Welcome to Gainesville Community Acupuncture!

Please take a minute to read this introduction to our clinic and to our community prior to your first appointment, as it provides essential information regarding how our clinic functions. You may wish to print this out for your reference.

Welcome to Gainesville Community Acupuncture! We are delighted that you have chosen us for your healthcare needs. We offer skilled and compassionate acupuncture and herbal medicine in a comfortable group setting with sliding scale rates that make this highly effective healing system affordable.

Community Supported Acupuncture depends upon your cooperation. So that we may best focus on your health and treatment, please fill out the Health History, Informed Consent and Financial Policy prior to your first visit and bring them with you to your appointment. These forms may be found online on our website for you to print out at **www.GainesvilleCommunityAcupuncture.com**. We are very grateful for your participation in Community Supported Acupuncture!

Gainesville Community Acupuncture is a sustainable community business model. We do not receive grants, state or federal money, or insurance reimbursement. GCA exists because patients pay for their treatments. The main reason that we are able to keep our prices so low is because of the extraordinary amount of marketing our patients do on our behalf -- we don't have to advertise. We cannot express how grateful we are for this. Our patients are such effective marketers because they have first-hand experience of how well acupuncture works.

What is different about the GCA clinic?

We treat in a community setting

Most US acupuncturists treat patients on tables in individual cubicles. This is not traditional in Asia, where acupuncture treatments usually occur in a community setting. In our clinic we use recliners within a large, quiet, soothing space. Treating patients in a community setting has many benefits: it's easy for friends and family members to come in for treatment together; many patients find it comforting; and a collective energetic field becomes established which actually makes individual treatments more powerful. In some styles of acupuncture, the needles are removed after only a few minutes or after a half hour at most. The style of acupuncture we practice at GCA allows patients to keep their needles in as long as they want, and the "right" amount of time varies from patient to patient. Most people learn after a few treatments when they feel "done." This can take from twenty minutes to an hour. Many people fall asleep, and wake feeling refreshed.

We have a sliding scale

Most acupuncturists in the U.S. charge $65 to $175 per treatment. They tend to spend a long time talking with each patient, going over medical records, and asking many questions. We don't. The way GCA can make acupuncture affordable is to simplify treatments and see multiple patients in an hour. To do this we have returned to a more traditional Asian treatment structure. During your treatment time, your Acupuncture physician will briefly interview you and then use pulse diagnosis to decide how to treat you. This treatment structure is exactly how acupuncture is practiced traditionally in Asia -- many patients per hour and very little talking. Please see our website which explains our sliding scale rates.

Because we have a sliding scale, we cannot do insurance billing (that is the insurance companies' rule). If your insurance covers acupuncture therapy, we will be happy to give you a payment receipt and you can submit it; that's OK with the insurance companies.

Our Commitment to You:

We want to make it possible for you to receive acupuncture regularly enough and long enough to get better and stay better. We want our clinic be welcoming to all different kinds of people, and we want to give you the tools to take care of your own health without costly, high-tech interventions. We will provide a safe environment with skilled practitioners.

What We Need From You:

Responsibility

GCA does not provide primary care medicine! Acupuncture is a wonderful compliment to Western medicine, but it is not a substitute for it. If you think you have a problem that is not "garden variety" (meaning, you are worried that you might have a serious infection, a malignant growth, or an injury that won't heal), or if you want someone to go over the details of your medical history from a western medical perspective, you do need to consult with a primary care physician (ND, MD, or DO). Please do not expect us to diagnose something really serious. We *can* provide complimentary care for any conditions that require a physician's attention. For instance, we often treat patients for the side effects of chemotherapy.

Flexibility

The community setting requires some flexibility from you. For instance, many patients have a favorite recliner, and when we are busy, someone may be sitting in yours. Similarly, we have a few patients who snore, so patients who dislike snoring bring earplugs to their treatments. We are grateful for this! Some of our patients prefer to bring favorite pillows or blankets from home with them rather than use the ones we provide. That's fine with us! Basically, we ask that you participate in making yourself comfortable in the community room before we arrive to treat you. In terms of how long you want to stay – when you check in tell the receptionist or Acupuncturist if you need to be somewhere at a certain time! We'll make sure you're out on time. In general, communication is essential. If you feel done, open your eyes and give us a meaningful look and we'll come take out your needles. If your eyes are closed, we may think you're asleep and may not wake you up in time to leave.

Community-Mindedness

The soothing atmosphere in our clinic exists because it is created by all of our patients relaxing together. We appreciate everyone's presence! This kind of collective stillness is a rare and precious thing in our rushed and busy society. Maintaining this reservoir of calm requires that the clinic be a quiet zone. **We ask that you please silence or turn off your cell phone** and keep talking in the clinic space to the little you will do with your Acupuncturist. Unfortunately, we can't explain what every point does, or how acupuncture

works, while we are treating you -- these are very large topics! Therefore, if you would like to speak to an Acupuncture practitioner one-on-one at any length, please let us know. If you want to have a substantial conversation, we will usually need to schedule that separately and might need to do it by phone. If you have questions about acupuncture and how it works, please ask our receptionist for the materials we have on that subject, and we can also suggest reading material. We love questions! We just will need to find another time outside of the clinic to answer them. Part of our success is that our patients learn the "routine" and take on a lot of responsibility for the appointments. Some general guidelines: please take all personal belongings, (bags, shoes, etc.) with you back into the treatment room; each treatment chair has its own basket for you to store your belongings in.

Commitment

Acupuncture is a process. It is very rare for any acupuncturist to be able to resolve a problem with one treatment. In China, a typical treatment protocol for a chronic condition could be acupuncture every other day for three months! Most of our patients don't need that much acupuncture, but virtually every patient requires a course of treatment, rather than a single treatment, in order to get what they want from acupuncture. On your first visit, your acupuncturist will suggest a course of treatment, which can be anything from "we'd like to see you once a week for six weeks" to "we'd really like to see you every day for the next four days". This suggestion is based on our experience with treating different kinds of conditions. If you don't come in often enough or long enough, acupuncture probably won't work as well or as fast for you. One of the purposes of our sliding-scale rate structure is to help you make that commitment. If you have questions about how long it will take to see results, please ask us, or if you think you need to adjust your treatment plan, please let us know. We need you to commit to the process of treatment in order to get good results.

And, last, but not least….enjoy the space. We do, and hope that Gainesville Community Acupuncture can be an important part of your community.

Thank you,
Gainesville Community Acupuncture Staff

Gainesville Community Acupuncture

HEALTH HISTORY

Date: ____ / ____ / _____

Name:		Sex:	Age:
Address:	City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:	Employer:	Occupation:	
Health Care Providers:	Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: _____		
Height:	Usual Blood Pressure:		
Weight:	Weight One Year Ago:	How did you hear of our clinic?	
Are you or may you be currently pregnant?		Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when ____/____/____	

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

2 _____

When did this start? _____ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

3 _____

When did this start? _____ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

HEALTH HISTORY

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? _____	❒	_____	❍
Diabetes	❒	_____	❍
Hepatitis	❒	_____	❍
High Blood Pressure	❒	_____	❍
Heart Disease	❒	_____	❍
Stroke	❒	_____	❍
Seizure Disorder	❒	_____	❍
Thyroid Disease	❒	_____	❍
Asthma	❒	_____	❍
Pacemaker	❒	_____	❍
Arthritis	❒	_____	❍
Chronic Fatigue	❒	_____	❍
Gastritis/Pancreatitis	❒	_____	❍
Hypo/Hyperglycemia	❒	_____	❍
Lyme Disease	❒	_____	❍
Infertility	❒	_____	❍
Elevated Cholesterol	❒	_____	❍

	YOU	Year	FAMILY
Osteoporosis	❒	_____	❍
Herpes	❒	_____	❍
AIDS / HIV	❒	_____	❍
Other STD	❒	_____	❍
Rheumatic Fever	❒	_____	❍
Alcoholism	❒	_____	❍
Allergies type(s)? _____	❒	_____	❍
Mental Illness	❒	_____	❍
Kidney Disease	❒	_____	❍
Anemia	❒	_____	❍
Chronic Pain	❒	_____	❍
Diverticulitis/IBS	❒	_____	❍
Emphysema	❒	_____	❍
Raynaud's Disease	❒	_____	❍
Venereal Disease	❒	_____	❍
Addiction	❒	_____	❍
Other _____			

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American
Current or past eating disorder?

Typical Breakfast: _____
Typical Lunch: _____
Typical Dinner: _____
Typical Snacks: _____

HABITS

	Amount/Week	If quit, Year?
Coffee/Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly?
If so, what types? What frequency/duration?

_____
_____
_____
_____

MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take regularly.

_____
_____
_____
_____

INJURIES & TRAUMAS (PHYSICAL/EMOTIONAL)

When What Happened?

_____ _____
_____ _____
_____ _____

SURGERIES

When What Surgery?

_____ _____
_____ _____
_____ _____

CHILDHOOD HEALTH HISTORY

☐ Allergies ☐ Frequent Earaches ☐ Scarlet Fever ☐ Forceps Delivery
☐ Asthma ☐ Frequent Sore Throat ☐ Premature Birth ☐ Other Birth Trauma_____
☐ Chicken Pox ☐ Frequent Cold / Flu ☐ Prolonged Labor ☐ Other_____

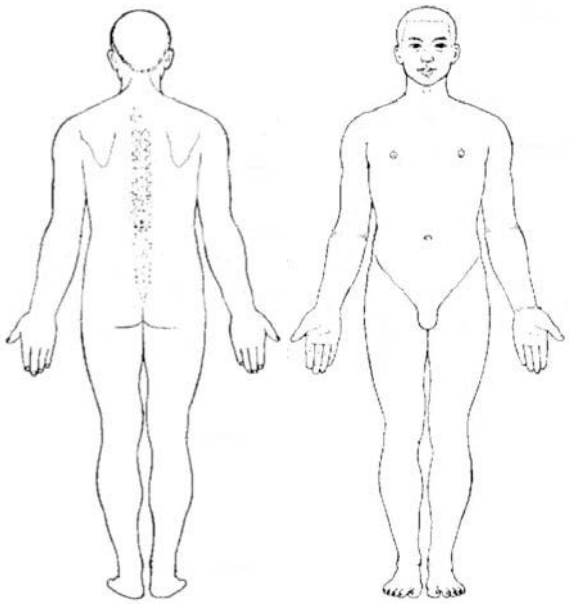
MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

☐Head ☐Wrists ☐Legs
☐Neck ☐Hands ☐Knees
☐Shoulders ☐Fingers ☐Ankles
☐Arms ☐Back: U/M/L ☐Feet
☐Elbows ☐Hips ☐Toes

☐Joint Swelling ☐Edema ☐Carpal Tunnel
☐Broken Bones ☐Tendonitis ☐Sprains/Strains
☐Bone Deformities ☐Muscle Pain ☐Rotator Cuff
☐Paralysis ☐Bursitis ☐Poor Balance
☐Whole Body Pain ☐Sciatica ☐Restricted Movement
☐Other_____

Please Mark All Places on the Body Where You Have Any Concern ⟶



HEAD, EYES, EARS, NOSE, THROAT

☐Migraines ☐Eye Strain ☐Poor Hearing ☐Sinus Problems ☐DryLips/Mouth
☐Poor Vision ☐Dizziness ☐Earaches ☐Sore Throats ☐Dry Throat
☐Blurry Vision ☐Eye Pain ☐Ear Ringing ☐Lip/Mouth Sores ☐Difficulty Swallowing
☐Night Blindness ☐Cataracts ☐Excess Ear Wax ☐Tongue Sores ☐Headaches
☐Glasses ☐Red/Itchy Eyes ☐Nose Bleeds ☐Grinding Teeth ☐Heavy-headed
☐Spots in Eyes ☐Color Blindness ☐Poor Smell ☐Jaw locks/clicks ☐Light-headed

CARDIOVASCULAR

☐Shortness of Breath ☐Irregular Heart Beats ☐ Blood Clots ☐Bleed/Bruise Easily ☐Phlebitis
☐Slow Heart Rate ☐Palpitations ☐Spontaneous Sweating ☐Chest Pain/Pressure ☐High Blood Pressure
☐Fast Heart Rate ☐Varicose/Spider Veins ☐Fainting ☐Hands/Feet Swelling ☐Low Blood Pressure

RESPIRATORY

☐Cough/Wheezing ☐Pneumonia ☐Difficult Inhale/Exhale ☐Bronchitis
☐Frequent Colds ☐Coughing Blood ☐Pain on Deep Inhalation ☐Phlegm (color:_____)
☐Frequent Fevers ☐Asthma ☐Chest Tightness ☐Difficulty Breathing when lying down

GASTROINTESTINAL

BM: How Often? __x/__day(s)
Stools keep shape? Y/N
☐Indigestion
☐Nausea/Vomiting
☐Peculiar Tastes/Smells
☐Black Stools
☐Bloating
☐Belching
☐Bad Breath
☐Excess Saliva
☐Hemmorhoids
☐Bowel Incontinence
☐Poor Appetite
☐Excessive Hunger
☐Feel a "lump in throat"
☐Hiatal Hernia
☐IBS/Crohn's Disease
☐Blood in Stool
☐Heartburn/Reflux
☐Stomachaches
☐Dry Stools
☐Difficult to Pass
☐Tired after BM
☐Cramps w/ BM
☐Unsatisfying BM
☐Gas
☐Rectal Pain
☐Abdominal Pain

DIARRHEA ——— CONSTIPATION

GENITO-URINARY

☐Clear Urine
☐Dark Urine
☐Cloudy Urine
☐Burning Urine
☐Scanty Urine
☐Profuse Urine
☐Frequent Urine
☐Urgent Urine
☐Blood in Urine
☐Painful Urine
☐Incontinence
☐Kidney Stones
☐Frequent UTI
☐Erectile Dysfunction
☐Difficult Start/Stop
☐Fluid in = Fluid out
☐Prostate Disease
☐Decreased Libido
☐Premature Ejaculation
☐Nocturnal Emission
☐Testical Pain
☐Herpes
☐Genital Pain
☐Genital Sores
☐Jock Itch
☐Vasectomy
☐Hernia
☐Excess Libido

GYNECOLOGICAL

☐Vaginal Dryness
☐Vaginal Sores
☐Vaginal Discharge
☐Infertility
☐Irregular Periods
☐Ovarian Cysts
☐Endometriosis
☐Fibroids
☐PMS
☐Painful Periods
☐Heavy Periods
☐Light Periods
☐Cramps
☐Clots
☐Breasts Tender
☐Mood Changes
☐Period Fatigue
☐Spotting
☐Digestive changes w/Period
☐Fibrocystic Breast Tissue
☐Polycystic Ovarian Disease
☐Difficult/Painful Intercourse
☐Age at First Menses_____
☐Date of Last Menses_____
☐Length of Cycle:_____days
☐Length of Menses:_____days
☐Menopause: Age_____
☐Number of Pregnancies:_____
☐Number of Births:_____
☐# of Abortions/Miscarriages:_____

NEURO – PSYCHO – EMOTIONAL

☐Seizures
☐Loss of Balance
☐Vertigo/Dizziness
☐Areas of Numbness
☐Lack of Coordination
☐Nervousness
☐Anxiety
☐Panic Attacks
☐Irritable
☐Depression
☐Bi-Polar
☐Poor Memory
☐Forgetful
☐ADD/ADHD
☐Fearful
☐Angry
☐Sad
☐Grief
☐Joy
☐Indecision
☐Concussion
☐Poor Concentration
☐Overthinking
☐Tremors
☐Easily Stressed
☐Seasonal Affective Disorder
☐Difficulty Expressing Emotions
☐Frequently Sigh/Yawn
☐Other_____

ENERGY

☐Wired
☐Dependence on Caffeine
☐Energy Drop after Eating
☐Sudden Energy Drop: Time of Day:_____
☐Fatigue
☐Body feels Heavy
☐Body feels Weak

LOW ——— HIGH

SLEEP

☐Difficulty Falling Asleep
☐Difficulty Staying Asleep
☐Excessive Sleep
☐Not Enough Sleep
☐Sleep Walk/Talk
☐Disturbing Dreams
☐Wake to Urinate
☐Restless Sleep
☐Not Rested Upon Waking
☐Wake ____x / night
☐Sleep:____hrs./night

Too Little (Insomnia) ——— Too Much (Hypersomnia)

SKIN, HAIR, & NAILS

☐Rashes
☐Acne
☐Dandruff
☐Itching
☐Warts
☐Eczema
☐Psoriasis
☐Dermatitis
☐Face Flushing
☐Hives
☐Thick Skin
☐Scaly Skin
☐Thin Skin
☐Thin Nails
☐Dry Skin
☐Dry Nails
☐Discolored Skin
☐Dark under eyes
☐Nail Fungus
☐Abscesses/Infections
☐Hair Loss
☐Dry/Brittle Hair
☐Premature Greying
☐Recent Moles
☐Lumps
☐Ulcerations
☐Weak Nails
☐Ridged Nails
☐Change in Skin/Hair Texture
☐Other_____

DRY ——— OILY

TEMPERATURE & THIRST

☐Cold Hands/Feet
☐Cold "in the bones"
☐Areas of Numbness
☐Chills
☐Thirst for Cold Drinks
☐Thirst for Hot Drinks
☐Thirst, No desire to Drink
☐Absence of thirst
☐Excessive Thirst
☐Hot Hands
☐Hot Feet
☐Hot Chest
☐Hot Flashes
☐Hot in Afternoon
☐Hot at Night
☐Night Sweats
☐Unusual Sweats:
Where on Body:_____
What Time:_____am/pm

COLD ——— HOT

A Users Guide to the GCA Clinic

- Silence or turn off your cell phone.
- Enter the clinic quietly.
- Take a cloth head-rest cover from the stand.
- Choose a recliner to sit in and cover the upper back of the chair with your head-rest cover.
- Remove your shoes, coat and dangling jewelry and store them in the basket next to your chair provided for your personal belongings.
- Have a seat and your Acupuncturist will be with you shortly.
- After your treatment, take your head-rest cover and place it in the laundry basket on your way out.
- Leave the clinic quietly.
- Have a lovely day!

Financial Policy

In respect for our intention to offer high quality healthcare at affordable prices, we ask for 24 hour notice in advance if it is necessary to cancel or reschedule an appointment. All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged $20 for that appointment. If appoinments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments n that package.

Late policy

We will do our best to accommodate you if you arrive late for your appointment. However, if you arrive more than than 10 minutes late and we are unable to accommodate you, we will consider it a missed appointment and enforce our financial policy.

Returned checks

There will be a $20 charge for any returned checks.

Thank you for your understanding.
Gainesville Community Acupuncture Staff

Signature_____ Date:_____

Printed name_____

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.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

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

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

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

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

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

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the 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 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 REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X** (Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Gainesville Community Acupuncture.
1330 NW 6th St., Suite A
Gainesville, FL. 32601
(352) 371-0012

HIPAA CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and Physician certifications.

I have been informed by you; of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____