PATIENT NAME:

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 be 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 further condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: TONI EATROS, AP

PATIENT SIGNATURE **X** **(**Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

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 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, 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 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 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.

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 if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Consent for Health Care Operations (HIPAA)

I consent to the use or disclosure of my protected health information by Acupuncture & Natural Health Solutions for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Acupuncture & Natural Health Solutions.

I understand that diagnosis or treatment of me by Toni Eatros, AP may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Acupuncture & Natural Health Solutions is not required to agree to the restrictions that I may request. However, if Acupuncture & Natural Health Solutions agrees to a restriction that I request, the restriction is binding on Acupuncture & Natural Health Solutions and Toni Eatros, AP.

I have the right to revoke this consent, in writing, at any time, except to the extent that Toni Eatros, AP or Acupuncture & Natural Health Solutions has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Acupuncture & Natural Health Solutions' Notice of Privacy Practices prior to signing this document.

If desired, Acupuncture & Natural Health Solutions' Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Acupuncture & Natural Health Solutions.

The Notice of Privacy Practices for Acupuncture & Natural Health Solutions is also provided at 2355 Vanderbilt Beach Rd, Suite 146, Naples, FL 34109 and on the Acupuncture & Natural Health Solutions web site at www.AcupunctureSolutionsOnline.com.

This Notice of Privacy Practices also describes my rights and the duties of Toni Eatros, AP with respect to my protected health information.

Acupuncture & Natural Health Solutions reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing Acupuncture & Natural Health Solutions' web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_

_____ _____

Name of Patient or Personal Representative Relationship to Patient

Financial Agreement

It is our goal for patients to clearly understand their financial responsibility before their treatment begins. We want to make your financial responsibilities as easy as possible. Therefore, we offer the following financial agreements.

1. Patients with insurance: Estimated portion not covered is due at time of service.
2. Patients without insurance: Payment is due at the time of service.
3. Patients with treatment related to an accident must inform Acupuncture & Natural Health Solutions at the time of the first appointment.
4. Balances due that are not paid within 90 days will be sent to collections.
5. A 1% service charge will be attached to unpaid balances past 30 days.

I HAVE READ AND UNDERSTAND THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Patient Signature:_____ Date: _____

PATIENTS WITH INSURANCE:

- As a courtesy we bill your insurance carrier. However, it must be understood that the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay.
- Our office does not guarantee that your insurance will pay. Some insurance companies do not cover acupuncture or massage. We will assist you, if necessary, in making every attempt to receive verification of your policy. If for any reason your claim is denied, you are responsible for the full amount of your bill.
- Our office will not enter into a dispute with your insurance company over any unpaid claim.
- If your insurance requires a referral from your primary care physician for treatment, you will be responsible for payment of all services until our office has received a hard copy of the referral. If at a later date your insurance reimburses for services that you paid for at the time of the visit, that amount will be refunded to you.
- Failure to provide us with adequate information regarding your insurance may result in a denial from your insurance carrier and you will be responsible for any unpaid balance. Please make sure that we have all the necessary information to process your claim.
- A copy of our fee schedule is available upon request.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE OFFICE POLICIES DESCRIBED ABOVE.

Print Patient's Name:_____

Patient Signature:_____ Date: _____

ASSIGNMENT AND RELEASE: I hereby authorize my benefits to be paid directly to Acupuncture & Natural Health Solutions. I am financially responsible for any balance due. I also authorize the practitioner(s) listed to release any information required for this claim.

Patient Signature: _____

Late Cancellation & No-Show Policy

It is the office policy of Acupuncture & Natural Health Solutions to request appointment changes or cancellations at least **24 hours before your scheduled appointment time.**

If you cancel after that time or fail to attend a scheduled appointment, you will be charged the full appointment fee. Payment of this fee is due before or at the time of your next appointment.

I understand that in order to enter into a patient-practitioner contract Acupuncture & Natural Health Solutions requires that I agree to the terms of the late cancellation and no-show policy.

Patient Signature: _____ Date: _____

Printed Name: _____