THE ALTERNATIVE CLINIC INTAKE FORM

Name:	DOB:
Address:	City: State: Zip:
Email:	Have you had acupuncture before? Yes No
Phone #:	Have you had bodywork before? Yes No

Occupation:

Emergency Contact Name: Phone:

How did you hear about The Alternative Clinic?

What is your main concern / What are your goals for treatment?

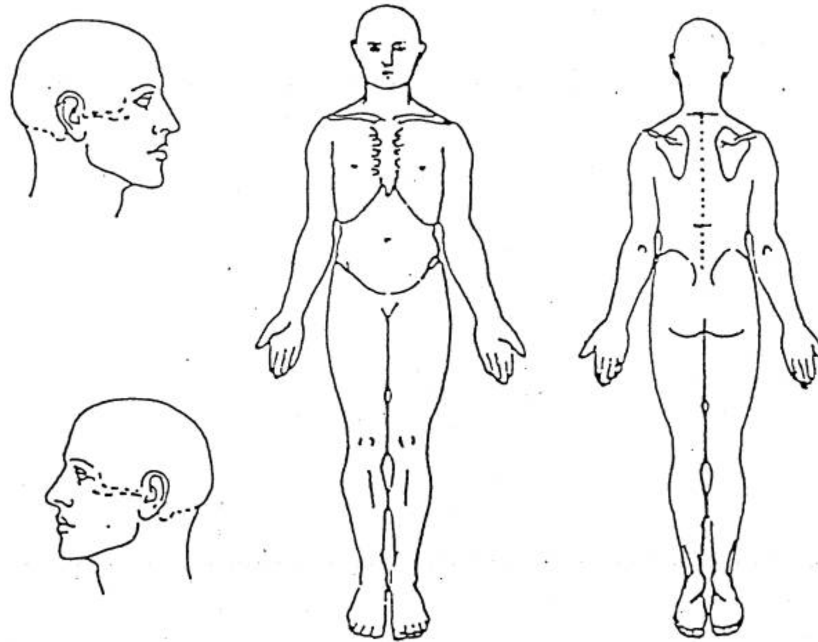
When did you first notice symptoms?

If you have been diagnosed, what is diagnosis?

What kinds of treatment or therapies have you tried?

Hospitalizations / Medications

Please mark painful or distressed areas on the charts below.



Please list any food allergies or dietary restrictions:

Please list any herbs & supplements you currently take:

As bodywork is typically part of treatment,
are there areas where you are sensitive to/dislike touch?

THE ALTERNATIVE CLINIC ACUPUNCTURE & BODYWORK INFORMED CONSENT

I, ____ hereby authorize The Alternative Clinic practitioners and Interns, all of which are licensed practitioners of Chinese medicine or licensed bodyworkers, to perform treatment on me (or on the patient named below, for whom I am legally responsible). This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. As a teaching clinic, I understand that I may be observed by interns in the treatment room, and my case may be discussed (without identifying information) for educational purposes.

Scope of Practice
I understand that the scope of practice includes, but is not limited to, the following:

- Using Chinese medical theory to assess, diagnose and treat a patient in order to improve overall body function and/or to relieve pain
- Using treatment techniques that may include:
    - Insertion of sterile acupuncture needles, and acupuncture stimulation
    - Cupping and application of heat with moxibustion
    - Bodywork techniques including but not limited to pressing points, rubbing, dermal friction or traction, hot stones, herbal steams, topical ointments and salves
    - Herbal therapies
    - Breathing techniques, exercises & nutritional advise according to Oriental medical principles

Risks and Possible Side Effects
I understand that there are possible side effects to my treatment that may include the following:

- Minor pain or soreness in the treatment area
- Transient bruising
- Infection
- Needle sickness (dizziness, nausea, fainting)
- Broken needles
- Sensations of heat, cold, tingling or numbness
- Skin irritation or slight bleeding at needle site
- Generalized fatigue
- Gastrointestinal disturbance from herbal remedies
- Minor burns from moxibustion (heat stimulation)
- Spontaneous miscarriage
- Pneumothorax

Treatment Outcomes
I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time.

Western Biomedical Diagnosis
I understand that it is not within the scope of practice for acupuncturists or bodyworkers to offer Western medical diagnosis and that it is my responsibility to seek such diagnosis elsewhere. I understand that Chinese medicine is not recognized to provide primary care in the State of North Carolina. Consequently, if I have a western medically diagnosed condition, I may not legally receive treatment from The Alternative Clinic for that condition unless I am concurrently under the care of a licensed physician.

I **have / have not** *(circle one*) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the practitioner of the diagnosis.

____ ____________________
Physician's Name & Phone Number

____ ____________________
Patient (or Guardian) Signature Date

____ ____________________
Witness Date

NOTICE OF PRIVACY POLICIES

We love our small town of Asheville, NC, and are thrilled to provide wellness care to the community. We understand that medical information about you and your health is personal. Yet, living in a small town means that we may bump into you in the grocery store, the farmers market or at a restaurant on any given night. Protecting your privacy and healthcare information is fundamental in the course of our relationship, and we employ a strict policy not to discuss health concerns outside of the clinic.

For HIPPA laws, we must let you know that we keep on file non-public personal information such as:

- Your patient record, including diagnostic information, as well as the care and services you receive.
- Your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversation to our office.
- Your financial transactions but do not store credit card numbers.

Your Rights

When it comes to your health information, you have certain rights, including the following:

- Upon written request, get an electronic or paper copy of your medical records
- Ask us to limit what we use or share
- Upon written request, get a list of those with whom we've shared information
- Get a copy of this privacy notice
- File a complaint if you feel your rights are violated, by:
  - Contacting us using the information below
  - Sending a written complaint to the U.S. Department of Health and Human Services (address at bottom of page)
- We will not retaliate against you for filing a complaint

Marketing

We will never share or sell your information for any reason. We will use phone or ei mail to contact you or confirm appointments.

Disclosure of Information

In order to maintain the level of service that you expect from our office, we may need to share limited information for treatment, payment and healthcare operations. We typically use or share your health information in the following ways:

- We can use your health information and share it with other professionals who are treating you
- We can use and share your health information to run our practice, improve your care, and contact you when necessary
- We can use and share your health information to bill and get payment from health plans or other entities.
- We can use and share the minimum necessary amount of your health information for the training of supervised interns, as well as non-treating interns observing treatment.
- We will also share information about you if state or federal laws require it, to comply with law enforcement and other government requests, and to respond to lawsuits and legal actions.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you now promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it for review. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

If you have questions, complaints or want more information, contact:
DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building, Washington, DC 20201

I understand I have the right to read and discuss the Notice of Privacy Policies form of The Alternative Clinic before I sign this consent form regarding the use and disclosures of my protected health information.

I authorize the The Alternative Clinic to share my personal health information with interns and as part of the clinic's teaching operations.

I have the right to revoke this consent, in writing, at any time except to the extent that the The Alternative Clinic has acted in reliance on this consent.

I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services at The Alternative Clinic

Print Name: ____

Patient or Personal Representative 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 North Carolina and federal law, and not by a lawsuit or resort to court process, except as North Carolina 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 North Carolina 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.

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)
PROVIDER SIGNATURE **X**	