Sharon Natural Medical Center LLC

Registration Form / Medical History & Health Conditions:

Name: _____ Date: _____ Ref # _____

Name: Mr./Mrs./Miss_____ Date of Birth: _____-_____-_____

Phone no. [mobile] _____-_____-_____ [home] _____-_____-_____ Email:_____

Address:_____, _____, FL-_____ **Race**: Indian / African / White / Hispanic / Chinese / other:_____ **Language**: / English / Spinach /Chinese / other: _____

Employer Name: _____ Occupation:_____

Employer address: _____ phone _____-_____-_____

Emergency contact: Name_____ phone_____-_____-_____ relationship_____

Primary Family Physician: Name_____ phone_____-_____-_____

You know us from / Facebook / Yelp / website / flyer / a friend /insurance [name]:_____

Primary Insurance: _____

Policy Holder Name: _____

Insurance ID: _____Group ID: _____ Relation to insured: / Self / Spouse / Child/

Claim no. _____ Address:_____

Patient Signature_____ Date: _____

Cancellation Policy:

We understand that there are times when a patient must miss an appointment due to emergencies or obligations for work or family. Please give us 24 hour notice to reallocate your appointment to another patient and avoid cancellation fee. However, if your appointment is taken by someone else, you will not be charged.

Patient Signature_____ Date: _____

*** Please **circle** where are applicable to you and/or **fill** in the **related Medication / Treatment / Surgery and Date*****

Your last physical exam/ blood test was on_____

Yes / No You have been treated with Acupuncture / Oriental Medicine before_____

Yes / No **Cardiovascular**: Stroke/ Heart disease/_____

Yes / No **Chest:** Oppression / Fullness / Palpitation / Pain_____

Yes / No **Blood disorder:** Anemia/ High B/P / bleeding easily_____

Yes / No **Liver disease**: Hepatitis (A B C D)/ Fatty Liver/ other_____

Yes / No **Kidney disease**: KD failure/ stone / other_____

Yes / No **Respiratory**: COPD/ Pneumonia/ TB / Sinus / Nasal / other_____

Yes / No **Allergies**: Food / Pollen / Medication_____

Yes / No **Gastrointestinal**: Stomach/ Gallbladder/ Intestine/ Hemorrhoid_____

Yes / No **Neurological:** MS/ Numbness / Tremor / Brain or spinal tumor/damage_____

Yes / No **Immune system disorder**: RA / HIV / Fibromyalgia_____

Yes / No **Diabetes:** Type I / Type II / Pregnancy_____

Yes / No **Thyroid problem**: / Hypo-thy. / Hyper-thy/ other_____

Yes / No **Cancer:** Lung /skin / breast / other_____

Yes / No **Psychological**: Depression / Anxiety / Bipolar disorder / ADD / Post-Traumatic Stress Disorder (PTSD) / Panic attacks

_____

*** Please **circle** where are applicable to you and/or **fill** in the **related Medication / Treatment / Surgery and Date** ***

Yes / No **Implant**: Heart pacemaker / Coronary stents / Hips / Knees / Spine / Cosmetic or breast Implant

Yes / No **Headache** / Dizziness / Vertigo / Fogginess

Yes / No **Eye**: / Red / Dry / Blurry / Floaters / Glaucoma / Cataract / Retinal disorder / Night Blindness

Yes / No **Hearing impaired / Ear ringing:** Poor / Use Hearing Aid /

Yes / No **Skin**: Eczema / Psoriasis / Shingles / Pimples / Recent Moles / Sjogren's syn. / Dryness / Rash / Hives / Ulceration / Loss of hair / Excessive hair growth

Yes / No **Recent weight gain/loss** since _____, due to Exercise / Unknown / Diet

Yes / No **Other Medication & Supplement**:

Yes / No **Physical exercise**: _____ hours per day/week

Yes / No **Feel /Aversion to: Hot/Cold/Wind**

Yes / No **Family History of:** Heart disease / Stroke / High blood pressure / Cancer / Diabetes / Blood disease

Yes / No **Sleeping problem:** Apnea / Excess Sleepiness / Difficult to Fall Asleep / Stay Sleeping

Yes / No **Dreaming**: Rarely / Always / Unmemorable / Vivid / Strangely / Threatening

Sleeping time: Lay on bed at _____, get up at _____ am. Wake up from sleeping

Breakfast at: _____am. **Lunch** at: _____pm. **Dinner** at: _____pm. **Snacks**: daily / sometimes

Dietary: Salt: little/average/much. **Sugar**: little/average/much. **Fat/dairy**: little/average/much. **Meat**: little/average/much.
Vegetable: little/average/much. **Fruit**: little/average/much. **Grain**: little/average/much.
Alcohol/Smoking: _____per day / week. Daily **fluid intake**: water / coffee / tea / juice / soda
Feel **hungry:** Always / Rarely / Normal. Feel **thirsty:** Always / Rarely / Normal.

Bowel Movement: _____ time(s) per ____day or week, stool is formed / loose

Urination: _____ time(s) per night. Burning /uncolorable/

Sweating / Swelling:

Recent Emotion: Calm / Frustrated / Easily angered / Over-thinking / Over worried / Sad and Cry/weep / Mood swinging

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Male: / Prostate / Testicular / Pain / Inflamed / Enlarged / Cancer, when _____. Desire of Libido: / Low / High.
/ Impotence / Premature Ejaculation / Spermatorrhea / STD / other

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Female Menstruation: Your first menses at age: _____. Last menses was on _____. Menopause age: _____.
Infertility / Post-menopausal syn. / Endometriosis / Polycystic ovary syn. / Hysterectomy / STD / PMS / other
Menses come / Regularly / Irregularly / Scanty / Moderate / Heavy / Clots. Color: / Dark Red / Red / Dark/
Duration ____days, interval ___ days. **PMS**: / Mild / Moderate / Sever. Abdominal pain: / Before / During / After menses.
Vaginal discharge: / Always / Sometimes / Rarely / Abnormal Bleeding / Vaginal infection / other
Pregnant: / No / Possibly / Yes, due date _____. **Birth control pills:** / No / Have been taking for (____) years.
Lactation: / No / Yes. Miscarriage / premature birth _____ times. Live birth _____ times.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Acupuncturist or her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ Date: _____

Sharon Natural Medical Center LLC
924 N Magnolia Ave, Suite 332, Orlando, FL 32803
Tel: 407-758-0179

HIPAA NOTICE OF PRIVACY PRACTICES

The terms of this Notice of Privacy Practices apply to Sharon Natural Medical Center LLC, its affiliates and its employees. Our practice will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information.

You have been informed of, and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of your protected health information, and your rights under HIPAA. We reserve the right to change the terms of this Notice from time to time and that you may contact us at any time to obtain the most current copy of this Notice.

You have the right to request restrictions on how your protected health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree to these requested restrictions, but if we do, we are bound to comply with this restriction.

These rights are given to you under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). By signing this consent, you authorize us to use and disclose your protected health information to carry out:

- Treatment, (including direct or indirect treatment by other healthcare providers involved in your treatment);
- Obtaining payment from third party payers (e.g. Insurance companies);
- The day-to-day healthcare operations of our practice.

_____ _____

Print Patient Name Date

_____ _____

Patient / Representative Signature Relationship to Patient (if other than patient)

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 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 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 proviser, including those working at the health care provider's clinic or office or any other office whether signatories 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 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 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 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 the 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 PRACTICE 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: Date:

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

OFFICE SIGNATURE Dr Josephine Chan X Date:

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of 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, 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.

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

Acupuncture Physician: Dr. Josephine Chan X	Date:

Patient Name: _____

COVID-19 Patient Screening Questionnaire

Screening Questions	Pre-Appt	**In-Office**	**In-Office**	**In-Office**	**In-Office**	**In-Office**	**In-Office**
Do you have a fever, or have you felt feverish, chills or repeated shaking with chills recently?	Yes / No	Yes / No Temp:	Yes / No Temp:	Yes / No Temp:	Yes / No Temp:	Yes / No Temp:	Yes / No Temp:
Do you have a cough, shortness of breath or any difficulty breathing?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you have any recent onset of headache, sore throat, or any other flu-like symptoms?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you experienced any recent GI upset or diarrhea?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you have any recent loss of taste or smell?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you contacted anyone who has been confirmed to be COVID-19 positive?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you traveled in the past 14 days to any regions affected by COVID-19?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Are you over the age of 65?	Yes / No						
Do you have: Heart disease, Lung disease, Diabetes, Kidney disease, or Autoimmune disorders	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Patient initial: Date:	_____ / /21	_____ / /21	_____ / /21	_____ / /21	_____ / /21	_____ / /21	_____ / /21