

New Patient Information

Welcome to Yellow Dragon Acupuncture, PLLC (YDA). Treatments are available from licensed acupuncturists in YDA' clinic. Please initial next to each paragraph and sign below.

_____ **For All Clinic Appointments – Arbitration Agreement.** By signing this form, you are acknowledging that you have read YDA's Arbitration Agreement and are agreeing to have any issue of medical malpractice decided by neutral arbitration and are giving up your right to a jury or court trial. See Article 1 of YDA's Arbitration Agreement on the reverse side of this form.

_____ **Cancellation Policy** – Treatments are by appointment only, although walk-in visits are often able to be accommodated. If you find that you need to cancel an appointment, YDA must receive at least a 24-hour notice to enable us to fill the appointment. We reserve the right to charge a \$25.00 fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment. Should YDA need to close the clinic due to inclement weather or other severe circumstances, YDA will post the closing or schedule changes on its website at www.yellowdragonacupuncture.com and on its main telephone voice message (830) XXX-XXXX.

_____ **Payment for Clinic Services Rendered** – Payments are due at time of service and may be paid in cash, by check or with all major credit cards, except American Express. YDA is not a Medicare/Medicaid Provider.

_____ **Insurance Information** – YDA files for claims for patients with acupuncture benefits insured with United Health Care and Blue Cross/Blue Shield. Please provide your insurance card and valid ID at time of appointment. Upon request, we will provide you with a printed receipt containing the necessary information enabling you to file your claim with other insurance carriers. Coverage, co-pays, deductibles and percentage covered varies widely by plan, this office makes no representation that your plan covers acupuncture. The patient is personally responsible for payment of deductibles, as well as any balances in this office. Your full portion of the bill is expected once payment is received from your insurance carrier. Any unpaid balance will be considered past due 30 days following insurance reimbursement.

_____ **Assignment of benefits** – For covered patients this document will serve as an assignment of benefits form which directs your insurance company to pay YDA directly. If your insurance carrier sends payment to you for services rendered incurred in this office, you agree to send or bring those payments to this office upon receipt. You are ultimately responsible for payment for all services received in this office regardless of insurance coverage.

_____ **Verifying insurance** – As a courtesy to you, we will verify your insurance for eligibility benefits upon receipt of insurance card & valid ID as well as any time you notify us of a change in your coverage. Insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing the details of your insurance coverage, including but not limited to deductible amounts, co-payments and waiting periods. Any remaining balance that is not covered by your insurance will be your financial responsibility. New insurance information or changes to existing insurance must be provided to this office prior to an appointment. Failure to provide current or correct insurance information may result in the entire bill being your responsibility.

_____ **Requests for additional information** – Requests from the YDA insurance team or from your insurance company for additional information must be immediately. Such requests may include letters of denial, proof of full-time-student status, records from other health providers, etc. Failure to provide this information in a timely manner may result in the entire balance from your treatment being your responsibility.

_____ **Herbal Refills** – Please call no less than 24 hours before you wish to pick up herbal refills at YDA to allow time to process the request. Herbal formulas will not be prepared in advance unless they are guaranteed with a valid credit card payment. Herbal refills are available at YDA from other licensed acupuncturist with prior coordination between YDA and that practitioner.

Patient Signature Required _____ Date _____

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to a 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 such dispute decided in a court of law before or 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, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to claims, including claims arising out of or relating to treatment or services provided by the health care provider including his 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 and the health care provider and / or other licensed health care providers or rise to any claim. This agreement is intended to bind the patient and the health care provider and / or other health care providers or preceptorship 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 healthcare provider, including those working at the healthcare provider's 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 healthcare 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 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 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 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, the right to have a judgment of future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules for the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provisions: 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 notice thereof received, the claim, if asserted in a civil action, would be barred by applicable legal statute of limitations or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures described herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare 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. 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 receive a copy of this Arbitration Agreement.

Article 6: Retroactive Effect: If the patient intends this agreement to cover service 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. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature on the reverse, I acknowledge that I have received a copy.

Notification Form Regarding Evaluation of Patient by Physician

In the State of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Yellow Dragon Acupuncture is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302V.A.C.S article 4495b, governing the practice of acupuncture)

I (patient's name) _____ am notifying Yellow Dragon Acupuncture of the following:

____ Yes ____ No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated with 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician, or dentist for the condition being treated by the acupuncturist.

OR

____ Yes ____ No I have received a referral from my chiropractor with the last 30 days for acupuncture. The date of the referral is _____ and the most recent date of treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 120 days or 30 treatments, which ever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

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 seek treatment for symptoms related to one or more of the following conditions:

____ Chronic Pain

____ Smoking addiction

____ Weight loss

____ Alcoholism

____ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

Patient Signature Required

Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

Patient Signature Required

Date

Acupuncturist Signature

Date

Yellow Dragon Acupuncture, PLLC

HIPPA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to Yellow Dragon Acupuncture's "Notice of Privacy Practices". I understand that I have the right to review Yellow Dragon Acupuncture's "Notice of Privacy Practices" prior to signing this document.

I understand that Yellow Dragon Acupuncture staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be for educational and / or research purposes by Yellow Dragon Acupuncture or individuals authorized by Yellow Dragon Acupuncture. All information that can identify me personally will be removed.

By signing this form, I am giving Yellow Dragon Acupuncture authorization to contact me and am giving informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at Yellow Dragon Acupuncture will be held confidential except in instances where my safety or the safety of others may be at risk.

Patient Name (print)

Date

Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Yellow Dragon Acupuncture the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the Party(s) authorized to receive my information is / are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons / Organizations authorized to receive information: (please print)

Patient's Signature

Date

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or patient named below, for whom I am legally responsible) by the licensed acupuncturist on staff at Yellow Dragon Acupuncture who now or in the future treat me while employed by, working or associated with or substituting for Yellow Dragon Acupuncture, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedure including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas on my body, observation, range of motion, muscle and orthopedic testing, modes of manual or physical therapy such as body work, manipulation of joints and / or viscera, heat and / or cold therapy and electrical and / or magnetic stimulation, cupping and / or moxibustion; the prescription of herbal or homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my acupuncturists, and / or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture or other procedures used in Oriental medicine have helps millions of people, I understand that no guarantee of cure or improvement is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental Medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is a reasonable cause to believe that treatment is not appropriate for a patient who is under that influence of illegal drugs, alcohol or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its contents, and by signing below I agree to the above named procedures and conditions of my treatment. 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 at Yellow Dragon Acupuncture.

Patient's Name (please print)

Patient's Signature

Print Name of Patient's Representative (if applicable)

Relationship or Authority of Patient's Rep.

Signature of Patient's Representative (if applicable)

Date Signed