In Ergy

Acupuncture & Wellness

Consent to Treatment

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: _____

Patient Signature:

(or Patient's Representative) (Indicate relationship if signing for patient)

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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 thee 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:

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Notice of Privacy Practices & Consent to the Use and Disclosure of Health Information

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 ☐ _____ _____ _____

☐ Denied Signature Title Date

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Patient Health History

Date: _____

Name: _____ Date of Birth: _____ Age: ____
(first) (middle) (last)

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	**Father**	**Mother**	**Brothers**	**Sisters**	**Spouse**	**Children**
Age (if living)						
Health (G=good, P=poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever						
Kidney Disease						
Age (at death)						
Cause of Death						

6. **Hospitalizations and Surgeries**:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. **Childhood Illnesses**:

☐ Scarlet Fever ☐ Chicken Pox ☐ Mumps ☐ Others (list)
☐ Rheumatic Fever ☐ Measles ☐ Diphtheria _____
☐ Polio ☐ Birth Trauma (yours) ☐ Whooping Cough _____

8. **Immunizations**:

☐ Tetanus ☐ Rubella ☐ Typhoid Fever ☐ Others (list)
☐ Influenza ☐ Diphtheria ☐ Hepatitis B _____
☐ Polio ☐ Pertussis ☐ Tuberculosis _____

9. **Past Medical History (Diagnosed Disorders):**

☐ Addiction (identify) ☐ Chronic Bronchitis ☐ Infectious Diseases: ☐ Seizures
_____ ☐ Concussion Aids/HIV _____ ☐ Stroke
☐ Allergies (list) ☐ Diabetes Herpes _____ ☐ Thyroid Disorders
_____ ☐ Emphysema Hepatitis B or C ____ ☐ Major Trauma (list)
_____ ☐ Epilepsy Tuberculosis _____ _____
_____ ☐ Fibromyalgia Venereal Disease ___ _____
☐ Arteriosclerosis ☐ Goiter ☐ Multiple sclerosis ☐ Ulcers
☐ Arthritis ☐ Gout ☐ Pacemaker ☐ Others (list)
☐ Asthma ☐ Heart Disease ☐ Pleurisy _____
☐ Cancer ☐ High Blood Pressure ☐ Pneumonia _____

10. **General Symptoms**:

☐ Poor Appetite ☐ Poor sleep ☐ Poor circulation ☐ Vertigo/Dizziness
☐ Heavy Appetite ☐ Drowsiness ☐ Shortness of breath ☐ Bleed/bruise easily
☐ Strongly dislikes cold ☐ Dream disturbed sleep ☐ Fever ☐ Peculiar taste in mouth. (describe)
☐ Strongly dislikes hot ☐ Fatigue ☐ Chills _____
☐ Recent weight change ☐ Lack of strength ☐ Night sweats ☐ Other symptoms (list)
Increase or Decrease ☐ Bodily heaviness ☐ Sweats easily _____
How much? _____ ☐ Cold hands and feet ☐ Muscle cramps _____

11. **Head, Eyes, Ears, Nose, Throat:**

☐ Glasses ☐ Macular Degeneration ☐ Excessive saliva ☐ Poor hearing
☐ Eye strain ☐ Teeth Problems ☐ Sinus Problems ☐ Earaches
☐ Red eyes ☐ Grinding teeth ☐ Excessive phlegm ☐ Headaches
☐ Itchy eyes ☐ TMJ ☐ Recurring sore throat ☐ Migraines
☐ Spots in eyes ☐ Facial pain ☐ Swollen glands ☐ Other head or neck problems (list)
☐ Blurred vision ☐ Bell's Palsy ☐ Lumps in throat _____
☐ Night blindness ☐ Lip/Tongue sores ☐ Enlarged thyroid _____
☐ Glaucoma ☐ Gum Problems ☐ Nose bleeds _____
☐ Cataracts ☐ Dry mouth ☐ Ringing in ears _____

12. **Respiratory**:

☐ Positional breathing difficulties ☐ Tight Chest ☐ Frequent colds ☐ Others problems (list)
☐ Asthma/wheezing ☐ Coughing blood _____
☐ Shortness of breath ☐ Chronic cough ☐ Collapsed lung _____

13. **Cardiovascular**:

☐ High/Low blood pressure ☐ Chest Pain ☐ Varicose veins ☐ Others problems (list)
☐ Phlebitis ☐ Fainting ☐ Palpitations _____
☐ Blood clots ☐ Mitral Valve Prolapse ☐ Irregular Heartbeat _____

14. **Gastrointestinal**:

☐ Nausea ☐ Diarrhea ☐ Intestinal pain/cramps Bowel movements:
☐ Vomiting ☐ Constipation ☐ Itchy anus Frequency _____
☐ Acid reflux ☐ Laxative use ☐ Burning anus Color _____
☐ Gas ☐ Black stools ☐ Rectal pain Odor _____
☐ Bloating ☐ Bloody stools ☐ Hemorrhoids Form _____
☐ Hiccup ☐ Mucus in stools ☐ Anal fissure ☐ Other problems (list)
☐ Bad breath ☐ Food in stools _____

15. **Musculoskeletal**:

☐ Neck/Shoulder pain ☐ Low back pain ☐ Limited range of motion ☐ Other problems (list)
☐ Muscle pain ☐ Joint pain _____
☐ Upper back pain ☐ Rib pain ☐ Limited use _____

16. **Skin and Hair**:

☐ Rashes ☐ Psoriasis ☐ Hair loss ☐ Other problems (list)
☐ Hives ☐ Acne ☐ Premature graying _____
☐ Ulcers ☐ Dandruff ☐ Fungal infections _____
☐ Eczema ☐ Itching ☐ Recurring sore throat

17. **Neuropsychological**:

☐ Seizures ☐ Depression ☐ Abuse survivor ☐ Seeing therapist
☐ Numbness ☐ Anxiety ☐ Considered/Attempted suicide ☐ Other problems (list)
☐ Tics ☐ Irritability _____
☐ Poor memory ☐ Easily stressed ☐ ADD/ADHD _____

18. **Genito-Urinary**:

☐ Pain on urination ☐ Incontinent ☐ Increased libido ☐ Premature ejaculation
☐ Frequent urination ☐ Incomplete urination ☐ Decreased libido ☐ Nocturnal emission
☐ Urgent urination ☐ Bedwetting ☐ Kidney stone ☐ Other problems (list)
☐ Blood in urine ☐ Wake to urinate ☐ Impotence _____

19. **Gynecological**:

Age menses began _____ ☐ Irregular periods # pregnancies _____ Date of last PAP _____
☐ Painful periods # births _____
Length of cycle _____ ☐ PMS # miscarriages ____ Date of last period _____
☐ Vaginal discharge # abortions _____
Duration of flow _____ ☐ Clots Menopause age _____ ☐ Other problems (list)
☐ Breast lumps ☐ Birth control use _____
Chance of pregnancy? Yes / No Type:_____ _____

20. **Pharmaceuticals / Vitamins / Herbs or Supplements taken the last 2 months:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

21. **Your diet:**

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

22. **Your Lifestyle:**

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

Interests/Hobbies: _____
Level of education completed: High School Bachelors Masters Doctorate Other