On Point
Acupuncture & Wellness

New Patient Intake Form

Date:____/_____/_______

Personal Information

Name:____ **Age:**________
(first) (middle) (last)

DOB:_____/_____/_______ **Gender:** ☐M ☐F **Height:**________ **Weight:**________

Marital status: ☐S ☐M ☐D ☐W **Occupation:**_________________________

Address:____
(Street) (City/State) (Zip)

Email:____________________ **Phone:** (_____)______-__________ **Alt Phone:** (_____)______-__________

Emergency Contact Name:_________________________ **Phone:** (_____)______-_______

Referred by:____

Primary Care Provider:_________________________________ **May we contact them?** ☐Yes ☐No

Health Insurance Information

Insurance Company Name:______________________________ **Policy Number:**___________________

Address:____
(Street) (City/State) (Zip)

Phone: (_____)______-__________

Reason for Visit

Have you had acupuncture before? ☐Yes ☐No **Chinese Herbal Medicine?** ☐Yes ☐No

Reason for visit today:____

How long have you had this condition? _______________ **Is it getting worse?** ☐Yes ☐No

Does it bother your ☐Sleep ☐Work ☐Other:______________________________________

What seemed to be the initial cause? ____

What seems to make it better? ____

What seems to make it worse? ____

Additional **reason for visit today:** ______________________________

How long have you had this condition? ____________ **Is it getting worse?** ☐Yes ☐No

Does it bother your ☐Sleep ☐Work ☐Other:______________________________

What seemed to be the initial cause? ______________________________

What seems to make it better? ______________________________

What seems to make it worse? ______________________________

Additional **reason for visit today:** ______________________________

How long have you had this condition? ____________ **Is it getting worse?** ☐Yes ☐No

Does it bother your ☐Sleep ☐Work ☐Other:______________________________

What seemed to be the initial cause? ______________________________

What seems to make it better? ______________________________

What seems to make it worse? ______________________________

Additional **reason for visit today:** ______________________________

How long have you had this condition? ____________ **Is it getting worse?** ☐Yes ☐No

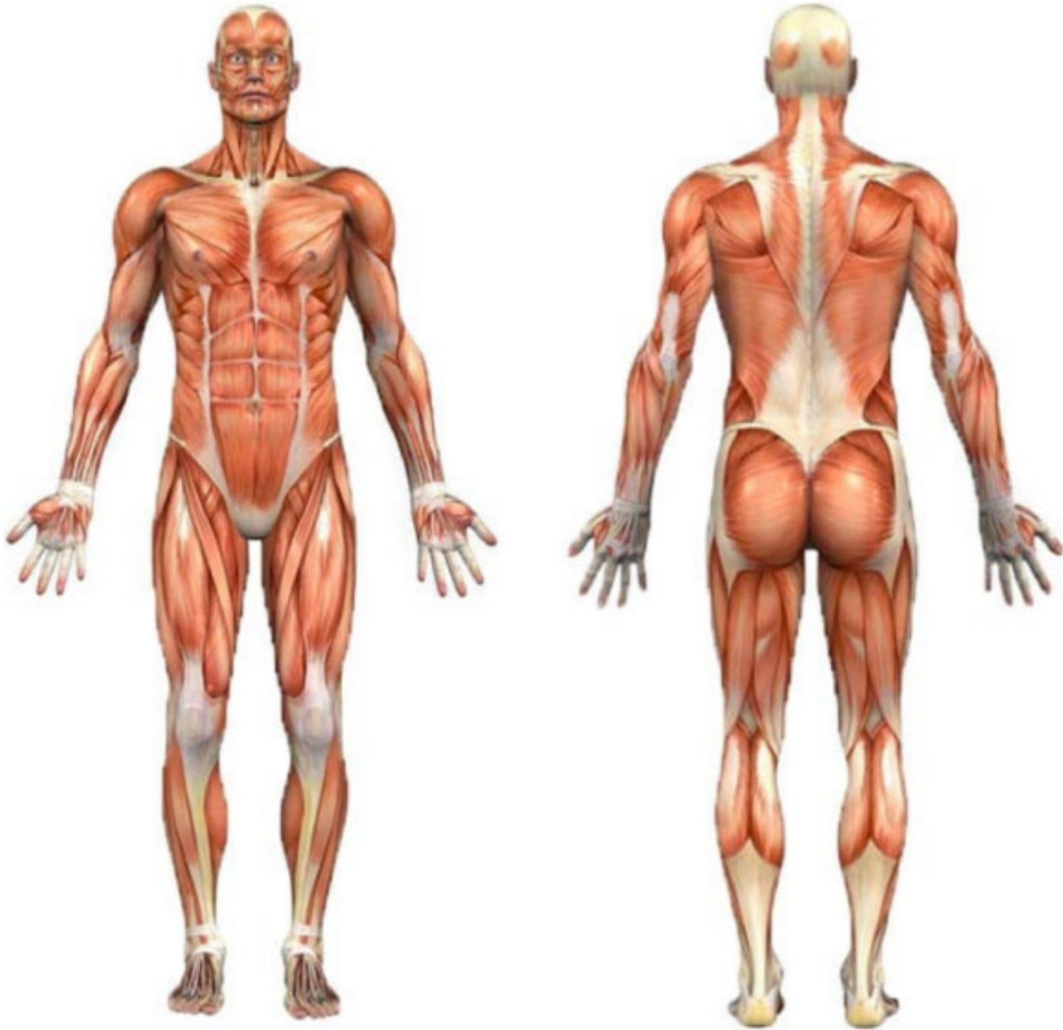
Does it bother your ☐Sleep ☐Work ☐Other:______________________________

What seemed to be the initial cause? ______________________________

What seems to make it better? ______________________________

What seems to make it worse? ______________________________

Please circle any areas of any type of pain or injury on the diagrams below:



Notes:____

____

Are you under the care of a physician now? ☐Yes ☐No **If yes, for what?** ______________________

Physicians Name:____________________ **Physicians Number:** (_____) _____ - ________

Other concurrent therapies? ____

Family Medical History

☐Allergies (List:)

____

☐Arteriosclerosis

☐Diabetes (Type:)

☐Alcoholism

☐Cancer (Type:)

☐Depression

☐Asthma

☐Heart disease

☐High blood pressure

☐Seizures

☐Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

☐AIDS/HIV
☐Alcoholism
☐Allergies
☐Appendicitis
☐Arteriosclerosis
☐Asthma
☐Birth trauma (your own birth)
☐Cancer
☐Chicken pox
☐Diabetes (Type:)
☐Emphysema

☐Epilepsy
☐Goiter
☐Gout
☐Heart disease
☐Hepatitis (Type:)
☐ Herpes (Type:)
☐High blood pressure
☐Measles
☐Multiple Sclerosis
☐Mumps
☐Pacemaker (Date:)

☐Pleurisy
☐Pneumonia
☐Polio
☐Rheumatic fever
☐Scarlet fever
☐Seizures
☐Stroke
☐Thyroid disorders
☐Surgery (List)
____
____

☐Tuberculosis
☐Typhoid fever
☐Ulcers
☐Venereal disease
☐Whooping cough
☐Major trauma (List)
____
____
☐Other (Specify)
____
____

Your Diet

Appetite:
☐Low
☐High

☐Coffee/Tea
☐Soft Drinks
☐Fruit Juices

☐Artificial Sweeteners
☐Sugar
☐Salty foods

Protein Intake:
☐Low
☐High

Thirst for water
☐yes ☐no
Glasses per day _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months? ____________________

Vitamins/supplements taken in the last 2 months? ____________________

Your Lifestyle

☐Alcohol
☐Tobacco
☐Marijuana

☐Drugs
☐Stress
☐Occupational hazards

Regular Exercise:
Type ______________
Frequency __________

General Symptoms

☐Poor appetite
☐Heavy appetite
☐Strongly like cold drinks
☐Strongly like hot drinks
☐Recent weight loss/gain
☐Poor sleep

☐Heavy Sleep
☐Dream-disturbed sleep
☐Fatigue
☐Lack of strength
☐Bodily heaviness
☐Cold hands or feet

☐Poor circulation
☐Shortness of breath
☐Fever
☐Chills
☐Night sweats
☐Sweat easily

☐Muscle cramps
☐Bleed or bruise easily
☐Peculiar taste (Describe)
____
____
____

Musculoskeletal

☐Neck/shoulder pain
☐Muscle pain
☐Upper back pain

☐Low back pain
☐Joint pain
☐Rib pain

☐Limited range of motion
☐Limited use
☐Other ______________

Head, Eyes, Ears, Nose, Throat

☐Glasses (What Age?)
☐Eye strain
☐Eye pain
☐Red eyes
☐Itchy eyes
☐Spots in eyes
☐Poor vision
☐Blurred vision
☐Night blindness

☐Myopia or Presbyopia
☐Glaucoma
☐Cataracts
☐Teeth problems
☐Grinding teeth
☐TMJ
☐Facial pain
☐Gum problems
☐Sores on lips or tongue

☐Dry mouth
☐Excessive saliva
☐Sinus problems
☐Excessive phlegm
Color: ______________
☐Recurrent sore throat
☐Swollen glands
☐Lumps in throat
☐Enlarged thyroid

☐Nosebleeds
☐Ringing in ears
☐Poor Hearing
☐Earaches
☐Headaches
☐Migraines
☐Concussions
Other head/neck problems:
____

Respiratory

☐Difficulty breathing
☐Shortness of breath
☐Tight chest
☐Asthma/wheezing

☐Difficult inhalation or exhalation
☐Coughing up blood
☐Pneumonia

☐Cough
Wet or Dry? ______________
Thick or thin? ______________
Color of phlegm? ___________

Cardiovascular

☐High blood pressure
☐Blood clots
☐Low blood pressure
☐Fainting

☐Chest pain
☐Difficulty breathing
☐Tachycardia
☐Heart palpitations

☐Phlebitis
☐Irregular heartbeat

Gastrointestinal

☐Nausea
☐Vomiting
☐Acid regurgitation
☐Gas
☐Hiccup
☐Bloating
☐Bad breath
☐Diarrhea

☐Constipation
☐Black stools
☐Bloody stools
☐Mucous in stools
☐Hemorrhoid
☐Itchy anus
☐Intestinal pain or cramping
☐Burning anus

☐Rectal pain
☐Anal Fissures
☐Laxative use (Kind:) (Color:)
Bowel movements:
Frequency:______________
Texture:______________
Color:______________
Odor:______________

Skin and Hair

☐Rashes
☐Hives
☐Ulcerations
☐Eczema

☐Psoriasis
☐Acne
☐Dandruff
☐Itching

☐Hair loss
☐Change in hair/skin texture
☐Fungal infections
☐Other ______________

Genitourinary

☐Pain on urination
☐Frequent urination
☐Urgent urination
☐Blood in urine
☐Unable to hold urine

☐Incomplete urination
☐Venereal disease
☐Bedwetting
☐Wake to urinate
☐Kidney stone

☐Increased libido
☐Decreased libido
☐Impotence
☐Premature ejaculation
☐Nocturnal emission

Neuropsychological

- ☐Seizures
- ☐Numbness
- ☐Tics
- ☐Poor memory
- ☐Depression
- ☐Anxiety
- ☐Irritability
- ☐Easily stressed
- ☐Considered/attempted suicide
- ☐Other ________________

Gynecology

Age menses began _________
Length of cycle ____________
☐Duration of flow _________
☐Irregular periods
☐Painful periods

☐Vaginal discharge
*Color*_____________
☐Vaginal sores
☐Vaginal odor
☐Clots

☐Breast lumps
Pregnancies _____
Live births _____
Premature births _____
Age at Menopause _____

Date of last PAP
____
Date last period began
____

Other

____

____

____

____

24 Hour Appointment Cancellation & Late Policy

On Point Acupuncture & Wellness has a 24-hour cancellation and/or rescheduling policy.

If you cancel, change or miss your appointment with less than 24-hour notice, you will incur a "rescheduling fee" in the amount of $50. *(Initial)*________

If you are running late, it will cut into your appointment time. (Initial)________

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24-hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for On Point Acupuncture & Wellness as described above.

Thank you for your understanding and cooperation.

______________________________ ______________________________

Printed Name Signature

____

Date

On Point Acupuncture & Wellness

Kalpesh L. Patel, L.Ac.

HIPAA-Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to acupuncturist.

Legal Responsibilities of Kalpesh L. Patel, L.Ac. : As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and

disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whoever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name: Kalpesh L. Patel, L.Ac.
Telephone: 972-863-2895

I have read and understood the HIPAA privacy policies of On Point Acupuncture & Wellness

____________________	__________	____________________
Name	Date	Relationship to patient (if applicable)

Authorization for Release of Health Information (Optional)

I, ______________________________, hereby authorize On Point Acupuncture & Wellness the use or disclosure of my individually 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)

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Patients' Signature *Date*

Patient Name:

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 SIGNATURE X (Date)

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

OFFICE SIGNATURE X (Date)

ALSO SIGN THE INFORMED CONSENT ON NEXT PAGE

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 indicated 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, Tui-Na (Chinese massage), Chinese herbal medicine, and 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 have an 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 disposable needles and maintains a clean and safe environment.

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 traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME:

PATIENT SIGNATURE X (Date)

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

ALSO SIGN THE INFORMED CONSENT ON PREVIOUS PAGE

On Point Acupuncture & Wellness

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of 22 T.A.C section 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ Code Ann., section 205.351, governing the practice of acupuncture)

I (patient's name),____
am notifying On Point Acupuncture & Wellness of the following:

Yes _____ *No* _____ I have been evaluated by a physician or dentist, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

Yes _____ *No* _____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _______________, and the most recent date of chiropractic treatment prior to acupuncture treatment is _______________. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

____
Patient Signature (required) Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

____
Patient Signature (required) Date

____
Acupuncturist's Signature (required) Date