SUN WELLNESS
HOLISTIC HEALTHCARE

Thank you for including us in your health care decisions. The following forms help us gather important information so we can begin your care right away. All provided information is strictly confidential.

Patient Information	**Contact Information**
Today's Date: _____ /_____ /_____ Name: _____ Address: _____ City:_____ State:_____ Zip:_____ Date of Birth: _____ /_____ /_____ Age: _____ Soc. Sec # _____ Occupation: _____ Employer: _____	Preferred Phone: _____ *May we leave a message at the number above?* Y/N Email: _____ *We will never spam, sell, or distribute your email.* Emergency Contact: _____ Phone: _____ Relation: _____ How did you find us? Please help us reach others! _____ May we connect with you via social media such as: ☐ Twitter ☐ Facebook ☐ Google+ ☐ Instagram

Focus of Visit

What is your primary reason for your visit?_____

What was the cause of this condition? _____

When did it start? _____

What makes it better?_____

What makes it worse? _____

Privacy Policy

I have received and reviewed the privacy policy/HIPPA guidelines for this practice. I understand that my personal information is protected and will not be shared without my written consent. I also acknowledge that a copy of this policy will be provided to me upon request.

Signature: _____ Date:_____

Insurance Information

This information can be obtained by calling the number on the back of your insurance card.

Company:_____ Ins. Phone #: _____

Member/Policy ID #:_____ Group#_____ Plan Name:_____

For insurance purposes, are you listed as a dependent? Y/ N If yes, please provide the following:

Primary Insured Name::_____ Date of birth::_____ Policy #_____

Acupuncture Coverage

Co-Ins/Co-Pay: _____

Deductible: In Net: _____ of _____ // Out of Net: _____ of _____

Visit/Benefit Limits:

Chiropractic Coverage

Co-Ins/Co-Pay: _____

Deductible: In Net: _____ of _____ // Out of Net: _____ of _____

Visit/Benefit Limits:

Date Contacted: _____ Rep Name: _____

Notes:

Medical History

Do you have environmental allergies? Y/N To what: _____ Low/Med/High/Extreme

Do you have food allergies? Y/N To what: _____ Low/Med/High/Extreme

What medication do you take? (Dosage/**Purpose**?)

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

What supplements do you take? (Dosage/**Purpose**?)

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

Do you notice any negative side effects from your prescribed medication or supplements? Y/N

List side effects_____

Please list all surgeries & dates:_____

TCM Medical History

Have you ever received any of the following TCM therapies:

Acupuncture: Y/N ***Herbal Medicine***: Y/N ***Cupping***: Y/N ***TuiNa***: Y/N ***QiGong***: Y/N

If yes, when? (Approx dates):_____ By whom/where?_____

Medical Signs/Symptoms

○ Abdominal pain	○ Dark stools	○ Heart palpitations	○ Muscle cramps/pain	○ Short temper
○ Abuse survivor	○ Decreased libido	○ Hiccough	○ Nasal congestion	○ Shortness of breath
○ Acid reflux	○ Depression	○ High blood-pressure	○ Neck/shoulder pain	○ Sinus pressure
○ Acne	○ Dizziness/vertigo	○ Impotence	○ Night sweats	○ Skin infection
○ Asthma	○ Dry mouth/throat	○ Increased libido	○ Nocturnal emission	○ Smells/body odor
○ Bad breath	○ Diarrhea	○ Indigestion	○ Nosebleeds	○ Spots in eyes
○ Blood in stools	○ Ear aches	○ Intestinal pain	○ Numbness	○ Sweat easily
○ Blood in urine	○ Enlarged thyroid	○ Irritable	○ Odorous stools	○ Sore throat
○ Blurry vision	○ Eye pain/strain	○ Itchy eyes	○ Painful urination	○ Sudden energy drop
○ Breast lump/pain	○ Excess phlegm	○ Itchy skin	○ Peculiar tastes	○ Swollen glands
○ Bruise easily	*Color*:_____	○ Joint pain	○ Poor appetite	○ Teeth/gum problems
○ Chest pains	○ Excessive saliva	○ Kidney stones	○ Poor circulation	○ Upper back pain
○ Chills	○ Fatigue	○ Laxative use	○ Poor memory	○ Urgent urination
○ Cold hands/feet	○ Fever	○ Limtd range of motion	○ Poor sleep	○ Vomiting
○ Concussion	○ Frequent urination	○ Loss of hair	○ Psoriasis	○ Wake to urinate
○ Cancer:_____	○ Gas/bloating	○ Low back pain	○ Rash	○ Weight loss
○ Constipation	○ Grinding teeth	○ Migraines	○ Red eyes	○ Weight gain
○ Cough	○ Headache	○ Mouth sores/ulcers	○ Seizures	○ Wheezing
○ Coughing blood	○ Hemorrhoids	○ Mucus in stool	○ Therapy/counseling	

Women's Health

Date of last menstruation:_____ Is your cycle regular? Y/N Days between periods: _____

Is your period painful? Y/N ☐ PMS ☐ Cramps ☐ Mood swing ☐ Emotional ☐ STDs_____

How long does your period last? _____ days; Clotting? Y/N If yes, approx. size _____mm

Birth control? Y/N Type/Brand: _____ How long? _____

Men's Health

Are you experiencing any of the following?

☐ Testicular pain/swelling ☐ Prostatitis

☐ Difficulty start/stop urination ☐ Discharge/sores ☐ Erectile difficulty

☐ Premature ejaculation ☐ Painful urination ☐ STDs_____

Other:

Pain (If applicable)

Please indicate the areas of pain/tightness/discomfort on the chart.

Pain intensity levels:
None Moderate Severe Terrible

Frequency of Pain?
25% of time 50% 75% Constant

How much work can you perform?
Usual work 25% 50% 75% No work

Does this pain affect your sleep?
No Mildly Greatly Cannot Sleep

Please describe how the pain feels. (Sharp/dull/achy/hollow etc.)

_____

When did you first experience this pain?

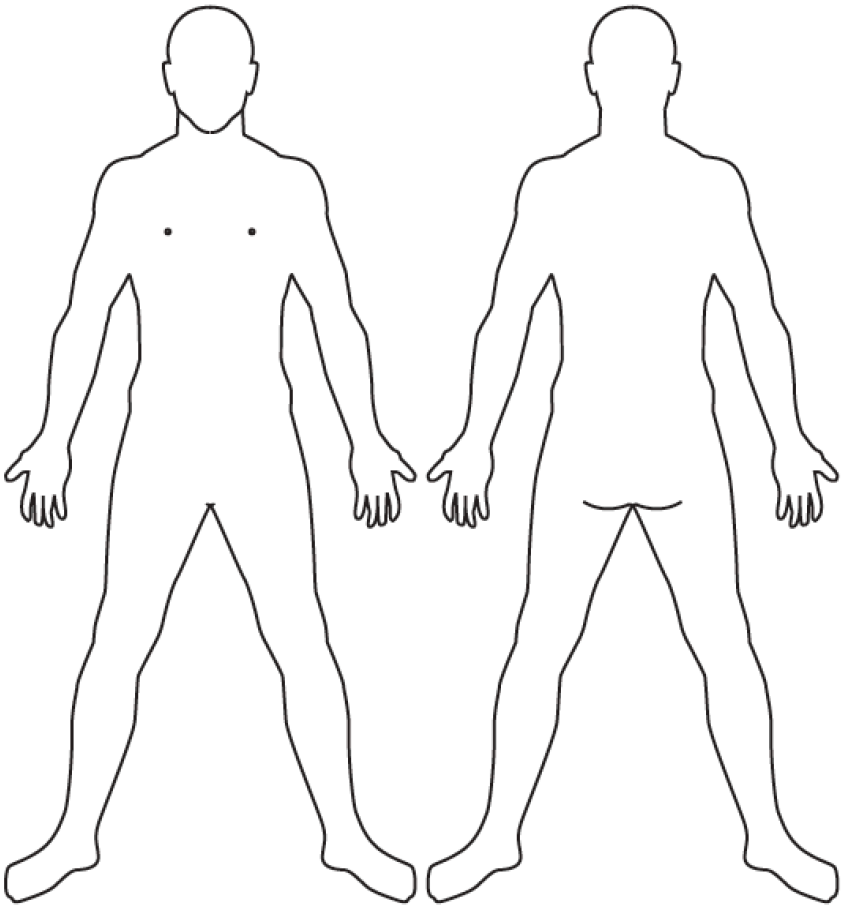
_____

How has the pain changed since that time?

_____

_____

FRONT BACK



Practitioner notes: _____

_____

_____

_____

Sun Wellness – Holistic Healthcare

Informed Consent to Treat

I hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture and traditional Asian medicine. Methods of treatment may include, but are not limited to, acupuncture, massage, moxibustion, cupping, electrical stimulation, gua sha, herbal therapy, and nutritional consultations.

I am hereby informed that the aforementioned treatment methods are all generally safe but, as with any medically related treatment or procedure, there may be some side effects or risks, but not limited to, the following:

- Acupuncture may cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection. Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and gua sha are temporary bruising and redness lasting up to 10 days.

- The herbal and nutritional supplements recommended to me are generally safe in the traditionally recommended doses. Examples of possible side effects of herbal and nutritional supplements include nausea, gas, stomach ache, diarrhea, and headache. Examples of unusual side effects of herbs include vomiting, rashes or hives. I understand I must stop taking any herbal and nutritional supplements and notify my acupuncturist if I experience any discomfort or adverse reaction.

- I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

- I understand that I can discuss risks and benefits further before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise their judgment in my best interest during the course of treatment based upon the facts then known.

- I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

- I understand that my practitioner will keep all of my records confidential.

The Georgia Code 360-6-16 states that an acupuncturist is not allowed to make a medical diagnosis of a person's disease. If you are seeking to obtain a medical diagnosis, then you should seek a licensed physician and obtain medical advice from a licensed physician.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; healthcare operations received, incurred or carried out by my practitioner.

Printed Name of Patient or Responsible Party	Current Date

Signature of Patient or Responsible Party

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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.

PATIENT SIGNATURE X_____ **(Date)**_____
(Or Patient Representative - Indicate relationship)

OFFICE SIGNATURE X_____ **(Date)**_____

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Clinic Appointments

We respect your time and the energy you put into managing your health care. We will always do our absolute best to provide attentive treatment in a timely manner after you arrive at the clinic. Please help us offer this to you and other patients by arriving *on time* for your scheduled appointment.

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Cancellations

If you find you need to cancel please call provide 24 hours notice.

We reserve the right to charge our full fee for appointments cancelled with less than twenty-four hours notice or for "no show" appointments.

If you need to change your appointment please call us directly at (844) 878-6935

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Payment for Services Rendered

Payment is due at the time of service and may be paid in cash, check or credit card.

All returned checks are subject to an additional $35 charge.

To help keep costs low we prefer payment via check, cash or debit card.

____ ________________

Patient signature or Responsible Party (required) **Date**

____

Patient's printed name