Patient Information

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954-530-0125

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Male:** _____ **Female:** _____

Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Occupation: _____ **Employer:** _____

Insurance Company: _____

Emergency Contact:

Name: _____ **Phone #:** _____

How did you hear about us? _____

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I authorize the release of medical information to my insurance company, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care. I also authorize my provider to file a request for reconsideration or grievance on my behalf, and request my insurance company to pay directly to Vibrant Health Center for those medical services. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.

Date: _____ **Patient Signature:** _____

Health History Questionnaire

Patient Name:_____ **Date:** _____

Major Complaint(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

How do these conditions affect your daily activities? _____

_____

Primary Physician: _____

Other physicians/therapists: _____

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.): _____

_____

_____

_____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

Test	Year	Test Results
☐ Physical	_____	_____
☐ Cholesterol	_____	_____
☐ Prostate	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Blood	_____	_____
☐ HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Mononucleosis	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

PATIENT NOTIFICATION OF CREDENTIALS & INFORMED CONSENT FOR EAST ASIAN MEDICINE TREATMENT & WAIVER OF CONSULTATION

Notification of Credentials

Ashley A. Herrin is licensed in the state of Florida to practice Acupuncture and Herbal Medicine. She has a Master's in Acupuncture and Oriental Medicine from Atlantic Institute of Oriental Medicine (2007). She also holds a Diplomate in Chinese Herbology, Acupuncture and Oriental Medicine from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). Florida State Department of Health license: FL2452.

Informed Consent

I, the undersigned patient, hereby request and consent to the performance of "East Asian medicine", a health care service utilizing East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders and includes acupuncture, including the use of acupuncture needles or lancets to directly and indirectly stimulate acupuncture points and meridians; superficial heat and cold therapies; use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; moxibustion, use of lit end of a moxa stick and holding it an inch or two away from the skin, usually around the inserted needles to bring mild warmth to the area without burning, until the skin becomes slightly red; acupressure, applying finger pressure to acupoints on body; cupping, an induced vacuum detoxification technique; dermal friction technique; infra-red; sonopuncture, use of sound vibrations; laserpuncture, using laser light instead of needles; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; Qi gong, internal Qi gong is a self-directed technique that involves the use of sounds, movements, and meditation & external Qi gong is performed using hands on a patient with the aim to project qi for the purpose of healing; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, pain, 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. A patient may also be injured by a broken needle.

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 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant. I represent that I do not suffer from severe bleeding disorders. I do not have an implanted pace maker.

_____
Initial

I do not expect the practitioner to be able to anticipate all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure(s) which the practitioner feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of East Asian medicine treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the East Asian medicine treatments. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that it is in my best interest to receive East Asian medicine treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Written Waiver to Continue East Asian Medical Treatment

I, the undersigned patient, acknowledge I may have a potentially serious disorder. The nature of the disorder is:

(Initial each applicable disorder)

[ ] Cardiac conditions including uncontrolled hypertension
[ ] Acute abdominal symptoms
[ ] Acute undiagnosed neurological changes
[ ] Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period
[ ] Suspected fracture or dislocation
[ ] Suspected systemic disorders
[ ] Any serious undiagnosed hemorrhagic disorder
[ ] Acute respiratory distress without previous history or diagnosis

_____
Client Initial

Because of the above disorder, Vibrant Health Center, Inc. and the undersigned practitioner requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder. I acknowledge that failure to pursue treatment from my primary health care provider may involve risks not limited to as death, additional distress, aggravation of underlying condition, disability, pain, and impairment. I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment. I have previously signed a patient notification, informed consent, and scope of practice form with Vibrant Health Center, Inc.

I understand the services and techniques the East Asian medicine practitioner is authorized to provide may not resolve my underlying potentially serious disorder(s).

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You can access it online at **www.vibranthealthcenter.com**.

Your signature below is acknowledgment that you have been provided a copy of our Notice of Privacy Practices to read.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name and signed on behalf of the patient Relationship
Parent, legal guardian, representative.

_____
Witness/Staff Member

(Notation, if any, by staff)

This form will be retained in your medical record.

24 Hour Appointment Cancellation Policy

Vibrant Health Center has a 24-hour cancellation rescheduling policy. **If you miss your appointment, cancel or change your appointment with less than 24-hour notice, you will be charged the FULL PRICE of your appointment.**

Cancellations with less than 24-hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule that time slot. We strive to give all our patients the best care possible and that means having the ability to give each patient the time commitment required for that care.

By signing below, you acknowledge that you have read and understand the cancellation Policy for Vibrant Health Center as described above.

Date: _____

Printed Name: _____

Patient Signature: _____