Corey DiStasio, L.Ac.

Patient Questionnaire

The information provided will be kept confidential. If you have questions, please ask. Thank you.

Personal Information

Date: _____

Patient Name: _____ Sex: ❑ Male ❑ Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

I am: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Living With

Date of Birth: _____ Occupation: _____ Height: _____ Weight: _____

Emergency Contact: Name: _____ Phone: _____

Who can we thank for referring you to this office? _____

Medical History

Please indicate any illnesses you have/had:

Illness		Illness		Illness	
Cancer	❑	Diabetes	❑	Kidney Disease	❑
Heart Disease	❑	Digestive Disorder	❑	Seizures/Alzheimer's	❑
Hypertension	❑	Allergies/Asthma	❑	Depression/Anxiety	❑
Stroke	❑	Tuberculosis	❑	Drug/Alcohol Abuse	❑

You have/had: ❑ Hepatitis ❑ HIV ❑ Gonorrhea ❑ Syphilis ❑ HPV ❑ Chlamydia ❑ Herpes

Name of Physician: _____ Date of last physician's visit: _____

Current Medications/Supplements	Dosage	Reason	How long	Prescribed by

Hospitalizations/Surgeries/Accidents	Date	Name of Hospital

Please check if true: ❑ I have a pacemaker ❑ I am taking Aspirin, Coumadin, Heparin or Warfarin

Habits: (check all that apply) ❑ Caffeine ❑ Alcohol ❑ Tobacco ❑ Recreational Drugs ❑ Junk Food ❑ TV ❑ Exercise ❑ Travel/Adventure

217 East 22 Street, Suite 32 New York, NY 10010 Tel (917) 881-4878 Corey@CoreHealthNY.com

Corey DiStasio, L.Ac.

Notice of Privacy Practices and Policies

Please review this information carefully.

This notice describes how health information about you may be used and disclosed. It also describes how you can gain access to your health information.

Understanding Your Health Record and Rights:

A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis, treatment, and other pertinent information provided by you or another of your health care practitioners. Your health record is owned by the clinic, however, the content is always available for your review. You have a right to request a review of your file and to obtain copies of documents in your file. You also have the right to request that amendments be made to your record. You may request that the use of your information be restricted from certain uses and disclosures and mayo request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us in writing.

Our Responsibilities:

We are required to maintain the privacy of your health information. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

Communication:

We routinely communicate with patients by phone and email to schedule and confirm appointments and relay relevant information about treatment and related services.

24-Hour Cancellation Policy:

Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects of treatment will not be interrupted. All scheduled appointments require a 24-hour minimum cancellation notice or the patient will be charged for a full office fee.

Advisory to Consult a Physician:

We at this office are committed to your health and well-being and believe that while Traditional Chinese Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, to comply with Article 160, Section 8211.1 (b) of NYS Education Law, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

I have read this Notice of Privacy Practice and Policies and the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient Name: _____ (please print)

Patient/Guardian Signature: _____

Date: _____

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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 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, Tiu-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 be 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 effect 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 SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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.

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 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 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 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.

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 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 SIGNATURE	**X**	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	**X**	(Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE