TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE

Step One:
All new patients are requested to fill out this personal health history questionnaire to gain more information about your overall health.

Step Two:
A one-on-one consultation with the Acupuncturist will be done to discuss your health problems and to determine what may be the cause.

Step Three:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

Step Four:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

Step Five:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

Step Six:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

Step Seven:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

New Patient Intake

Thank you for choosing Renewed Health, LLC as your wellness provider. 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 any questions, please ask. Thank you. **Date** ___/___/___

Patient name: (first) ____________________ (last) ____ (middle init.) ____

(preferred to be called) __________________________________

Address: ____

City: ______________________________ State: ______ Zip: __________

Age: _______ ☐ Male ☐ Female

Date of birth: ___________________

Marital status: ☐ S ☐ M ☐ D ☐ W

Emergency Contact

Name: ___________________

Phone: ___________________

Relationship: _____________

Phone: (home) _______________________

(work) _______________________

(cell) _______________________

E-mail: ____

Family physician: ____

Do you have health insurance? ☐ Yes ☐ No

How did you find out about us? ____

***Current Health Concerns*:**

What health concerns brought you here today: (list in order of importance)

1) Condition: ____

Have you seen other practitioners for this condition? ☐ Y ☐ N Who? ______________________________________

Past treatment: _________________________________ Results? ____

When did condition first begin? ___________________ Has condition occurred before? ☐ Y ☐ N

2) Condition: ____

Have you seen other practitioners for this condition? ☐ Y ☐ N Who? ______________________________________

Past treatment: _________________________________ Results? ____

When did condition first begin? ___________________ Has condition occurred before? ☐ Y ☐ N

Any other conditions that you may want to address in the future:

1) Condition: _____________________________________ 2) Condition: _____________________________________

***Current Health*:**

Please mark the symptoms below that have occurred in the las 6 months even though they may seem unrelated to your main health conditions that you came in for today. As a holistic practitioner, we look at the all symptoms occurring in the body in order to develop your Oriental Medicine diagnosis. Height: ________ Weight: _________

	Orig	Now

General

☐ I usually feel hot ☐ I usually feel cold ☐ Cold hands/feet ☐ Fever ☐ Chills ☐ Tremors ☐ Fatigue

☐ Poor balance ☐ Localized weakness ☐ Bleed/bruise easily ☐ Slow wound healing

☐ Thirsty during day ☐ Thirsty during night ☐ Sweat easily ☐ Sweat at night ☐ Sweat for no reason

☐ Sudden fatigue in afternoon   Fatigue: Worst level in last week (0-10 where 10=Severe fatigue) ____

Sleep: ☐ Trouble getting to sleep ☐ Trouble staying asleep ☐ Poor quality of sleep ☐ Dream disturbed sleep

☐ I wake to urinate ☐ Wake tired   # hours sleep per night? ____ # hours sleep <u>needed</u> per night? ____

Stress: Highest stress level in last week (0-10 where 10=High stress) ____

☐ I find it difficult to manage stress ☐ Stress gives me anxiety ☐ Stress makes me angry/irritable

Head, Ear, Eyes, Nose, Throat

☐ Poor vision ☐ Night blindness ☐ Eye floaters ☐ Eye tearing ☐ Eye dryness ☐ TMJ/jaw problems

☐ Sinus congestion/pressure ☐ Nasal congestion ☐ Nose bleeds ☐ Frequent colds/flu/infections

☐ Poor hearing ☐ Ear ringing (high/low pitched) ☐ Ear pain/blockage ☐ Teeth/gum problems

☐ Skin Issues ☐ Premature gray hair/hair thinning or falling out

Cardiovascular

☐ Palpitations ☐ High blood pressure ☐ Low blood pressure ☐ Irregular heartbeat ☐ Tight chest

☐ Swelling of ankles ☐ Varicose veins ☐ Numbness/tingling, where: ________________________________

Respiratory

☐ Asthma ☐ Wheezing ☐ Difficulty breathing ☐ Cough ☐ Coughing blood ☐ Lung issues

☐ Hx Bronchitis ☐ Hx Pneumonia ☐ Phlegm (coughing / nasal) – what color? (clear / yellow / green)

Gastrointestinal

☐ Underweight ☐ Overweight ☐ Recent weight change ☐ Poor appetite ☐ Excessive appetite ☐ Cravings

☐ Peculiar tastes ☐ Bad breath ☐ Ulcers ☐ Nausea ☐ Vomiting ☐ Indigestion/heartburn ☐ Belching

☐ Gas ☐ Bloating ☐ Abdominal pain/cramps ☐ Parasites ☐ Gall bladder problems ☐ Liver disease

☐ Hemorrhoids ☐ Rectal bleeding ☐ Rectal pain ☐ Chronic laxative use ☐ Colitis ☐ Diverticulitis

How often do you have a bowel movement? ____ x/week   ☐ Diarrhea ☐ Constipation

Neurological/Emotional

☐ Lack of coordination ☐ Depression ☐ Anxiety ☐ Easily angered ☐ Irritable ☐ Sadness/grief

☐ Vertigo/dizziness ☐ Poor Memory ☐ Poor Concentration ☐ Worrier/overthinker ☐ Fearful

☐ Frequent headaches/ migraines ☐ Paralysis

Genital/Urinary

☐ Daily, I urinate more liquid out than I drink in ☐ Daily, I urinate less liquid out than I drink in

☐ Trouble holding urine ☐ Excessive frequency of urination ☐ Unusual urine color (dk. yellow/pink/red)

☐ Pain on urination ☐ Urgent to urinate ☐ Dribbling of urine ☐ Hx Kidney stones ☐ Genital pain

☐ Genital itching ☐ Frequent urinary tract infections ☐ Vaginal/genital discharge

Male Reproductive

☐ Prostrate problems ☐ Testicular pain/swelling ☐ Impotence ☐ Fertility problems ☐ Ejaculation problems ☐ Sexual difficulties: Explain ____

Female Reproductive/Breasts	Orig	Now

Female Reproductive/Breasts

☐ Frequent vaginal pain ☐ Frequent vaginal infections ☐ Endometriosis ☐ Fibroids ☐ Cysts ☐ Hot flashes

☐ Breast lumps ☐ Breast tenderness/pain ☐ Menopausal ☐ Post-Menopausal bleeding ☐ Fertility problems

☐ Sexual difficulties/pain during sex: Explain ____

Menses: First date of last period: _______________ How many days does bleeding last? ________

☐ Begins with spotting ☐ Light flow ☐ Heavy flow ☐ Clots: (large/small) ☐ Cramping/pain

☐ Black/brown color ☐ Pink/watery color How many days between periods? _______

Any bleeding between normal periods? ☐ Y ☐ N Moodiness related to menses? ☐ Y ☐ N

PMS? ☐ Y ☐ N Describe: ____

Age of first menses: _____ # Pregnancies _____ # Births _____ # Miscarriages _____ # Abortions _____

Musculoskeletal and Pain

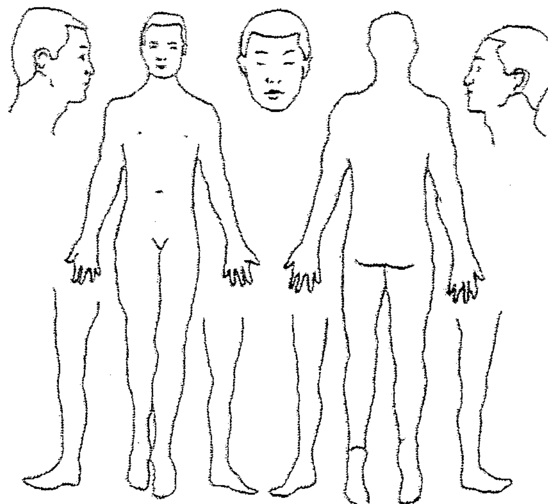
If you have pain or problems in specific area, then answer the questions to the right of the pain area.

Severity: Rate the pain that you feel when at its worse from 1-10, where 1 = minimal pain and 10 = severe pain.
Circle a number.
Frequency: Is the pain constant or on/off. Circle one.
Duration: When you feel the pain, how long does it last, for minutes, hours or days? Circle one.
Nature: When you feel the pain, is the pain sharp, dull, or both. Circle one.

Pain Area	Severity(1=slight,10=severe)	Frequency	Duration	Nature
Headaches	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Face	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Migraines	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Earaches	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Jaw	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Neck	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Shoulder joint	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Arm	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Elbow	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Wrist	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Hand/finger	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Chest	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Abdominal	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Upper back	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Middle back	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Lower back	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Hip/Sciatica	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Leg	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Knee	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Ankle	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Foot/toe	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both
Other:______________	1 2 3 4 5 6 7 8 9 10	Constant / On-Off	Min / Hrs / Days	Sharp / Dull / Both

☐ Weak muscles ☐ Muscle spasm/cramping ☐ Stiffness ☐ Spinal curvature ☐ Hernia ☐ Walking problems

Indicate painful or distressed areas: place an "**X**" over severe pain or an "**O**" over dull pain areas



***Your Medical History*:**

Special Conditions

Hepatitis: ☐ Y ☐ N If Yes, type: (A/B/C/D) HIV/AIDS: ☐ Y ☐ N Chronic infectious diseases? ☐ Y ☐ N

Pacemaker/defibulator ? ☐ Y ☐ N Is there any chance you might be pregnant? ☐ Y ☐ N

Significant Illness (please include year when the diagnosis was established)

☐ Cancer _____ ☐ Thyroid disease _____ ☐ Diabetes _____ ☐ Seizures _____ ☐ Pneumonia _____

☐ Arthritis _____ ☐ Tuberculosis _____ ☐ Anemia _____ ☐ Sexually transmitted diseases _____ ☐ Bi-polar _____

☐ Fibromialgia _____ ☐ Heart disease _____ ☐ Mental disorders _____ ☐ Breathing problems _____

☐ Concussion _____ ☐ Stroke _____ ☐ Heart attack _____

Explain: ____

Surgeries/hospitalizations: (please include year of each incident)

____

____

____

Trauma (auto accidents, sports injuries, etc): ____

Previous acupuncture care? ☐ None ☐ Acupuncturist's name ______________________ Date of last visit ____________

Allergies (drugs, chemicals, food): ____

Any other conditions: ____

____

____

____

Current Medications (including prescriptions, vitamins, supplements, over-the-counter, drugs, herbs)

______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx
______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx
______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx
______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx
______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx
______________ Used for: ________ ☐Rx		______________ Used for: ________ ☐Rx

***Family Medical History*:**

Please indicate if any immediate family members have had the following diseases.

	Relation		Relation
☐ Cancer	______________	☐ Heart disease	______________
☐ Diabetes	______________	☐ High blood pressure	______________
☐ Stroke	______________	☐ Alcoholism	______________
☐ Asthma	______________	☐ Allergies	______________

Other: ____

***Lifestyle*:**

Diet: My diet is: ☐ Very healthy ☐ Moderately healthy ☐ Not healthy Vegetarian? ☐ Y ☐ N Yes, but not so strict ☐

☐ I eat out frequently ☐ I eat fast food frequently ☐ I eat a lot of spicy food

Coffee/day? _______ # Soda/day? _______ # Water/day? _______

Exercise: Do you exercise? ☐ Y ☐ N How often? ____________ What kind? ______________________

Habits: Do you use tobacco? ☐ Y ☐ N What type? ____________ How many times a day? _______ Since when? _____

Do you use any drugs for non-medical purposes? ☐ Y ☐ N Explain: ______________________

What kind of alcohol beverage do you usually drink? ______________________ Ave. # drinks per week: ________

Education: ____

Occupation: ______________________________ How many hours do you work per week? _______

Do you enjoy your work? ☐ Y ☐ N Why/why not? ______________________________

Patient's Signature ______________________________________ Date __________

Consent to Treat a Minor ______________________________________
(Guardian Signature)

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Acupuncturist will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Acupuncturist to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Renewed Health, LLC** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Renewed Health, LLC** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature ____ Date __________

Consent to Treat a Minor ____ Date __________
(Guardian Signature

Physician Evaluation

I (patient's name) ____, am notifying the licensed acupuncturist of **one** of the following:

NOTICE: At least One of the items below (numbers 1, 2, or 3) must be answered "Yes" for the Acupuncturist to be able to treat you.

1) I have been evaluated by a physician or dentist for the condition(s) being treated within the 6 months before this acupuncture treatment was performed. Yes ____ No ____
I recognize that I should be evaluated by a physician for the current condition(s) or any future condition(s) treated by the licensed acupuncturist ______________ (patient initials)

2) I understand that the following conditions do not require evaluation from a physician within the last 6 months and I am coming for treatment for one of these conditions. Yes ____ No ____
(please circle those that apply): Smoking Cessation Weight Loss Chronic Pain Cosmetic Facial Ac.

3) I have received a referral from my chiropractor within the last 30 days for acupuncture. Yes____ No____
After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the licensed acupuncturist is required to refer me to a physician. It is my responsibility and **choice** whether to follow this advice.

Signature of Patient ____ Date: _______________

Financial Policy

Renewed Health, LLC does accept most insurance. Your insurance will be verified for in-network or out-of-network benefits. All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductibles, or copay. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment. If your insurance company does not pay within 45 days, we will require you to pay the balance by cash, check, credit card or debit card. Payment for copay and/or deductible is due at the time services are rendered. You understand that if you suspend or terminate care, any fees for professional services rendered will be immediately due and payable. You also agree that you are responsible for all bills incurred at this office.

MasterCard, Visa, Discover, American Express, and Debit cards are accepted as well as cash and checks. Any checks with insufficient funds will be charged an additional $50 by this clinic.

Your appointment time is reserved specifically for you. If you need to cancel your appointment, call us at least 24 hours before the appointment to avoid being charged $80 for that appointment. You may also be charged $80 for missed appointments.

Herbs are non-refundable once purchased.

Please indicate your understanding and acceptance of these policies by signing below.

____ ____ ___________
Signature Printed Name Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

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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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 damages 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, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

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 healthcare 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 (print): ________________________ Signature: ________________________________ Date: _______________

Parent or Guardian (print): ____________________ Signature: ________________________________ Date: _______________

Office Name: ______________________________ Signature: ________________________________ Date: _______________

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

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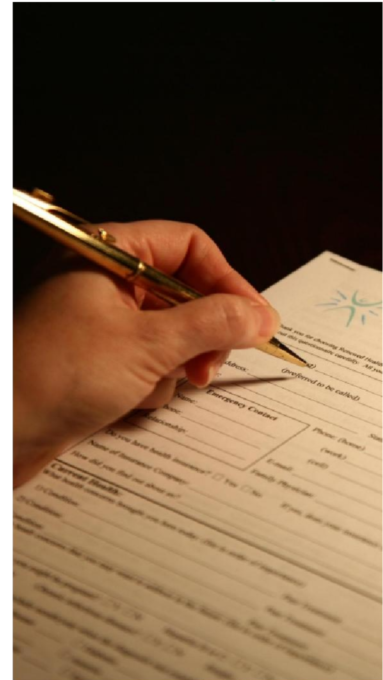
Renewed Health
Patient Policies

The following policies were created to reduce waiting and help you get the best results.

1. Please sign in when you arrive at the office.
2. Pick up a “Patient Condition Assessment” form and fill out the top portion. We ask that you fill out how you’re responding to care by rating on a scale from 0-10 how your symptoms are doing today. This gives us the most accurate description of your progress to determine if changes are needed in your program.
3. If you are here for an Acupuncture Treatment, once you are in the treatment room we would like you to lie down, face up, and begin to relax.
4. Keep your appointments. We have recommended a certain frequency of care. The first visit of the week makes the changes necessary for your body to respond. The next visit holds the change and makes the change more permanent. Whatever schedule is recommended, results will not be achieved unless the frequency is kept. You will lose time and money if you don’t keep your appointments. We also recommend, once we know the time you prefer, that you reserve that time for yourself as far in advance as possible so you don’t lose this appointment slot. Also, to be considerate of other patients and the staff, please be on time to your appointments.
5. We recognize emergencies occur and an appointment might not be able to be kept. In such a case we request the following:
    a. Call us at least 24 hours before the appointment.
    b. Reschedule your make-up appointment the same day, the next day or within the same week.

   If a treatment is missed and not made up in 7 days you will most likely need one visit more than the recommended series. This will cost you time and money. A set make-up time can be worked out in advance to make it easier for rescheduling purposes. Remember our results are based on the number of kept appointments per week. Please understand that appointment times are reserved specifically for you and that any ‘no show’ appointments or appointments cancelled less than 24 hours prior to the appointment will be charged the normal fee for that appointment.
6. Since insurance reimbursement is unpredictable, no matter what their representatives say or their booklets have in writing, we want to work out with you in advance how to address non-payment by the insurance company. Our experience is that if you pursue your company regarding any denied claim they will be more likely to pay since you are the customer. We will notify you of any non-payment and explain what you can do to help yourself and us receive the reimbursement that is deserved. Remember: The insurance companies will often blame our office for their non-payment, no matter what we do or send to them.
7. Herbal medicine is an important part of your treatment plan and in gaining the desired health results. Please take the prescribed herbs on time in the recommended dosages. If you run out of herbs before your next appointment, please call the office. If you have any problems or negative reactions from the herbs, call the office as soon as possible. If you have a severe reaction, call 911 or go to the emergency room.
8. Diet and lifestyle changes are an important part of your program. Please adhere to any diet and lifestyle changes that were recommended as part of your program.



______________________	______________
Patient Name	Date
______________________	______________________
Patient Signature	Clinic Representative

Renewed Health Acupuncture and Herbal Medicine

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Round Rock, TX 78664
info@RenewedHealthAc.com

(512) 341-9900

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HIPAA Acknowledgment and Appointment Reminders Form

I acknowledge that **Renewed Health, LLC** has provided me with the “Notice of Privacy Policy”. I understand I have a right to review said policy prior to signing this document.

Members of the staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information

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Patient Name (printed)

__________________________ ____________________

Patient Signature *Date*