I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of acupuncture on me (or on the patient named below, for whom I am legally responsible) by John Magera, M.Ac. I understand that acupuncturists practicing in the state of Pennsylvania are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic’s practitioner.

I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion (burning an herb on the skin), electrical-stimulation, Tui-Na (Chinese massage), Chinese herbal medication, essential oils and nutritional supplements. I also understand that I may refuse any of these therapies.

I have been informed that acupuncture is accomplished by inserting thin needles a short distance beneath the skin’s surface and while it is generally considered a safe procedure, 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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including collapsed lung. Infection is another possible risk, although this clinic uses only sterile disposable needles and maintains a clean safe environment. Burns and/or scarring are a potential risk of moxibustion. Electrical-stimulation may have adverse effects associated with it such as electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. Tui-Na massage while used to modify or prevent pain perception and normalize physiologic function, may produce bruising, sore muscles, and also carries the risk of aggravating pre-treatment symptoms. The herbs and nutritional supplements recommended, though considered generally safe, could be toxic in large doses. Some possible side effects of taking these substances are stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. Should I experience any problems with these substances, I should suspend taking them and call the clinic as soon as possible. I also understand some herbs are inappropriate during pregnancy and agree to notify the clinic if I am or become pregnant while under therapy. In some individuals, the application of essential oils may produce local skin irritation.

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 their clinical judgment during the course of treatment that they think at the time, based upon the facts then known, is in my best interest.

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 alternative procedures, and have had the 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.

Printed Name: ___________________________________________        Date: _____________
(or Patient’s Representative)                     (Indicate relationship if signing for patient)
Acupuncture & Wellness  
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 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 to whether or not a dispute is subject to arbitration, will also be determined by binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim.

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

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and these party arbitrators shall then select a third arbitrator (neutral arbitrator) 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, not including counsel fees, witness fees, or other expenses incurred by a party for such party’s own benefit.

Either party shall have the 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 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 of the notice thereof 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 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 the patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment) patient should initial here _______ effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. By my signature below, I acknowledge that I have received a copy of this Arbitration Agreement.

Patient Signature: ________________________________  (or Patient’s Representative) ________________________________

(Indicate relationship if signing for patient)

Office Signature: ________________________________
Name: ___________________________________________            Birth Date: _________

I understand as part of my health care, this clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future treatment.

The following describes how this clinic uses and discloses health information about me and how I can get access to this information. According to HIPPA (Health Information Portability and Accountability Act), this includes any information that can identify me.

**I understand that this information may be used to:**
- Plan my care and treatment.
- Communicate with other healthcare professionals or persons whom I have designated.
- Contact me for follow-up care or appointment scheduling.
- Provide verification to a third-party payer for my reimbursement of eligible treatment costs.
- Carry out routine healthcare operations, such as: assessing care quality and reviewing the competence of healthcare professionals.
- Notify government officials, as required by law, in instances related to public health, national security, or suspected abuse.

**I understand I have the right to:**
- Request specified confidential communications between this clinic and myself.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health operations.
- Read, review, and copy health information from my chart; however, I understand that reasonable fees to duplicate and assemble a copy would be applicable.
- Ask to update or modify my records if I believe they are incorrect or incomplete.
- Obtain a list of how and where this clinic used my health information for any reason other than treatment, payment, or health operations.
- Revoke this consent, except to the extent that this clinic has already taken action in reliance thereupon.
- Express complaints to this clinic or the Secretary of health and Human Services in writing if I believe my privacy rights have been compromised.

*Note: All requests must be in writing and any restriction request may be denied by this clinic.*

- Persons, if any, whom we may inform about your health condition and treatment:
  
- Persons, if any, whom we may contact ONLY IN AN EMERGENCY:
  Name: ___________________________ Telephone: __________________________
  
- If other than your home, address where you would like correspondence sent:
  Address: __________________________________________________________________________
  
- Indicate if you want correspondence marked “CONFIDENTIAL” ⊘
  
- If other than your home, telephone number where you would like to receive calls: __________________________
  
- Indicate if we can leave confidential messages on your voice mail: ⊘ Yes ⊘ No

**Patient:**
X __________________________

Patient Signature or Legal Representative  Date  Witness Signature

Official Use Only:
Accepted ⊘ __________________________  Title  Date
⊡ Denied  Signature  Date
Name: ________________________________________ (first) ___________________________ (last) ___________________________
Date of Birth: ______________  Age: ________
Marital Status:  S  M  D  W  Occupation: ___________________________ Email: ______________
Address: ________________________________________________________ Phone: ______________

Successful health care and preventative medicine depend on the complete understanding of your physical, mental and emotional history. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? ___________________________________________
For what reason? _______________________________________________________________________

2. Primary Care Physician’s Name: ________________________________________________________
Address: ________________________________________________________ Phone: ______________

3. Please identify the health concerns that have brought you to this clinic in order of importance:
   Condition
   a. ___________________________________________ Length of Time: _______ Initial Cause: ___________
      How does it affect you? ___________________________ What makes it better? ______________
      Worse? ____________ Past Treatments: _______________________________________________
   b. ___________________________________________ Length of Time: _______ Initial Cause: ___________
      How does it affect you? ___________________________ What makes it better? ______________
      Worse? ____________ Past Treatments: _______________________________________________
   c. ___________________________________________ Length of Time: _______ Initial Cause: ___________
      How does it affect you? ___________________________ What makes it better? ______________
      Worse? ____________ Past Treatments: _______________________________________________
   d. ___________________________________________ Length of Time: _______ Initial Cause: ___________
      How does it affect you? ___________________________ What makes it better? ______________
      Worse? ____________ Past Treatments: _______________________________________________

4. Height: _______ Weight: _______ Past Maximum _________ When? ________

5. Family Medical History:
   Check those applicable
<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Brothers</th>
<th>Sisters</th>
<th>Spouse</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (if living)</td>
<td>Health (G=good, P=poor)</td>
<td>Cancer</td>
<td>Diabetes</td>
<td>Heart Disease</td>
<td>High Blood Pressure</td>
</tr>
</tbody>
</table>
6. Hospitalizations and Surgeries:

<table>
<thead>
<tr>
<th>Reason</th>
<th>When</th>
</tr>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

7. Childhood Illnesses:
- Scarlet Fever
- Rheumatic Fever
- Polio
- Chicken Pox
- Measles
- Birth Trauma (yours)
- Mumps
- Diphtheria
- Others (list)

8. Immunizations:
- Tetanus
- Rubella
- Typhoid Fever
- Others (list)

9. Past Medical History (Diagnosed Disorders):
- Scarf Fever
- Chicken Pox
- Mumps
- Rheumatic Fever
- Measles
- Diphtheria
- Hepatitis B
- Tuberculosis
- Others (list)

10. General Symptoms:
- Poor Appetite
- Heavy Appetite
- Strongly dislikes cold
- Poor sleep
- Drowsiness
- Dream disturbed sleep
- Fever
- Chills
- Night sweats
- Other symptoms (list)

11. Head, Eyes, Ears, Nose, Throat:
- Glasses
- Eye strain
- Red eyes
- Itchy eyes
- Spots in eyes
- Blurred vision
- Night blindness
- Glaucoma
- Cataracts
- Macular Degeneration
- Teeth Problems
- Grinding teeth
- TMJ
- Facial pain
- Bell’s Palsy
- Lip/Tongue sores
- Gum Problems
- Dry mouth
- Excessive saliva
- Sinus Problems
- Excessive phlegm
- Recurring sore throat
- Swollen glands
- Lumps in throat
- Enlarged thyroid
- Nose bleeds
- Other symptoms (list)

12. Respiratory:
- Positional breathing difficulties
- Shortness of breath
- Tight Chest
- Asthma/wheezing
- Chronic cough
- Frequent colds
- Coughing blood
- Collapsed lung
- Others problems (list)

13. Cardiovascular:
- High/Low blood pressure
- Phlebitis
- Blood clots
- Chest Pain
- Fainting
- Mitral Valve Prolapse
- Varicose veins
- Others problems (list)
### Gastrointestinal:

- Nausea
- Vomiting
- Acid reflux
- Gas
- Bloating
- Hiccups
- Bad breath
- Diarrhea
- Constipation
- Black stools
- Bloody stools
- Mucus in stools
- Intestinal pain/cramps
- Rectal pain
- Hemorrhoids
- Anal fissure
- Bowel movements:
  - Frequency

### Musculoskeletal:

- Neck/Shoulder pain
- Muscle pain
- Upper back pain
- Low back pain
- Joint pain
- Rib pain
- Limited range of motion

### Skin and Hair:

- Rashes
- Psoriasis
- Ulcers
- Hives
- Acne
- Dandruff
- Eczema
- Itching
- Recurring sore throat

### Neuropsychological:

- Seizures
- Numbness
- Tics
- Poor memory
- Depression
- Anxiety
- Irritability
- Easily stressed
- Abuse survivor
- Considered/Attempted suicide
- Seeing therapist
- ADD/ADHD

### Genito-Urinary:

- Pain on urination
- Incontinent
- Frequent urination
- Incomplete urination
- Urgent urination
- Blood in urine
- Wake to urinate
- Increased libido
- Decreased libido
- Premature ejaculation
- Nocturnal emission
- Impotence

### Gynecological:

- Age menarche began
- Painful periods
- Length of cycle
- Vaginal discharge
- Duration of flow
- Clots
- Breast lumps
- Menopause age
- # pregnancies
- # births
- # miscarriages
- # abortions
- Date of last PAP
- Date of last period
- Menopause age
- Other problems (list)

### Pharmaceuticals / Vitamins / Herbs or Supplements taken the last 2 months:

- Type:

### Your diet:

- Appetite: High _____ Low _____
- Water per day ________
- Artificial sweeteners
- Coffee/caffeine
- Meals per day ________
- Sugar
- Soft drinks
- Typical foods eaten
- Spicy food

### Your Lifestyle:

- Alcohol
- Tobacco
- Recreational Drugs
- Stress
- Occupational Hazards
- Reading habits: __________
- TV habits: __________
- Sleep habits: __________
- Regular exercise
- Type:
- Frequency:
- Spiritual practice:
- Type:
- Frequency:

Interests/Hobbies: __________

Level of education completed: High School  Bachelors  Masters  Doctorate  Other