invisible GRACE
ACUPUNCTURE CLINIC

NEW PATIENT INTAKE FORM – For MEN

Personal Information: Date Completed: __ __/ __ __/ __ __ __ __

Name: _____ Social Security #: __ __ __ - __ __ - __ __ __ __

Home Address: _____

City _____ State_____ Zip_____

Home Phone: ( ) _____ Cell Phone: ( )_____

May we leave messages on your (home) phone? __Yes __No

E-Mail Address: _____

Marital Status: __Single __Married __Divorced __Partnership __Widowed Gender: __Male __Female

Date of Birth: _____ Age *(years completed):* ____

Partner's (*Parent if minor*) Name: _____

# of children: ____

Employer: _____ [___ Retired]

Occupation: _____

Work Phone: (_____) _____

Emergency Contact Information:

Name:_____

Relationship to you: _____

Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Referral Information:

Who referred you to the Invisible Grace Acupuncture Clinic?

_____

Please Note:

* Payment is expected at the time of service.
* You are responsible for billing your primary insurance company.

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POLICIES AND REQUESTS

- We require payment in full for all services rendered and herbal medicine items purchased at the time of visit.
- If you are unable to keep your appointment, **PLEASE GIVE US AT LEAST 48 HOURS NOTICE**.
  If you fail to keep your appointment or cancel without 48 hours prior notice, you will be billed for **½** of the appointment fee.

  Initial here to acknowledge that you have read and understand the Invisible Grace Acupuncture Clinic cancellation and payment policies. ☐
- Many of our patients are extremely sensitive to perfumes and scents. Please refrain from wearing them during your office visits.

Thank you.

Statement of Financial Responsibility and Consent for Treatment

I, the undersigned, certify that I am financially responsible for all charges for services and medicinary products provided to me (or my dependent) by Invisible Grace Acupuncture Clinic.

- In addition, I acknowledge that payment is due at the time of each visit.
- In the event that my account becomes more than ninety days past due, I agree to pay interest at the rate of 1.5% per month, or a minimum of $10.00 per month until such time my account is paid in full.
- I also agree to pay for any reasonable attorney fees and expenses incurred in collecting all sums not paid when due.

I acknowledge that the Invisible Grace Acupuncture Clinic will **NOT** bill my insurance company directly and that I am entitled to submit insurance claims independently. Should my insurance company need my health care information to process my claim, I hereby authorize the Invisible Grace Acupuncture Clinic to release any and all information necessary to secure the payment of benefits to me.

My signature is an acknowledgement that:

1) I have read the policies listed above and agree to abide by the same; and

2) that I voluntarily consent to receive treatment from the practitioners of the Invisible Grace Acupuncture Clinic.

Signature of Patient or Responsible Party Date

Relationship to Patient (if applicable) Date

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ACUPUNCTURE CLINIC

I, _____, consent to the use or disclosure of my protected health information by Gwen LoVetere, L.Ac., M.Ac.O.M. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care operations of Gwen LoVetere, L.Ac., M.Ac.O.M. I understand that diagnosis or treatment of me by Gwen LoVetere, L.Ac., M.Ac.O.M may be conditioned upon my consent as evidenced by my signature on this document.

I understand that 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 the health care operations of the practice. Gwen LoVetere, L.Ac., M.Ac.O.M.is not required to agree to the restrictions that I may request, however, if Gwen LoVetere, L.Ac., M.Ac.O.M. agrees to a restriction that I request, that restriction is binding.

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 clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Invisible Grace Acupuncture Clinic's notice of Privacy Practices prior to signing this document and a copy of the Privacy Practices document has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Gwen LoVetere, L.Ac., M.Ac.O.M. with respect to my protected health information.

Gwen LoVetere, L.Ac., M.Ac.O.M. 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 contacting the HIPPA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Gwen LoVetere, L.Ac., M.Ac.O.M. reserves the right to leave a message on the patient's home answering machine/recorder. As the patient, I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly. `

_____ _____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____
Description of Personal Representative Authority Date

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 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. 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME: Gwen LoVetere, L.Ac., M.Ac. O.M.

PATIENT SIGNATURE: _____ (Date) _____
(or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT
AAC-FED A2004

Invisible Grace Acupuncture Clinic 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.
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, as to whether this agreement is unconscionable, and any procedural disputes, 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.
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.

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

(Date) OFFICE SIGNATURE X _____

ALSO SIGN THE INFORMED CONSENT
AAC-FED A2004

Invisible Grace Acupuncture Clinic Patient Name: _____

PERSONAL HEALTH HISTORY

Main Purpose of this Appointment:

_____

_____

_____

_____

To what extent does this problem interfere with your daily activities? [work, sleep, exercise, sex, etc.]

_____

Major Current Health Concerns:

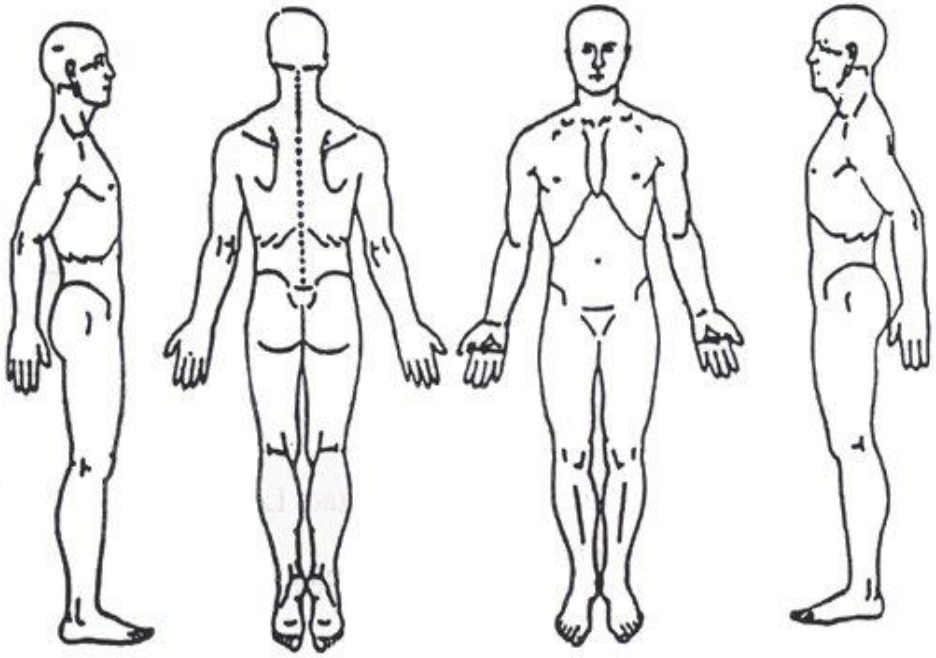
_____

_____

_____

_____

PLEASE INDICATE YOUR AREAS OF PAIN OR DISCOMFORT



Briefly describe if not already covered above:

_____

_____

_____

Allergies: Do you have any allergies or major intolerances to the following? **(Please check all that apply)**

☐ Sulfa ☐ Penicillin ☐ Tetracycline ☐ Morphine ☐ Codeine ☐ Aspirin ☐ NSAIDS
☐ Sulfites ☐ Latex ☐ Lidocaine ☐ Contrast Dye

☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Pollen ☐ Bees
☐ Wheat ☐ Shellfish ☐ Fish ☐ Peanuts ☐ Eggs ☐ Milk ☐ Soy

☐ Other (please specify: _____)

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Medication / Supplement	Strength	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following?
(Please check all that apply -AND- circle those for which you have been treated within the last 12 months.)

☐ Heart Disease ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol
☐ Asthma ☐ COPD ☐ Stroke ☐ Cancer
☐ Depression/Anxiety ☐ Liver Disease ☐ Diabetes ☐ Thyroid Disorder
☐ Adrenal Disorder ☐ Kidney Disease ☐ Digestive Problems ☐ Other: _____

Surgeries / Hospitalizations: Have you had any of the following surgeries? **(Please check all that apply)**

☐ Appendectomy	☐ Brain Surgery	☐ Breast Surgery	☐ CABG
☐ Cholecystectomy	☐ Colon Surgery	☐ Cosmetic	☐ Eye Surgery
☐ Fracture Surgery	☐ Heart surgery	☐ Hernia Repair	☐ Joint Replacement
☐ Prostate Surgery	☐ Small Intestine Surgery	☐ Spine Surgery	☐ Tonsillectomy
☐ Vasectomy	☐ Other (please specify):		

Invisible Grace Acupuncture Clinic Patient Name: _____

Family History: Do you have a family history of any of the following? **(Please "X" the boxes that apply to you)**

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Additional Siblings (gender): M F	M F	M F
Alcohol / Drug Addiction											
Arthritis											
Asthma											
Cancer											
Heart Disease											
Depression											
Diabetes											
High Cholesterol											
High Blood Pressure											
Kidney Disease											
Mental Illness											
Stroke											
Vision Problems											

Social History: Please answer the following questions regarding your social history

Do you drink alcohol? ❑ Yes. ❑ No
If "YES", how many of the following per week: __ glasses of wine __ shots of liquor __ cans of beer

Do you consume caffeine in any form? ❑ Yes. ❑ No
If "YES", how many 8oz. (1 cup), or equivalents, do you consume per week of:
__ coffee __ tea __ soda __ energy drinks

Are you sexually active? ❑ Yes ❑ No ❑ Not currently
Partners? ❑ Male ❑ Female ❑ Both

What is your current birth control method? (Please check all that apply):

❑ Abstinence ❑ Cervical Cap ❑ Condom ❑ Diaphragm ❑ Hormone Patch ❑ Implant
❑ Injection ❑ Inserts ❑ IUD ❑ IUS ❑ Pill ❑ Rhythm
❑ Spermicide ❑ Sponge ❑ Surgical ❑ Vaginal Ring ❑ Withdrawal ❑ None

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

❑ Cocaine ❑ Ecstasy ❑ Crack ❑ Heroin ❑ Other IV drug
❑ Marijuana ❑ Meth ❑ LSD ❑ E-Cigs ❑ Other (specify) _____

Do you use any of the following tobacco products? (Please select all that apply):

❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Snuff ❑ Chew ❑ Other: _____
___Packs per day (current)
Years of smoking: ____ Current users: Ready to Quit? ❑ No ❑ Yes, Quit Date:_ _ __/__/__ __
Former Smoker (quit date M/Yr.): __ /__ __

Review of Systems: Please circle below: Y= Yes, present condition or N=No, never had the condition.

- **Constitutional**

Fever	Y N	Chills	Y N	Unplanned Weight Loss	Y N
Malaise/Fatigue	Y N	Sweating	Y N	Weakness	Y N

- **Skin**

Rash	Y N	Itching	Y N	Color changes	Y N

- **Head, Ears, Eves, Nose, Throat**

Headaches	Y	N	Hearing Loss	Y	N	Ringing in Ears	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Nosebleeds	Y	N
Congestion	Y	N	Noisy Breathing	Y	N	Sore Throat	Y	N
Migraine headaches	Y	N	Jaw/TMJ problems	Y	N		Y	N

Eyes

Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness	Y	N

- **Cardiovascular**

Chest Pain	Y	N	Palpitations	Y	N	Shortness of breath lying down	Y	N
Muscle cramping (legs)	Y	N	Leg Swelling	Y	N	Sleep Apnea	Y	N
Abdominal Pain	Y	N	Blood clots	Y	N	Heart disease	Y	N
Low blood pressure	Y	N	High blood pressure	Y	N			

- **Respiratory**

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N	Asthma	Y	N

- **Gastrointestinal**

Heartburn	Y	N	Nausea	Y	N	Vomiting	Y	N
Abdominal Pain	Y	N	Diarrhea	Y	N	Constipation	Y	N
Blood in Stool	Y	N	Black/Tarry Stools	Y	N			

How many bowel movements per day? _____

- **Genitourinary**

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Low Back Pain	Y	N	Incontinence	Y	N
Frequent infections	Y	N						

- **Musculoskeletal**

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle Spasms	Y	N

- **Endocrine /Blood /Allergies**

Excessive thirst	Y	N	Environmental Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat Intolerance	Y	N
Diabetes	Y	N	Thyroid problems					

- **Neurological**

Dizziness	Y	N	Tingling	Y	N	Tremor	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Facial Weakness	Y	N
Seizures	Y	N	Fainting	Y	N	Numbness	Y	N
Paralysis	Y	N	Loss of memory	Y	N			

- **Emotional (Psychological)**

Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N
Memory loss	Y	N	Mood swings	Y	N	Tension / Stress	Y	N
Relationship issues	Y	N	Chronic fatigue	Y	N			

- **Male Reproductive**

Hernia	Y	N	Testicular masses	Y	N	Sexual difficulty (specify): _____	Y	N
Inflamed or enlarged prostate	Y	N	Erectile dysfunction	Y	N	_____ _____ _____		