Jade Tree Wellness Center, Inc.
3039 49th St. N St. Petersburg, FL 33710

Please fill in the following information as completely as possible. This is a confidential record and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so, unless otherwise required by law.

NAME _____ DATE _____

ADDRESS _____ APT.# _____

CITY/STATE _____ ZIP _____

E-MAIL _____ Check if you do NOT want to receive e-mail from us ❒

SS# _____ BIRTHDAY _____

HOME PHONE _____ OTHER PHONE _____

MARITAL STATUS _____ PLACE OF EMPLOYMENT _____

WORK PHONE _____

Emergency Contact _____

Relationship _____ Phone _____

How did you hear about us? ❒ Yellow Pages - Acupuncture ❒ Yellow Pages - Massage ❒ Magazine Ad – Other
❒ Magazine Ad - Natural Awakenings ❒ Internet ❒ Direct Mail

❒ Personal Referral - Who? _____.

❒ Lecture - Where? _____.

❒ Brochure - Where? _____.

❒ Other - Where? _____.

Have you had an Auto Accident within the last two years? ___ Date: _____

PRIMARY INSURANCE COMPANY _____

ADDRESS _____

PHONE# _____ Name of Policy Holder _____

Policy# _____ Claim# _____

SECONDARY INSURANCE COMPANY _____

ADDRESS _____

PHONE# _____ POLICY# _____

Jade Tree Wellness Center, Inc.
3039 49th St N St. Petersburg FL 33710

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the physician.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DISCOVER, MASTERCARD, and VISA

Regarding Insurance

We will verify coverage prior to treatment. If for any reason we are not able to verify coverage prior to your treatment, you will be charged the usual customary rate for each treatment until verification is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under your medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X _____ Date _____

Signature of Patient or Responsible Party

Jade Tree Wellness Center, Inc.
Informed Consent

I, _____ (print name), hereby request and consent to the performance of acupuncture treatments and other procedures that are within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Jade Tree Wellness Center, Inc. and its licensed acupuncturists who now or in the future are employed by, working for, associated with or are serving as back-up for Jade Tree Wellness Center, Inc.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupoint injection therapy, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), other indicated massage modalities, Oriental herbal medicine, nutritional counseling, and hypnosis. I understand that I have the right to refuse any or all treatments recommended to me by Jade Tree Wellness Center, Inc. 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. 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 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 Oriental 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 pregnant, become pregnant, or am trying to 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 acknowledge that my condition and the potential benefits of acupuncture treatment have been discussed with me. I have had the likelihood of success explained to me, and I understand that results are not guaranteed, and that my participation in my own treatment may significantly influence the outcome of treatment.

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, unless otherwise required by law.

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 also acknowledge that other treatment options have been presented to me. 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 **DATE**
(Or Patient Representative - indicate relationship if signing for patient)

_____

PHYSICIAN/THERAPIST SIGNATURE **DATE**

Jade Tree Wellness Center, Inc.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

I agree that Jade Tree Wellness Center may ❑contact me and ❑leave a message at the following

phone numbers: _____ _____

This Consent was signed by: _____

Printed Name – Patient or Representative: _____.

Relationship to Patient (if other than patient):_____

Date:_____

Witness:_____

Printed name – Practice representative: _____.

Date:_____

Jade Tree Wellness Center, Inc.

Name _____ Date_____

Primary Complaint (including any Western Medical diagnosis): _____

_____

_____

When did it begin? _____ How did it begin? _____

_____

Are you under a physician's care now? ❒ Yes ❒ No If yes, for what? _____

Who is your physician? _____

What other treatments are you currently receiving? _____

Medications, herbs, over-the-counter medicines or supplements: _____

_____

Surgeries (include dates): _____

MEDICAL HISTORY	❒ Diabetes	❒ High blood pressure
❒ AIDS/HIV	❒ Epilepsy or Seizures	❒ Low blood pressure
❒ Allergies	❒ Gall Bladder Trouble	❒ Sexually Transmitted Diseases
❒ Arthritis	❒ Heart Disease	❒ Skin lesions
❒ Asthma	❒ Other Heart Condition	❒ Stroke
❒ Cancer or Precancerous conditions	❒ Hepatitis	

❒ Congenital Issues Explain _____
Do you use tobacco? ❒ Yes ❒ No How much?_____
Do you use alcohol? ❒ Yes ❒ No How many drinks per week?_____

Unusual Illnesses or very high fevers? ❒ Yes ❒ No Please explain _____

FAMILY HISTORY:
❒ Heart conditions - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ High Blood Pressure - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Stroke - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Diabetes - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Cancer - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Arthritis - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Epilepsy or seizures - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Stomach Ulcers - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child
❒ Other - ❒ Dad; ❒ Mom; ❒ Siblings; ❒ Grandmother; ❒ Grandfather; ❒ Aunt/Unc; ❒ Child

******* PLEASE COMPLETE BOTH SIDES OF THIS FORM!!! *******

*****PLEASE COMPLETE THIS SIDE!*****

❒ Chest Oppression ❒ Shortness of breath ❒ Sweat easily ❒ Cough ❒ Palpitations ❒ Anxiety	❒ Low back pain ❒ Knee pain ❒ Heel pain ❒ Ringing in the ears ❒ Hearing loss ❒ Decrease in sex drive ❒ Increase in sex drive ❒ Impotence ❒ Infertility	❒ Incontinence ❒ Difficult or painful urination How many times a day do you urinate?_____ How many times do you get up at night to urinate?_____	THIS COLUMN FOR OFFICE USE ONLY Color Odor Nature of pain
❒ Depression ❒ Irritability ❒ Rib side pain ❒ Pains that seem to move around ❒ Feeling of a lump stuck in your throat ❒ Burning, scratchy or itchy eyes ❒ Poor or decreased night vision ❒ Trouble with fingernails or toenails ❒ Trembling ❒ Muscle spasms	❒ Increase in appetite ❒ Decrease in appetite ❒ Diarrhea ❒ Constipation How frequently do you have a bowel movement _____X per ❒day ❒week ❒ Any blood in the stool ❒ Fatigue ❒ Abdominal distention or pain ❒ Do you bleed or bruise easily ❒ Hemorrhoids ❒ History of prolapse of any kind	❒ Acid regurgitation ❒ Bleeding gums ❒ Nausea or vomiting ❒ Stomach pain ❒ Unusual taste in the mouth ❒ Bad breath	OFFICE USE ONLY Undigested food Foul odor Consistency Hard Dry Incomplete Red, Black tarry Tired when Dist. Loc. Better with Worse with
❒ Dizziness ❒ Headache ❒ Blurry vision or vision changes ❒ Insomnia How many hours of sleep per night?_____ ❒ Aching joints ❒ Muscle pains ❒ Dry skin ❒ Rashes or itching In a room where everyone is comfortable, do you tend to feel: too warm ❒; too cold ❒; just right ❒? ❒ Hot flashes ❒ Night sweats ❒ Low grade Fever ❒ Increased thirst ❒ Decreased thirst ❒ Cold hands and/or feet ❒ Loss of memory	❒ Chills ❒ Body aches ❒ Aversion to cold ❒ Aversion to wind ❒ Sneezing ❒ Runny nose ❒ Nasal Congestion ❒ Fever ❒ Sore throat or hoarseness ❒ Extreme Sweating ❒ Heavy feeling in body, limbs Job Duties:_____ _____ _____ Hobbies:_____ _____	**WOMEN ONLY** ❒ Are you pregnant? ❒ Trying to get Pregnant? How many times have you been pregnant? _____ How many live births?_____ Date of last period _____ ❒ Are/were your periods painful How many days from the first day of one period to the first day of the Next _____ How many days do they last?_____ Is the flow heavy ❒, light ❒, or normal ❒ ❒ Clots ❒ Breast distention ❒ Lumps in the breast ❒ Treated for any female disorders ❒ Unusual vaginal discharge ❒ Infertility	OFFICE USE ONLY Severity of pain Quality of pain Modifiers of pain

Do you have any other concerns that you would like to bring to the attention of the physician? _____

_____

_____

Signature: _____ Date: _____