Unique Remedy || Dr. Nirali Patel, DAOM, L.Ac
NEW PATIENT PACKET

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information and now your privacy is being protected.

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file

Public Interaction: Should I see you socially, by coincidence or intent, I will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is my preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations: I consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, I may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all 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 comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release: Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply: Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Nirali Patel, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Nirali Patel, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.

Patient Print name: _____ **Patient Signature:** _____ **Date:** ____/____/____

Guardian Print name: _____ **Guardian Signature:** _____ **Date:** ____/____/____

Practitioner Print name: Dr. Nirali Patel, DAOM, L.Ac **Practitioner Signature:** 

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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

.

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

A2004 - FED

INFORMED CONSENT TO RECEIVE ACUPUNCTURE TREATMENT

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above 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 above 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, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

- **Acupuncture:** This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.
- **Traditional Chinese Herbal Medicine Treatments:** Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.
- **Heat Treatments with Moxa or a TDP Lamp:** These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.
- **Cupping**: This technique involves a localized suction produced by heating a small glass cup. A plastic suction cup may also be used. There is a possibility of local bruising from this suction. Very rarely, a slight burn or blister may appear due to the heat. The first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu – producing flu-like effects like nausea, headache, aches.
- **Gua Sha:** Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.
- **Electro-Acupuncture**: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.
- **Acupressure and Massage**: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage. This may involve the use of applying topical creams, carrier oils and essential oils.

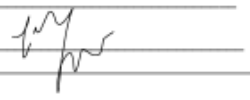
I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, 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 conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Nirali Patel is not a primary care physician.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient Print name: _____ **Patient Signature:** _____ **Date:** ____/____/____

Guardian Print name: _____ **Guardian Signature:** _____ **Date:** ____/____/____

Practitioner Print name: Nirali Patel, DAOM, L.AC **Practitioner Signature:** 

FINANCIAL POLICIES

Please read carefully and choose the plan which you prefer.

Self-pay - means that all fees will be paid when service is rendered.

Insurance - If you have insurance, we will check your benefits for you and bill as a courtesy. However, if we are given incorrect information by you/your insurance company, you will be responsible for any payments. We suggest you also contact your insurance company for benefit information. Payment for deductibles, if it has not been met, is the patient's responsibility as well as any copayment or remaining balance after insurance payment. Your co-pay is due as services are rendered. You are also responsible for portions of your bill that are not covered by insurance. It may take up to 60 days for claim to process.

- **You are required to pay for the service booked in office even if you have insurance. You will be refunded accordingly.**

Payment is due in full at the time services are rendered, even if you have insurance. Total payment between insurance + yourself is the cost of the service booked. You will be reimbursed if and when your insurance pays the claim. You and/or your insurance must cover the **office treatment rates** for your service booked.

Fees are as follows:

Acupuncture new patient $290, Acupuncture follow-up $165, Acupuncture facial new patient $290, Acupuncture facial follow-up $210; Cupping new patient and follow-up $85

Additional charges: 3% fee will be added to the cost of the serviced booked for credit, debit, FSA, HSA, any card.
This merchant fee is non-refundable.

CANCELLATION POLICIES

For cancellations made within 24 hours of your appointment or you do not show up for your appointment, you will be charged for your missed appointment in full for the service booked. Being 15 minutes late to your appointment is considered a no show.
Illness - If you are not feeling well, please inform the office at least 24 hours before your appointment. If you arrive with any signs of illness, you will be asked to leave and cancellation policy will be enforced. No exceptions will be made.

Fees are as follows:

Acupuncture new patient $290, Acupuncture follow-up $165, Acupuncture facial new patient $290, Acupuncture facial follow-up $210; Cupping new patient and follow-up $85

Please note, acupuncture appointment confirmation emails and reminders are a courtesy - missed appointments due to not receiving confirmations/reminders will incur the full no-show fee in the amount of the treatment booked.

Even if you are paying with insurance, if YOU cancel within 24 hours or are a no-show, YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR TREATMENT IN FULL OF THE SERVICE BOOKED. Refer to pricing listed above.

I understand and agree to each of the financial and cancellation policies.

Patient Name _____

Patient/Guardian Signature_____ Date_____

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Age: _____ Date Of Birth (Month/Day/Year): _____ Gender:_____

Address (Street, City, State, Zip): _____

Primary Contact Phone Number _____ Email: _____

Emergency Contact (Name, Relation, Phone Number): _____

Occupation: _____ Referral Source: _____

INSURANCE VERIFICATION INFORMATION

*If you have 2 insurance carriers, list all information for both to avoid claim denials (even if you mainly use only one).

Primary Insurance Carrier: _____	Primary Secondary Carrier: _____
Phone Number On Back Of Card:_____	Phone Number On Back Of Card:_____
Patient ID Number: _____	Patient ID Number: _____
BIN Number: _____	BIN Number: _____
Patient Date Of Birth: _____	Patient Date Of Birth: _____

HEALTH CONCERNS

Primary health concern: For how long: Past treatments:	Secondary health concern: For how long: Past treatments:
Is this your first acupuncture treatment? **Y/N**	

MEDICAL INFORMATION

Major Illnesses: 1. 2. 3.	Surgeries/hospitalizations: 1. 2. 3.
Medications/supplements: 1. 2. 3. 4. 5. 6.	Allergies/sensitivities: 1. 2. 3

Patient Name_____ Date_____

Check CURRENT symptoms

General o Changes in appetite o Sudden change in weight o Fatigue o Strong thirst o Night sweats o Other _____	**Head, ENT** o Dizziness/Light headedness o Headaches/migraines o TMJ o Eye pain o Blurry vision/floaters o Sudden loss of vision o Ear pain, infections o Sudden loss of hearing o Nose pain/infections o Sudden loss of smell o Throat pain, infections o Other _____	**Respiratory** o Difficulty breathing o Cough o Asthma o Easily winded o Pneumonia o Other _____
Skin and Hair o Rashes o Hives o Acne o Eczema o Hair loss o Moles/warts o Other _____	**Cardiovascular** o High blood pressure o Low blood pressure o Irregular heartbeat o Chest pain o Palpitations o Swelling of hands/feet o Other _____	**Gastrointestinal** o IBS/Crohn's o Nausea/vomiting o Constipation o Diarrhea o Hemorrhoids o Bad breath o Gas/bloating o Other _____
Urinary o Painful urination o Urinary tract infections o Urgency to urinate o Sudden frequency o Kidney stones o Sexually transmitted infections o Other _____	**Neuro** o Seizures o Numbness o Tremors/twitches o Lack of balance/coordination o Other _____	**Mental/Emotional** o Stress o Depression o Anxiety o Extreme irritability o Mood swings o Bipolar o Other _____
Musculoskeletal o Arthritis o Scoliosis o Weakness in joints, muscles o Muscle pain, weakness, spasms o Other _____	**Muscle Pain** Location: When did it start: Pain sensation (dull, sharp, throbbing, etc): What helps: What makes it worse: **On a scale of 1-10, what level is your pain:** (no pain) 1 2 3 4 5 6 7 8 9 10 (excruciating pain)	
Gynecology o Irregular periods o PMS o Menopause o Fertility concerns o Other _____	**Menses** Date of last menses: Duration of menses: Cycle length: Painful periods: Y or N Heavy periods: Y or N Clots: Y or N Spotting between periods: Y or N	