COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

SOUTHWEST ACUPUNCTURE COLLEGE
Patient Medical History

General Information

Patient Name _____ Date __/__/__
Gender: ❑Male ❑Female Age:_____ D.O.B. __/__/__ Occupation: _____
Address_____ City _____ State _____ Zip _____
Preferred Phone # _____ Alternate Phone # (optional) _____

Emergency Contact

Name_____ Relationship_____ Phone _____
Name_____ Relationship_____ Phone _____

Privacy Concerns

Do you wish to specify any restrictions in how we may contact you? ❑Yes ❑No
If yes, please specify: _____

Main Complaint

What is the primary reason for this visit? _____
_____
When did the symptoms begin? _____ Date of the injury/illness? __/__/__
This condition is due to: ❑ auto accident ❑ work injury ❑ sports/exercise injury ❑ illness ❑ other _____
Is this your first time receiving acupuncture/Chinese herbs? ❑Yes ❑No
Do you have specific questions you would like to discuss today? _____
_____

Personal History

How would you describe your health as a child? ❑Good ❑Fair ❑Poor

Check any diseases, illnesses or conditions with which you have been diagnosed:

❑AIDs/HIV	❑Alcoholism	❑Allergies	❑Antibiotic use	❑Asthma	❑Bleeding Issues	❑Cancer
❑Chicken Pox	❑Diabetes	❑Epilepsy	❑Glaucoma	❑Heart Dz	❑Hepatitis B	❑Hepatitis C
❑High BP	❑Jaundice	❑Ulcer	❑Meningitis	❑Mental Disorder	❑MS	❑Pacemaker
❑Polio	❑Pneumonia	❑Stroke	❑Thyroid	❑Tuberculosis	❑Kidney Dz	❑Vascular Dz
❑Venereal Dz	❑Other: _____					

Check any immunizations you have received:
❑DTaP ❑Tetanus only ❑Chicken Pox/Shingles ❑Typhoid ❑Hepatitis B ❑Measles/Mumps/Rubella

List any serious illnesses, injuries, and/or surgeries: (include dates if applicable) _____
_____
_____

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

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

I authorize treatment by students & faculty of Southwest Acupuncture College. All information provided on this form is correct.
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:** __/__/__

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)_____

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

Clinic Manager Signature: _____ **Date:** ____/____/____

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

HIPAA CONSENT FORM

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 give Southwest Acupuncture College Clinic my consent to use or disclose my 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 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 protected health information should be filed in writing with the Clinic Director.
I have read and acknowledged the receipt of notice of privacy practice of Southwest Acupuncture College and agree to its contents.

Patient Name: (Print)_____

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

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

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 may request a specific treatment if has been beneficial to you in the past. However, the requested treatment will only be performed if deemed pertinent/beneficial to the current complaint by the supervisor and intern.

- 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:** ____/____/____
(Or Patient Representative - Indicate relationship)

Clinic Manager Signature: _____ **Date:** ____/____/____

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 AND ADJUNCTS 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)_____

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

Supervisor Signature: _____ **Date:** ____/____/____

PLEASE SIGN BOTH SIDES OF THIS FORM