SOUTHWEST ACUPUNCTURE COLLEGE
Patient Medical History
Confidential

Supervisor Initials ____

General Information

Patient Name _____ Date __/__/__
Address_____ City _____ State _____ Zip _____
Email (Optional) _____ Primary Ph. _____ Work Ph._____
Gender _____ Age_____ D.O.B. __/__/__ Marital Status_____ Weight_____
Occupation_____
Primary Physician_____ Date of last visit __/__/__Reason_____
Have you received acupuncture/Chinese herbs in the past? ❑ Yes ❑ No
Name of Acupuncturist _____Date of last visit __/__/__ Reason_____

Emergency Contact

Name_____ Relationship_____ Phone _____
Address _____ City _____ State _____ Zip _____

Privacy Concerns

Do you wish to specify any restrictions in how we may contact you? ❑ No restrictions
❑ I wish the following contact restrictions to be followed (E.g., Do not call work number, no voicemail messages, etc): _____

Major Complaint

What is your primary reason for this visit? _____
_____
This condition is due to: ❑ automobile ❑ work injury ❑ sports/exercise injury ❑ not sure
❑ illness ❑ other _____
What was the date of the injury/illness? _____ When did your symptoms begin? _____
Did your symptoms develop: ❑ gradually or ❑ suddenly How long do symptoms last? _____
Is there a pattern to when your symptoms occur? ❑ No ❑ Yes If yes, what is the pattern:
❑ In the morning ❑Occasionally ❑During sleep
❑ In the evening ❑ Intermittently ❑ Upon awakening
❑ All day ❑ Constantly ❑ Other_____
What initiates your symptoms?_____
What makes them worse? _____ What makes them better? _____
Have your received treatment for this complaint? ❑ Yes ❑ No
If yes, what was done? _____
Did it help? ❑ Not at all ❑ Somewhat ❑ Very effective ❑ Not sure
Have any other family members had the same or similar complaint? ❑ Yes ❑ No
If Yes, what was their treatment? _____
Did it help? ❑ Not at all ❑ Somewhat ❑ Very effective ❑ Not sure
Do you have specific questions you would like to discuss today? _____
_____

Family History

Father ❑ Living – Age ____ ❑ Deceased – age at death ____ Cause _____
Mother ❑ Living – Age ____ ❑ Deceased – age at death ____ Cause _____
Other Parent ❑ Living – Age ____ ❑ Deceased – age at death ____ Cause _____
Spouse ❑ Living – Age ____ ❑ Deceased – age at death ____ Cause _____
Siblings Number _____ Health Status _____
Children Number _____ Health Status _____
Check illness(es) which have occurred in any of your blood relatives:
❑ Alcoholism ❑ Bleeding Disorder ❑ Diabetes ❑ Heart disease ❑ Kidney disease ❑ Obesity

❑ Epilepsy ❑ High blood pressure ❑ Stroke ❑ Mental Illness ❑ Allergy ❑ Cancer
❑ Other: _____

Personal History

How would you describe your health as a child? _____

Check any illnesses or conditions you have or had in the past:

❑ AIDs/HIV	❑ Alcoholism	❑Allergies	❑Antibiotic use	❑Asthma	❑Bleeding Issues
❑ Cancer	❑Chicken pox	❑Diabetes	❑Epilepsy	❑Glaucoma	❑Heart disease
❑ Hepatitis	❑High BP	❑High fevers	❑Jaundice	❑Kidney Disease	❑Measles
❑ Meningitis	❑Mental Disorder	❑MS	❑Mumps	❑Pacemaker	❑ Polio
❑Pneumonia	❑Rheumatic fever	❑Scarlet fever	❑Stroke	❑Thyroid DO	❑ Tuberculosis
❑Typhoid	❑Ulcers	❑Vascular Disease		❑Venereal Disease	

❑Other: _____

List illnesses not requiring surgery for which you have been hospitalized: _____

List illness requiring surgery (include dates): _____

List any other serious injury, broken bones, scars, etc.: _____

*__List all__ **allergies or sensitivities to any medicines or other substances**: (food, animals, etc.)_____

Check the diseases against which you have been immunized:

❑ Diptheria/Pertussis/Tetanus	❑ Tetanus only	❑ Measles/Mumps/Rubella	❑ Influenza
❑Varicella (chicken pox)	❑ Typhoid	❑ Hepatitis B	❑ Other: _____

List date and results of most recent lab tests:

DATE	TEST	RESULT	DATE	TEST	RESULT
	Physical			Stool	
	Cholesterol			HIV test	
	Hepatitis			PSA (prostate)	
	Mammography			Pap Smear	
	Other:			Other:	

Comments (anything else you would like to tell us): _____

I authorize treatment by the students and faculty at Southwest Acupuncture College. All information on this form is correct. I understand that I am responsible for payment of all fees to Southwest Acupuncture College on the day of services rendered unless other arrangements are made in advance.

Patient's Printed Name: _____

Patient's Signature: _____ **Date:** _____

Consent to treat a minor child: I hereby authorize Southwest Acupuncture College to administer treatment to my child (Name)_____

Parent/Legal Guardian Signature: _____**Date:** _____

Supervisor Initials _____

Southwest Acupuncture College

Boulder Campus
6630 Gunpark Dr. #200
Boulder CO 80301

Santa Fe Campus
1622 Galisteo St.
Santa Fe NM 87505

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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.

Patient Name: (Print)_____ **Date:** _____

Patient Signature: _____ **Date:** _____
(Or Patient Representative - Indicate relationship)

Clinic Manager Signature: _____ **Date:** _____

Supervisor Initials_____

PLEASE SIGN BOTH SIDES OF THIS FORM

Southwest Acupuncture College

Boulder Campus
6630 Gunpark Dr. #200
Boulder CO 80301

Santa Fe Campus
1622 Galisteo St.
Santa Fe NM 87505

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, magnets, bleeding, plum blossom, guasha 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. Bruising is a common side effect of cupping and guasha. 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.

Patient Name: (Print)_____ **Date:** _____

Patient Signature: _____ **Date:** _____
(Or Patient Representative - Indicate relationship)

Supervisor Signature: _____ **Date:** _____

PLEASE SIGN BOTH SIDES OF THIS FORM

INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the practitioner of Oriental medicine named below and/or other practitioners of Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the practitioner 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 the college is a teaching clinic and that several students and supervisors may discuss my case in order to teach students as well as to provide me with the best medical care possible within the auspices of the school.

I understand likewise that there may be limitations to the care provided by students and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside the facilities of the college.

I understand that there are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement.

I have had an opportunity to discuss with the practitioner named below the nature and purpose of Oriental medicine. I understand that results are not guaranteed.

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

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the practitioner is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Estimated Number Of Times The Patient May Need To Return For Treatment:

❒ 5-10 ❒ 10-20 ❒ 20-50 ❒ More Than 50 ❒ Other_____

Estimated Frequency of Treatment:

❒ Once Each Week ❒ Twice Each Month ❒ Once Each Month ❒ Other_____

Possible outcome of treatment:

❒ Relief from Discomfort ❒ Stabilization of Condition ❒ Reversal of Condition

❒ Other_____

The practitioner has discussed the above information with me; he/she has described all proposed procedures to me, and I understand this information.

Patient's Signature X_____ Date:_____

If signed by representative, state relationship to patient._____

❒ I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment. PRACTITIONER'S SIGNATURE:_____ Date:_____

Consulting SUPERVISOR: _____

SOUTHWEST ACUPUNCTURE COLLEGE

NOTICE OF PRIVACY PRACTICE AND ACKNOWLEDGEMENT

Dear patients,
This notice serves to inform you that your Southwest Acupuncture Clinic medical file may at times be used as a case study in one or more of the classes taught at Southwest Acupuncture College.

Confidentiality is strictly enforced. At no time will your file be taken from or information contained in your file disclosed for any reason outside the walls of this institution.

I have read and acknowledged the receipt of notice of privacy practice of Southwest Acupuncture College and agree to its contents.

Patient's name: (printed)_____ Date:_____

Patient's signature:_____ Date:_____

Southwest Acupuncture College
HIPAA Consent Form

I give Southwest Acupuncture College Clinic my consent to use or disclose my, or my child's if patient is a minor, protected health information to carry out the treatment, to obtain payment, and for health care operations such as quality reviews.

I understand that interns must convey all information concerning my, or my child's if patient is a minor, care to their supervisors and cannot keep any information confidential.

I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand this clinic has the right to change their privacy practices and that I may obtain my revised notices at the clinic.

I understand I have the right to request a restriction of how my protected heath information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Complaints concerning my, or my child's if patient is a minor, protected health information should be filed in writing with the Clinic Director.

Patient Name (Print)_____

Signature_____Date_____

If signed by patient representative, state relationship to patient:_____

Supervisor Initials _____

Southwest Acupuncture College
Student Clinic Policy

Southwest Acupuncture College is a private accredited masters-level institution dedicated to the instruction of Acupuncture & Oriental medicine. A concomitant goal of the college, to cultivate leadership and service to the community in this emerging field of effective medical care, is fostered in the curriculum as well as the life of the college community through the educational format and low cost public clinic. Student interns who are supervised by licensed practitioners administer many of the treatments at our clinic. There may be an observer present in these treatments. We also offer professional clinics where a licensed practitioner treats the patient and is observed by several students. Here are some things you should know about how our student clinic is run:

- Our clinic hours are generally Monday-Thursday 9am-9pm and Friday 9am-5pm. Please note that we are closed on weekends, major holidays, for special meetings, and most school breaks. See our semester clinic poster for days and hours, types of clinics offered, and supervisors. Our snow closure policy is available from the front desk.
- Our treatment times are up to 1.5 hours. Due to intern responsibilities, we cannot extend the time if a patient is late. However, if the intern is late, we will extend time (if needed) to complete the treatment.
- If a patient is 15 minutes late for a scheduled appointment, we reserve the right to fill that treatment slot with another patient. If filled, the scheduled patient will not receive a treatment that day. Consecutive missed appointments may result in your withdrawal from our clinic.
- Payment is due at the time of treatment. We accept cash, checks, or charge cards. Our payment schedule is available from the front desk. We will gladly provide a coded receipt for insurance reimbursement upon request.
- Due to graduation requirements, student interns are only able to treat an individual patient up to six (6) times. Your student intern will be happy to refer your case to another qualified student, often with the same supervisor.
- Our clinic is a professional health care provider. Patients are expected to conduct themselves accordingly. Anyone who threatens, intimidates or exhibits violent behavior will be immediately discharged as a patient and asked to leave the premises. Anyone who uses profanity or raises his or her voice to such a level that others can hear it outside of the treatment room will be discharged as a patient and asked to leave the premises. We will make allowances for children who raise their voices. Sexually oriented communications, comments, gestures, or physical conduct will not be tolerated and any patient who does so will be asked to leave the clinic immediately and shall be discharged as a patient. Unless specifically authorized by law, weapons, firearms, mace, pepper spray, and other types of similar chemical agents are not allowed in the clinic. Leave them in your vehicle before entering the clinic. Patients who come to the clinic under the influence of alcohol or non-prescriptive medications will be asked to leave and shall be discharged as a patient. A patient who is asked to leave means that the patient is discharged and ineligible to receive any further treatment.
- With the possible exception of children, a patient who is asked to leave because they continue to raise their voice to the point that they are disrupting other patients' treatments more than one time, will be discharged as a patient from our clinic.
- Treatment plans for each patient will be developed according to the judgment of the intern and the supervisor based on presenting signs and symptoms. You are welcome to let us know if you have had a treatment that has worked or not worked for you in the past. We will consider this information in our treatment plan.
- If we feel it necessary to the medical needs of a patient, we reserve the right to refer a patient to seek professional help from another health care practitioner. Failure to seek referred care could result in being discharged as a patient.
- A patient has the right to refuse any aspect of a treatment at any time.

As a patient at Southwest Acupuncture College Clinic, I have read, understand and agree to the clinic policy as stated above.

Patient Name (print):_____

Patient Signature:_____ Date:_____

Clinic Manager Signature:_____ Date:_____