Pain	☐ Panic Attacks
☐ Dribbling Urination	☐ Loss of Balance	☐ Low Back Pain	☐ Nervousness
☐ Frequent Urination	☐ Seizures/Epilepsy	☐ Leg Pain	☐ Anxiety
☐ Blood in Urine	☐ Headaches	☐ Muscle Spasms	☐ Frustration/Anger
☐ Frequent UTI	☐ Bell's Palsy	☐ Arthritis	☐ Sadness
☐ Incontinence	☐ Trigeminal Neuralgia	☐ Joint Pain	☐ Alzheimer's
	☐ Peripheral Neuralgia	☐ Osteoporosis	☐ Dementia

Constitution	Allergies/Immunologi	Other Symptoms: List anything you feel is helpful
☐ Low Energy	☐ Chronic Sinusitis	
☐ Poor Sleep	☐ Seasonal Allergies	
☐ Weight Gain	☐ Chronic Allergies	
☐ Weight Loss	☐ Medication Allegies	
☐ Chills	☐ Weak Immune Sys.	
☐ Fevers	☐ Aids	
	☐ Hepatitis	

☐ Reviewed and Signed by Doctor Date: _____ ☐ Updated: _____

Dr. Paul Dumont Sign: _____

Comment Pertinent Findings:_____

_____

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HIPAA NOTIFICATION

This notice describes our office policy concerning how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your medical insurance, legal representatives, Workman's Compensation (and with your employer in the case of Workman's Compensation), or with other medical practitioners.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for 3rd parties to contractually comply with privacy laws.
- All medical files/records (which may include email, regular mail, telephone, and faxes) are kept on permanent file.

Types of information that we gather and utilize, which may include non-public personal information:

- Concerning your financial transactions with us (billing transactions).
- From your medical history, treatment notes, test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, Workman's Compensation and your employer and other 3rd Party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you: name, address, policy/case numbers etc). We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during our regular business hours at (505) 897-6560.

AUTHORIZATION & FINANCIAL AGREEMENT

(X) **Cancellation Policy**: There is a $60.00 fee for missed appointments without 24 hours notice. A 48 hour advanced cancellation is preferred but a 24 hour advanced cancellation is required. If you are unable to keep your appointment, please notify us as soon as possible. Thank you very much for your consideration.

(X) **By signing below**: I agree to keep my records updated as needed and I authorize release of any medical records or pertinent information to other medical providers, relatives and/or caretakers involved in and/or associated with my care.

Authorization (Insurance/Workman's Compensation Cases/3rd Party Cases)

- I authorize *payment* of medical benefits to Dr. Paul Dumont/Westside Family Acupuncture.
- I authorize the *release of any medical or other information* necessary to process claims.
- I authorize the *use of this form or a photocopy*, which shall be considered as valid as the original, on any claim and I authorize the *use of my name as being a "signature on file*".

Financial Responsibility (Insurance/Workman's Compensation Cases/3rd Party Cases)

- I understand my Insurance/Case may not pay, leaving me liable for the entire non-discounted bill.
- I agree to pay any deductible issue, co-pay and/or co-insurance that my Insurance/Case requires.
- I agree to be fully responsible if my Insurance/Case does not pay for any reason and understand this may increase my expense.
- I understand that the actual fee with my Insurance/Case may not be the same as the Estimated Fee. Once my Insurance/Case adjudicates my claim, if my patient share was overestimated or underestimated, I will be refunded or charged the difference.
- I understand that my Insurance/Case requires that, for billing, services are identified by pre-defined numeric codes.
- My Insurance/Case may apply benefits based solely on the pre-defined numeric codes not the treatment actually provided

Time of Service (TOS) Discount and Full Billing Responsibility: I agree to pay for all services rendered at time of service. I agree that if I do not pay at time of service I will be billed the entire non-discounted bill. Medical Coding billing statements are not available for this payment option (or additional fees will apply).

Signature of Patient _____ Date _____

Name of Patient (Printed) _____ Chart # _____

Office Signature _____ Name of Witness (Printed) _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, **acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and life or nutritional counseling.** I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be un unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile one-use disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in larger doses than prescribed. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.
I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature:_____Date:_____

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

Patient Name:_____Date:_____

Office
Signature:_____Date:_____

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 of preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the , if asserted in a civil action, would be barred by the applicable legal statue 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:_____Date:_____

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

Patient Name:_____Date:_____

Office

Signature:_____Date:_____