MARY CETAN, ACUPUNCTURE PHYSICIAN

FLORIDA BOARD CERTIFIED ACUPUNCTURE PHYSICIAN - FLAP1303 (1999 TO CURRENT)
NATIONAL COMMISSION CERTIFICATION ACUPUNCTURE & ORIENTAL MEDICINE – DIPL.12571
NATURE'S WISDOM HEALING CENTER-MARY CETAN, P.A. (PROFESSIONAL ASSOCIATION)
4920 FRUITVILLE ROAD, SARASOTA, FLORIDA 34232
941-926-7899 WWW.SARASOTAACUPUNCTURECLINIC.COM
EMAIL: MARY@NATURALHEALING.CLINIC

PATIENT INFORMATION

Name_____

Address_____

City_____ State____ Zip_____

Phone number _____ Cell/Work/Home

Email_____

Birthdate _____Age_____ M____ F_____

Height_____ Current Weight____ Wt. Goal_____

Occupation_____

Referred by _____

List another person that we may contact if needed.

Name_____

Relationship _____Phone _____

Previous acupuncture? Yes/No Last visit _____

Acupuncturist's name _____

Are you currently taking herbal medicine? Yes/No

Primary MD _____

Have you had Nutrition Response Testing? Yes/No

Other concurrent therapies and practitioners you currently work with _____

_____

_____

Do you have any recent (within the past 6 months) blood chemistry lab results? Yes/No

Have you taken the DUTCH (Dried Hormone Test for Comprehensive Hormones)? Yes/No

Have you had cortisol salivary testing? Yes/No

Have you had hair tissue mineral testing? Yes/No

Other recent diagnostic tests

_____

_____

Occupation _____

Exercise Type & Frequency _____

Hobbies _____

Who do you live with? _____

Current Daily Stress Level: Mild 1 2 3 4 5 6 7 8 9 10 Severe

Stressors _____

Currently working with a mental health therapist? Yes/No

Caffeine _____

Alcohol_____

Water _____

Recreational Drugs _____

Past smoker Yes/No Date quit: ___Current smoker Yes/No

How many Covid vaccinations/boosters did you receive?

_____ ☐ None

Did you get swab tested for Covid? Yes/No

Medical Diagnoses & Dates ☐ None

_____

_____

_____

Medications (Rx/OTC) ☐ None

_____

_____

_____

Allergies_____ ☐ None

Diet type (Vegan, GF, DF, other)

_____

Have you been diagnosed with Celiac disease? Yes/No

Vitamins & Herbal Supplements ☐ None

_____

_____

_____

PATIENT HEALTH INTAKE

What is your primary health concern?

_____

_____

_____

How long have you had this condition? _____

What seems to be the initial cause? _____

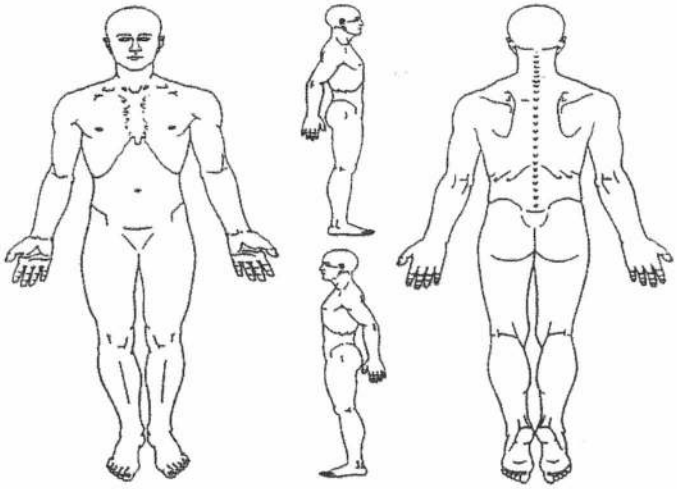
_____

_____

List other health concerns you have

1. _____
2. _____
3. _____
4. _____
5. _____

Indicate below areas where the problems exist.
X areas of pain, give X a number: Low (1) - High (10)
Circle area of problem other than pain



Details of XX's areas _____

_____

_____

_____

Details of Circled areas _____

_____

_____

_____

Accidents/Surgeries/Procedures ☐ None

_____

_____

_____

_____

Family History of Illness ☐ Unknown

_____

_____

_____

_____

Average hours sleep per night _____

Bowel Movement frequency & texture/form

_____

Ear Nose Throat Issues _____

Respiratory Issues _____

Cardiovascular Issues _____

Gastrointestinal Issues _____

Skin & Hair Issues _____

Neuropsychological Issues _____

Urinary Issues _____

Immune System Issues _____

Hormonal Issues _____

Gynecological Issues Females

# of pregnancies ___ # of births ___ # of miscarriages___

Age at first pregnancy _____ Age at last pregnancy ____

Did you use fertility treatments to get pregnant? Yes/No

Age menses began _____ Age at menopause_____

Birth control use_____

Other Health Issues _____

_____

_____

_____

_____

_____

_____

_____

The information on this two-page Patient Information & Health Intake form is correct to the best of my knowledge.

Name _____ Date _____

Signature_____

We help people regain & maintain natural health!

True health care is self-care.

Thank you for allowing us to help you with you!

Nature's Wisdom Healing Center-Mary Cetan

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Consent for Communication Disclosure

Your Name: _____

Phones: Circle the preferred one you wish us to use to contact you.

Cell: _____ Home: _____ Work: _____

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

May we text your cell phone number? Y or N

May we leave information on your voicemail and your home answering machine?

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

Addresses:

Email: _____
May we use this email to communicate with you? Y or N

Home Address:
Home: _____

Other: _____

Emergency Contact:

Name: _____ Phone: _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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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 **Service 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, the 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 is required to pay $5 per visit for processing fee. There are forms that must be filled out prior to being able to 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 cannot 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: _____

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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 or 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 you indicated on your patient form will be contacted in 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 permanently 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, worker's comp, and your employer, and other third party 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 Worker's Compensation and your employer 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: _____

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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 to 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 describes the use of; the duties of my practitioners with respect to; and my rights regarding my health information.

The Notice of Privacy Manual is physically available for review at our clinic. We reserve the right 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 on 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, 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 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

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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: Mary CeTan FLAP 1303

(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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A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration, rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by ***your state*** courts.

By signing this agreement, you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide you with quality medical care which fully meets your healthcare needs. We know that most problems begin with communication. Therefore, if you have any questions about your care, please contact us.

Answering Questions about Arbitration

Q. What is an arbitration agreement?

A. By signing an arbitration agreement, a patient and a healthcare practitioner agree to use a private, confidential, and expedited arbitration, rather than a public, lengthy and costly courtroom trial, to settle any malpractice claims. In arbitration, a neutral arbitrator (quite often a retired judge) decides the case. By agreeing to arbitrate, the parties preserve their right to present their claims fully; however, they choose a specific forum for dispute resolution: an arbitration hearing rather than a judge or jury trial.

Q. Why does arbitration provide a speedier resolution than civil litigation?

A. With the huge backlog in our civil courts, there is often a three- to five-year wait for an available courtroom and judge. In arbitration, the wait is usually less than one year. In addition, simplified procedural rules used in arbitration hearings reduce the number of motions made by attorneys, so a decision can be expedited. That means less worry time for both the patient and health practitioner.

Q. Are arbitration agreements legal?

A. Yes. In an effort to improve the court system, the federal, and most state, laws have been modified to incorporate arbitration as a standard system of dispute resolution. Our paperwork has been specifically designed and updated to meet these requirements.

Q. Is arbitration cheaper than a trial?

A. Yes. Attorney's fees in arbitration hearings are, on average, 60% less than in judge and jury trials. Thus, savings can be substantial, as attorneys' fees in a typical judge or jury trial range between $50,000 and $150,000.

Q. What if a patient won't sign an arbitration agreement?

A. While most patients sign willingly, some (statistically less than 1%) will refuse to sign and will go elsewhere for treatment. That may be to the health practitioner's advantage. That small minority of patients who won't sign is comprised of "professional plaintiffs" (people who make a living out of forcing settlements in nuisance suits) or patients who approach the doctor-patient relationship with the mind-set that they will file suit and they want to be in front of a jury the minute they think anything has gone wrong.

Most patients see the mutual benefit of arbitration in time and cost savings. In addition, patients understand that a malpractice insurance company may require its insured health practitioners to use arbitration forms. Patients appreciate that such a practitioner really cares and has taken the proper business attitude of getting malpractice insurance in case that practitioner should inadvertently injure a patient. And, with arbitration rather than civil litigation, that injured patient won't have to wait five years to get a settlement or judgment.