



Edgewater Acupuncture's mission is get you healthier and happier with affordable acupuncture. Our sliding scale is \$15-\$35 with a one time paperwork fee of \$10 for new patients. We are excited to be an important part of your healthcare and community.

Patients relax in a circle of recliners in a quiet and calm setting. Our streamlined approach is based on pulse and tongue diagnosis, much like how acupuncture is traditionally practiced in Asia. This allows you to receive acupuncture on a regular basis to get better quicker and stay better longer. If you wish to submit a claim to your insurance provider, we would be happy to provide a receipt.

We have quick and easy online scheduling available through our website. You can also call and leave us a message anytime. Walk-ins are always welcome, however appointments are recommended. Families and friends can conveniently enjoy treatments together at the same time.

Patients relax with the needles in for 20-45 minutes. You will learn when you are “done” after a few treatments. Many patients fall asleep and wake feeling refreshed.

Acupuncture is a compliment to, not a substitute for a doctor's care. We do recommend regular physician visits to rule out serious medical problems. We need you to take responsibility for your own health.

Our community setting requires some flexibility from you. For example, someone may be getting treatment in your favorite recliner. You are welcome to use earplugs or listen to ipods during treatment. Some patients prefer to bring their own pillows or blankets.

Acupuncture is a process. Almost every patient requires a course of treatment in order to get results. Generally, treatment plans are based on how long symptoms have been present and their severity. Our sliding scale makes it possible for you to commit to the treatment plan. Please let us know if you have questions about how long it will take to see results or if you think you need to adjust your treatment plan.

Please let us know if you need your treatment to end at a certain time. Otherwise, when you feel done, open your eyes and give us a meaningful look or we might think you are asleep or continuing to enjoy your treatment.

Part of our success is that our patients learn the “routine” and take on a lot of responsibility for the appointments. Please take all personal belongings with you back to the treatment room. Make yourself comfortable- grab a pillow or blanket if you need one, remove your shoes and socks and roll up pants and shirt sleeves to the knees and elbows. Do not walk around the clinic without shoes on. And of course, **please turn off your cell phone.**

Please do not have side conversations in the treatment space and try to keep your voice low when speaking to your practitioner. If you need to have a substantial conversation with your practitioner please let us know as we may need to schedule that separately, possibly by phone.

We are able to maintain our affordability because of the extraordinary amount of marketing our patients do on our behalf. They have first-hand experience of how acupuncture has helped them feel better! Please help us to continue to provide quality care at an affordable price by letting your friends and family know about **Edgewater Acupuncture.**

Patient Intake Form—Edgewater Acupuncture

Date: _____ Name: _____

Name of Parents/Guardians (if under 18): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Occupation: _____

Telephone: Cell _____ Home _____

Email: _____

Emergency Contact Name / Phone Number: _____

Name / Phone of Primary Care Physician: _____

Current Medications / Dosages: (Include over the counter, supplements, vitamins, herbs)

In order of importance, reasons for seeking treatment:

- 1.
- 2.
- 3.

How did you hear about us? (please be specific) Website: _____

Flyer : _____ Referral: _____ Ad: _____ Other: _____

Have you had acupuncture before? _____ From whom? _____

Acupuncture Treatment: \$15-\$35 (due at time of service) New Patient Paperwork Fee: \$10

Missed appointments: \$15 charge for appointments not cancelled with 24 hours notice.

Signature: _____ Date: _____

Name _____ Date _____

1. Health History: Have you ever been diagnosed with any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Coronary Disorder or Heart Attack | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Lung or Respiratory Disorder | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Liver Disease or Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain or Sciatica | <input type="checkbox"/> Urinary or Bladder Infection | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Chest Pain or Angina Pain | <input type="checkbox"/> Kidney Disorder or Kidney Stones | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Gall Bladder Disorder or Gall Stones | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Pelvic or Genital Pain | <input type="checkbox"/> Spleen or Lymphatic Disorder | <input type="checkbox"/> HIV+ or AIDS |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Gastric or Peptic Ulcer | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Irritable Bowel Syndrome or Colitis | <input type="checkbox"/> Polio or Mono |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Allergies or Hayfever |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Asthma or Bronchitis |
| <input type="checkbox"/> Bone Fracture/Joint Sprain | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Muscle Spasm or Tremor | <input type="checkbox"/> Dysmenorrhea (Painful Menstruation) | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Pre-Menstrual Syndrome | <input type="checkbox"/> Attention Deficit |
| <input type="checkbox"/> Tennis Elbow | <input type="checkbox"/> Prostate or Vaginal Disorder | <input type="checkbox"/> Obsessive-Compulsive |
| <input type="checkbox"/> Frozen Shoulder | <input type="checkbox"/> Skin Disorder, Eczema, Psoriasis | <input type="checkbox"/> Panic Attacks/Phobias |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Major Depression |
| <input type="checkbox"/> Shingles (Herpes Zoster) | <input type="checkbox"/> Deafness or Tinnitus | <input type="checkbox"/> Schizophrenia |

2. Accidents: Have you ever been injured in any of the following types of accidents?

- | | | |
|--|--|---|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Work Related Accident | <input type="checkbox"/> Accident at Home |
| <input type="checkbox"/> Athletic Injury | <input type="checkbox"/> Surgical Complication | <input type="checkbox"/> Other Accident |

3. Current Conditions: In the past year, have you noticeably experienced any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> Large Weight Gain or Weight Loss | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Pain in Arms, Wrist, Hands | <input type="checkbox"/> Overeating or Binge Eating | <input type="checkbox"/> Colds, Flu or Chills |
| <input type="checkbox"/> Cold Hands or Cold Feet | <input type="checkbox"/> Undereating or Poor Appetite | <input type="checkbox"/> Sore Throats |
| <input type="checkbox"/> Swollen Ankles or Feet | <input type="checkbox"/> Craving for Sweets or Chocolate | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Stiff, Aching Joints | <input type="checkbox"/> Craving for Drugs or Alcohol | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck or Shoulder Tension | <input type="checkbox"/> Dissatisfaction with Job | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Grinding Your Teeth | <input type="checkbox"/> Bored or Uninterested in Things | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Loneliness or Lack of Affection | <input type="checkbox"/> Lethargy, Fatigue |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Sex Life Not Satisfying | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Thoughts of Killing Yourself | <input type="checkbox"/> Disturbing Dreams |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Worried About Finances | <input type="checkbox"/> Relationship Problems |

4. Substances or Medications: In the past several months, did you regularly take any of these?

- | | | |
|---|--|--|
| <input type="checkbox"/> Cigarettes or Cigars | <input type="checkbox"/> Aspirin or Tylenol | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Several Cups of Coffee/Day | <input type="checkbox"/> Prescribed Pain Reliever Medication | <input type="checkbox"/> Anti-Anxiety Pills |
| <input type="checkbox"/> Glass of Beer or Wine | <input type="checkbox"/> Recreational Drugs/Marijuana | <input type="checkbox"/> Anti-Depressant Pills |
| <input type="checkbox"/> Liquor or Mixed Drinks | <input type="checkbox"/> Several Cans of Soda/Day | <input type="checkbox"/> Blood Pressure Pills |

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by Meaghan Massella Walker, M.Ac, L.Ac 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 Meaghan Massella Walker, M.Ac, L.Ac, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, herbal medicine and electrical stimulation.

Side effects such as local bruising, broken needles, pain at site of insertion, pneumothorax, spontaneous miscarriage, allergic reactions (with herbs) are rare but possible. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify the practitioner if I am or become pregnant. I will notify the practitioner if I have a bleeding or other serious health disorder.**

I do not expect the practitioner 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 practitioner thinks at the time, based upon the facts then known is my best interest. I understand that results are not guaranteed.

All records will be kept confidential and will not be released without my written consent. I understand that acupuncture is conducted in a group setting at *Edgewater Acupuncture*. I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone, e-mail or by scheduling an appointment to talk privately.

Payment in full is expected at the time of service. I understand that should I need to cancel an appointment, at least 24 hours notice will be given. I understand that I will be charged \$15 for cancellations with less than 24 hours notice.

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 future condition(s) for which I seek treatment.

Patient signature and date

Patient printed name

Parent / Guardian signature and date

Parent / Guardian printed name

Edgewater Acupuncture LLC, Meaghan Massella Walker, M.Ac, L.Ac.

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 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

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 named 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, Tiu-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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 future condition(s) for which I seek treatment.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE