New Patient Intake Form

Today's Date _____/_____/_____

Name | Marital Status: _____ | Birthdate / / Age _____

Address _____ ☐ Male ☐ Female

_____ Ht _____ Wt _____

Email | Occupation

Home Phone | Work | Cell

Referred by

Reason for visit today | Have you had acupuncture before? Chinese herbal medicine?

How long have you had this condition?

Is it getting worse? Does it bother your ☐sleep ☐work ☐other (specify)?

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

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

Physician's name: | Physician's phone:

Other concurrent therapies:

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

Your Past Medical History:

☐ AIDs/HIV	☐ Emphysema	☐ Mumps	☐ Cancer type:	☐ Tuberculosis
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker (Date:)	treatment:	☐ Typhoid fever
☐ Allergies	☐ Goiter	☐ Pleurisy		☐ Ulcers
☐ Appendicitis	☐ Gout	☐ Pneumonia		☐ Venereal disease
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Surgery (list)	☐ Whooping cough
☐ Asthma	☐ Hepatitis (Type:)	☐ Rheumatic fever		☐ Other
☐ Birth Trauma	☐ Herpes (Type:)	☐ Scarlet fever		
(your own birth)	☐ High Blood Pressure	☐ Seizures	☐ Major trauma (car,fall, pls list)	
☐ Chicken Pox	☐ Measles	☐ Stroke		
☐ Diabetes (Type:)	☐ Multiple Sclerosis	☐ Thyroid disorders		

Your Diet:

Appetite ☐ Low ☐ High

☐ Coffee/Tea ☐ Soft Drinks/ Fruit Juices

☐ Artificial Sweeteners ☐ Sugar ☐ Salty foods

Protein Intake ☐ Low ☐ High

Thirst for water: # glasses per day:

Pharmaceuticals (name and dosage):

Vitamins/Supplements (name and dosage):

Your Lifestyle:

☐ Alcohol ☐ Marijuana ☐ Stress
☐ Tobacco ☐ Drugs ☐ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms:

☐ Poor appetite ☐ Poor sleep ☐ Bodily heaviness ☐ Chills ☐ Bleed or bruise easily
☐ Heavy appetite ☐ Heavy sleep ☐ Cold hands or feet ☐ Night sweats ☐ Peculiar taste (Describe)
☐ Like cold drinks ☐ Dream-disturbed sleep ☐ Poor circulation ☐ Sweat easily _____
☐ Like hot drinks ☐ Fatigue ☐ Shortness of breath ☐ Muscle cramps _____
☐ Weight loss/gain ☐ Lack of strength ☐ Fever ☐ Vertigo/dizziness _____

Head, Eyes, Ears, Nose, Throat

☐ Glasses (age?) ☐ Night blindness ☐ Gum problems ☐ Recurrent sore throat ☐ Headaches
☐ Eye strain ☐ Myopia/Presbyopia ☐ Sores on lips/tongue ☐ Swollen glands ☐ Migraines
☐ Eye pain ☐ Glaucoma ☐ Dry mouth ☐ Lumps in throat ☐ Concussions
☐ Red eyes ☐ Cataracts ☐ Excessive saliva ☐ Enlarged thyroid Other head or neck problems
☐ Itchy eyes ☐ Teeth problems ☐ Sinus problems ☐ Nosebleeds _____
☐ Spots in eyes ☐ Grinding teeth ☐ Excessive phlegm ☐ Ringing in ears _____
☐ Poor vision ☐ TMJ Color: ☐ Poor hearing _____
☐ Blurred vision ☐ Facial pain ☐ Earaches

Respiratory

☐ Difficulty breathing wh ☐ Tight chest ☐ Cough ☐ Color of phlegm: ☐ Coughing up blood
lying down ☐ Asthma/wheezing Wet or Dry? _____ _____ ☐ Pneumonia
☐ Shortness of Breath □ Difficult inhale? Exhale? Thick or thin? _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Tachycardia ☐ Phlebitis
☐ Blood clots ☐ Fainting ☐ Difficulty breathing ☐ Heart palpitations ☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea ☐ Diarrhea ☐ Intestinal pain/cramps Bowel movements:
☐ Vomiting ☐ Constipation ☐ Burning anus
☐ Acid regurgitation ☐ Black stools ☐ Rectal pain Frequency_____ Texture/form_____
☐ Gas ☐ Bloody stools ☐ Anal fissures
☐ Hiccup ☐ Mucous in stools ☐ Laxative use Color_____ Odor_____
☐ Bloating ☐ Hemorrhoid What kind?
☐ Bad breath ☐ Itchy anus How often?

Musculoskeletal

☐ Neck/shoulder pain ☐ Upper back pain ☐ Joint pain ☐ Limited range of motion ☐ Other
☐ Muscle pain ☐ Low back pain ☐ Rib pain ☐ Limited use _____

Skin and Hair

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Change in hair/skin texture Other (Specify)
☐ Hives ☐ Psoriasis ☐ Itching ☐ Fungal infections _____
☐ Ulcerations ☐ Acne ☐ Hair Loss _____

Neuropsychological

☐ Seizures ☐ Poor memory ☐ Irritability ☐ Considered/attempted Other (Specify)
☐ Numbness ☐ Depression ☐ Easily sressed suicide _____
☐ Tics ☐ Anxiety ☐ Abuse survivor ☐ Seeing a therapist _____

Genitourinary

☐ Pain on urination ☐ Blood in urine ☐ Venereal disease ☐ Increased libido ☐ Impotence
☐ Frequent urination ☐ Unable to hold urine ☐ Bedwetting ☐ Decreased libido ☐ Premature ejaculation
☐ Urgent urination ☐ Incomplete urination ☐ Wake to urinate ☐ Kidney stone ☐ Nocturnal emission

Gynecology

☐ Age menses began ☐ Duration of flow ☐ Vaginal discharge ☐ Breast lumps Date of last PAP
_____ _____ days (color)_____ # Pregnancies_____ _____
Length of cycle (day 1-day 1) ☐ Irregular periods ☐ Vaginal sores # Live births_____ Date last period began
_____ ☐ Painful periods ☐ Vaginal odor # Premature births_____ _____
☐ PMS ☐ Clots Age at menopause_____

Mary Cetan, P.A., Doctor Oriental Medicine, Florida Acupuncture Physician 1303

4920 Fruitville Road, Sarasota, FL 34232 – 941-926-7899 – drmary@natureswisdomhealingcenter.com

---

Consent for Communication Disclosure

Your Name: _____

Phones: Circle the preferred one for us to contact you on.

Cell: _____ Home: _____ Work: _____

If we are unable to reach you at preferred number, may we use another? Y or N

May we leave the following information on your home voicemail?

Appointment Info? Y or N Billing Info? Y or N Medical Info? Y or N

Addresses:

E-mail: _____

May we use this e-mail to communicate with you? Y or N

Mailing Address:

Home: _____

Other: _____

Which address do we use and when?

_____

Emergency Contact:

Name: _____ Phone: _____

Whom May We Inform About Your Care & Financial Information? (Indicate: C / $)

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Do You Require Any Correspondence from Us to Be Marked Confidential? Y or N

Other Contact Information:

Your Website: _____ Your Skype: _____

Your Facebook: _____ Your LinkedIn: _____

Your Twitter: _____ Your Google: _____

I give permission to contact me and use the information as indicated on this form:

Signature: _____ Date: _____

Mary Cetan, P.A., Doctor Oriental Medicine, Florida Acupuncture Physician 1303

4920 Fruitville Road, Sarasota, FL 34232 natureswisdomhealingcenter.com
drmary@natureswisdomhealingcenter.com 941-926-7899

Policy Regarding Patient Financial Responsibility

Self-Pay: All services are required to be paid in full at the time of service

Fees: There is a separate **Services and Fees** sheet that shows our pricing

Discounted Care Plans: We offer discounted prices when a series of treatments are purchased and scheduled. The patient may have the money returned from a multiple treatment discounted option as follows: the used visits will be adjusted to non-discounted prices; the remainder of funds will be refunded to patient via check within 10 working days. The multi-treatment discounted plan can be given to a friend or family member with the intention that they use the remaining visits.

Cancellations: We have a 24-hour cancellation policy. Cancellations can be communicated via phone, text, email or in person. Barring a true emergency, patient will be charged a $50 missed appointment fee, or be required to use one of the visits on discounted Care Plan. This is applicable on the first visit missed. When a patient shows up late, the treatment time will be shortened to keep our schedule on-time. If the patient is more than 20 minutes late, the treatment is missed.

Insurance: Select the "Insurance Verification" button on our website to verify coverage. We accept only out of network plans. We will be notified of the status of your insurance coverage and let you know. If your care is verified to be covered by your insurance, you will be required to pay if your deductible has not been met. You will be required to pay co-pay if applicable. Everyone who is covered by insurance are required to pay $5 per visit for processing fee. There are forms that must be filled out prior to being able accept payment for your insurance that are not included here. Until your insurance coverage is verified and insurance payment forms filled out, all visits must be paid in full at the time of service.

Summary: Providing quality medical care for our patients is our goal. We require the flow of monies to continue providing care. We are not in the position to hold account balances for products or services for our patients.

Patient Statement: I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visits. I also understand that purchasing a multiple treatment discounted Care Plan with a specific number of visits does NOT guarantee success in treatment.

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____

Mary Cetan, P.A., Doctor Oriental Medicine, Florida Acupuncture Physician 1303

4920 Fruitville Road, Sarasota, FL 34232 www.natureswisdomhealingcenter.com
drmary@natureswisdomhealingcenter.com 941-926-7899

Privacy Policy for Our Patients

We value our relationship, and respect your right to privacy. Your visits and treatments will remain confidential and will not be discussed with other patients nor visitors to our clinic. This notice describes our policy for how your privacy is being protected and how your medical information may be used.

Emergency Contact Person: The person that you indicated on your patient form will be contacted in the event of an emergency. If this person changes during your care with us, please notify us verbally and via a written request so we can update your files.

Clinic Safeguards Include:

1. Limited and keyed access to location where information is stored
2. Policies and procedures for handling information
3. Requirements for our staff and others who work in our clinic to contractually comply with privacy laws
4. All medical files are kept on permanent file for 5-years per Florida law

Information We Use In Our Clinic:

In administering your health care, we gather and maintain information that may include non-public personal information as follows:

1. Financial/billing transactions
2. Medical notes including health history; treatment notes; test results
3. Communications with other healthcare practitioners and professional associations including--insurance companies, workman's comp and your employer, and other third part administrators like requests for medical records, claim payment information, et cetera.

Information We May Share:

1. Limited personal medical and financial information with your insurance company
2. Limited personal medical and financial information with with Worker's Compensation and your employer as well in this instance
3. Medical information with medical practitioners that you authorize in writing
4. Medical and financial information with people that you authorize in writing
5. As health care practitioners, we are required by Florida law to report to those who can help, all suicide threats shared with us

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____

Mary Cetan, P.A., Doctor Oriental Medicine, Florida Acupuncture Physician 1303

4920 Fruitville Road, Sarasota, FL 34232 – 941-926-7899 – drmary@natureswisdomhealingcenter.com

---

Patient Acknowledgement of Our Privacy Policy

I, _____, consent to the use and disclosure of my health information by Mary Cetan, P.A. for the purposes of my diagnosis, treatment, obtaining payment, and as needed to conduct health care. When I sign this agreement, I consent my health care, including diagnosis and services to Mary Cetan, P.A.

My health information includes demographic information, my health plan, my employer or a health care clearinghouse (i.e. insurance processing company). This acknowledgement includes past, present and future health conditions.

I have the right to view Mary Cetan, P.A.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the use of; the duties of my practitioners with respect to; and my rights regarding my health information.

The Notice of Privacy Practices Manual is physically available for review at our clinic. We reserve the rights to change the information contained in this manual at any time and we will notify you of any changes that affect you.

Consent to the Use and Disclosure of Health Info for Treatment, Payment and Care

I understand that the clinic of Mary Cetan, P.A. originates and maintains health records describing my health history, on-going symptoms, exams, test results, diagnoses, treatment and plans for future care.

I understand that my health records serve as a basis for planning my treatment per my diagnosis. I also understand that my health records can be used by a third-party payer to verify that services billed were provided; by a team of healthcare providers that contribute to my care; and as a tool for assessing the care quality of healthcare professionals.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment/payment/healthcare operations and that Mary Cetan, P.A. is not required to agree to the restrictions request as based on laws and regulations. For personal or professional reasons, I request the following restrictions to the use of my health care information:

1.

2.

3.

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____

Office 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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

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:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE