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: Bryan Ellett, L.Ac. or Tracy Tucker L.Ac.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

LAKE HIGHLANDS
ACUPUNCTURE AND HERBS

10252 E Northwest Highway
Dallas, TX 75238
214-267-8636
info@lakehighlandsacupuncture.com

Notification Regarding Evaluation of Patient by Physician

According to Texas law (pursuant to the requirements of Section 183.10(a)(11) and Section 205.302, Article 4495b governing the practice of acupuncture) I am required to inform you that in the State of Texas, acupuncture and Oriental medicine is not considered primary health care. As a result, you must respond in the affirmative to *at least one* of the following three statements. Please be advised that per the law, I will not be permitted to treat you unless *at least one* of the 3 statements below is answered in the affirmative.

I, _____, am notifying Lake Highlands Acupuncture and Herbs of *at least one of the following*:

1. I have been evaluated by a physician, dentist, or nurse practitioner for the condition for which I am requesting treatment within the 12 months prior to being treated by Lake Highlands Acupuncture and Herbs.

☐ Yes ☐ No

-OR-

2. I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of this referral is _____. After being referred by a chiropractor if no substantial improvement occurs within 120 days or 30 treatments (whichever comes first), I understand that Lake Highlands Acupuncture and Herbs is required by Texas law to refer me to a physician. It is my responsibility and choice as to whether to follow this advice.

☐ Yes ☐ No

-OR-

3. I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I am seeking treatment for symptoms related to one of more of the following conditions:

☐ Weight loss
☐ Chronic Pain
☐ Smoking Addiction/Cessation
☐ Alcoholism
☐ Substance Abuse

Patient signature (required) _____ Date _____

Patient's printed name _____

Patient Representative's signature (if patient is a minor) _____ Date _____

Patient representative's printed name _____ Relationship to patient _____

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Notice of Privacy Policies/HIPPA Compliance

The information provided below illustrates the manner in which your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and will be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request either digitally or printed.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will *not* be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but *only with your written authorization*.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice. We will only do this with your written authorization. There is a form in your initial paperwork authorizing this. If you change your mind at any time, you may withdraw this authorization, but you must do so in writing.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Restrictions: You may request that we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensuring your privacy.
We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name:	Bryan Ellett
Telephone:	214-267-8636
Address:	10252 E Northwest Highway
City, State, Zip:	Dallas, TX 75238

I have read and understand the HIPAA privacy policies of Lake Highlands Acupuncture and Herbs.

_____ _____ _____

Signature Date Relationship to patient (if applicable)

_____

Printed Name

LAKE HIGHLANDS
ACUPUNCTURE AND HERBS

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex F M	Date
Date of birth	Age	Occupation	
Main phone #		Other phone #	
E-mail address		Allow email contact by LHA	Yes No
Address: Street		City State	Zip
Relationship status	# of children	Family physician	Chiropractor
Do you have health insurance? Yes No	If yes, name of insurance company		
Does your insurance cover acupuncture? Yes No ?	Who is your employer?		
Emergency contact name		phone	
How did you find out about our clinic? *Friends/Relatives(name)* _____ *Yelp* *Location or walk by* *Website* *Referred by* _____ *The Advocate* *Google search* *Coupon* *Facebook* *Other (please specify)*			

Main problem(s): _____.

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____Remarks and additional information:

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

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Payment/Cancellation Policy

Clinic Appointments

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

We understand that life can be unpredictable at times. If you find you need to cancel an appointment it is important that we receive twenty-four (24) hours notice. This enables us to fill the appointment. For cancellations with fewer than 24 hours notice, you will be required to pay the full session fee unless we are able to treat you within three business days.

** If you need to change your appointment please call us directly **

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 cash, check, or debit card.
We also happily accept Visa and Mastercard.

Patient signature (required)	Date
Patient's printed name	
Patient Representative's signature (if patient is a minor)	Date
Patient representative's printed name	Relationship to patient

LAKE HIGHLANDS
ACUPUNCTURE AND HERBS

Occupation : _____ Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits Do you smoke ? Yes No What? _____How many per day? _____Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly Yes No Please describe your exercise program: _____

How many hours do you sleep in general? _____ When time do you usually go to bed? _____

Diet How much coffee do you drink? _____cups/day Colas _____number/day Tea _____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

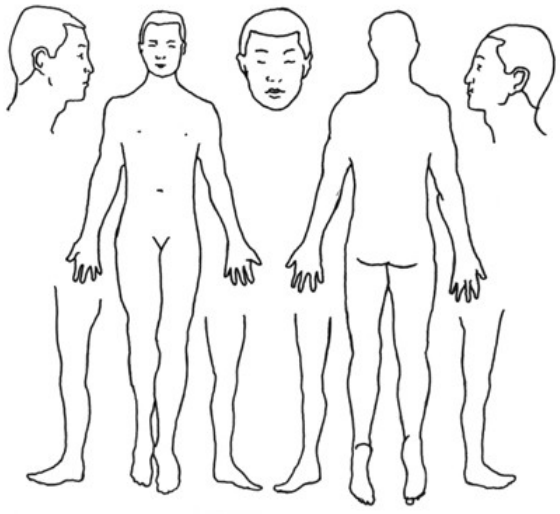
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



LAKE HIGHLANDS
ACUPUNCTURE AND HERBS

Please circle if you have or have had (in the last three months) any of the following diseases or conditions.

General	Poor appetite	Poor sleep	Fatigue	Fevers	Chills
Night sweats	Sweat easily	Tremors	Cravings	Change in appetite	
Poor balance	Bleed or bruise easily	Localized weakness	Weight loss	Weight gain	
Peculiar tastes	Desire hot food	Desire cold food	Strong thirst (cold or hot drinks)		
Sudden energy drop (What time of day) _____ Favorite time of year _____Worst time of year _____					
Skin & hair	Rashes	Ulcerations	Hives	Itching	Eczema
Pimples	Acne	Dandruff	Dry skin	Recent moles	Loss of hair
Purpura	Change in hair or skin texture		Other?		
Musculoskeletal	Joint disorders	Muscle weakness	Pain/soreness in the muscles		Tremors Cold
hands/feet	Difficulty walking	Swelling of hands/feet	Spinal curvature	Back pain	Hernia
Numbness	Tingling	Paralysis	Neck tightness	Neck pain	Shoulder pain
Hand/wrist pain	Hip pain	Knee pain	Joint Sprain	Other?	
Head, eyes, ears, nose, and throat		Dizziness	Concussions	Migraines	Glasses/lens
Eye strain	Eye pain	Color blindness	Night blindness	Poor vision	Cataracts
Blurry vision	Earaches	Ringing in ears	Poor hearing	Spots in front of eyes	
Sinus problems	Nose bleeding	Sore throat	Grinding teeth	Teeth problems	Facial pain
Jaw clicks	Sores on lips/tongue	Difficulty swallowing	Other?		
Cardiovascular	High blood pressure	Low blood pressure	Chest pain	Palpitation	Fainting
Phlebitis	Irregular heartbeat	Rapid heartbeat	Varicose veins	Other?	
Respiratory	Cough	Coughing blood	Wheezing	Difficulty breathing	
Bronchitis	Pneumonia	Chest pain	Production of phlegm – What color? _____		
Gastrointestinal	Nausea	Vomiting	Diarrhea	Constipation	Gas
Belching	Black stools	Blood in stools	Indigestion	Bad breath	Rectal pain
Hemorrhoids	Abdominal pain/cramps	Gallbladder problems	Parasites	Chronic laxative use	
Bowel movements: Frequency _____		Color _____	Odor _____	Texture/ Form _____	
Neuro-psychological		Loss of balance	Lack of coordination	Concussion	
Depression	Anxiety	Stress	Bad temper	Bi-polar	
Genital-urinary	Painful urination	Frequent urination	Blood in urine	Urgency to urinate	
Kidney stones	Unable to hold urine	Dribbling	Pause of flow	Frequent urinary tract infection	
Genital pain	Genital itching	Genital rashes	STD	Other?	

LAKE HIGHLANDS
ACUPUNCTURE AND HERBS

Female Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge

Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods

Breast tenderness Breast Lumps Fertility Problems Hot flashes Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____Miscarriages _____Abortions

_____Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____days

Do you practice birth control ? Yes No. If yes, what type and for how long?

If you're on birth control pills, what are you taking and for how long?

Male Prostate problems Discharge Erectile dysfunction Ejaculation problems

Frequent seminal emission Fertility problems Painful/swollen testicles Other

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I have completed this form correctly to the best of my knowledge.

Signature: Adult Patient Parent or Guardian Spouse

Are there any other health issues you want to discuss with us?

Signature **Date**

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ACUPUNCTURE AND HERBS

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Authorization to Contact

Appointment Reminders and Health Care Information Authorization

Bryan Ellett, L.Ac., or affiliated staff members may use your name, address, phone number, email and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone, a message will be left on your voicemail. Thank you cards, appointment reminders, holiday cards, and other correspondence that may be sent to your mailing or e-mail address.

Please be aware that you have a right to refuse or limit this contact. You may restrict the individuals or organizations to which your health care information is released. You may also revoke this authorization with us at any time as long as your revocation is in writing and is delivered to Lake Highlands Acupuncture and Herbs. You should also know that if you were required to give your authorization to release health care information as a condition of obtaining insurance, the insurance company may have a right to your health information should they decide to contest any of your claims.

☐ YES, I authorize Lake Highlands Acupuncture and Herbs to contact me as described above. (Your personal and contact information is protected at all times and will never be sold or distributed.)

☐ NO, I decline to be contacted by Lake Highlands Acupuncture and Herbs. I acknowledge I am responsible for remembering scheduled appointment and will not receive reminders.

Patient signature _____ Date _____

Patient's printed name _____

Patient Representative's signature (if patient is a minor) _____ Date _____

Patient representative's printed name _____

Representative's relationship to patient/Authorization to act for patient _____