Pediatric Intake Form

Patient's name: _____Date of first visit: _____
Age: Date of Birth (month/day/year): _____/_____/_____ Gender: ☐ female☐ male
Parent or Guardian name: _____
Address: _____City:_____ Zip: _____
Phone # (home): (_____)_____Parent's work/cell phone # (_____)_____
Parent's e-mail address: _____
Child's GP or Pediatrician: _____
Current health concerns: _____

MEDICAL HISTORY

Chicken pox _____ Scarlet fever _____ Roseola _____ Mononucleosis _____
Measles _____ Pneumonia _____Strep throat _____ Impetigo_____ Mumps _____
Whooping Cough _____ Ear Infections_____ Rubella _____ Rheumatic fever_____
other (please list) _____
_____
What screening tests has your child had? (blood, hearing, vision, etc)_____
Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list):
_____
_____
Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.)
_____
_____
Please list any past prescription medications:
_____
_____

FAMILY HISTORY

Heart disease _____ Diabetes_____ Birth abnormality _____ Celiac disease _____
Hypertension _____ Arthritis ___Tuberculosis ___ Eczema_____ Cancer _____Allergies
_____ Mental illness _____ Asthma_____ Other: _____

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth? _____ Mother's health during pregnancy? _____
Were any of the following experienced during pregnancy? Bleeding _____ Physical or emotional trauma _____ High blood pressure_____Nausea/Vomiting_____ Cigarettes, alcohol, drug consumption _____ Thyroid problems_____ Illnesses _____ Surgery_____
Medications _____ Gestational diabetes_____ Depression/Anxiety_____ Other_____

CHILD'S BIRTH HISTORY

Term: ☐Full☐Premature: ___weeks Weight at birth:_____lbs, _____ oz.

Length of labor _____ Any complications?_____

_____

Birth: ☐vaginal ☐C-section ☐Induced ☐Forceps ☐ Suction ☐Anesthesia used

Did your child have any of the following problems shortly after birth?

Birth abnormality_____ Birth injuries_____ Blue baby_____ Cerebral palsy_____ Seizures_____ Jaundice_____ Colic _____ Fever_____ Rashes_____ Other (explain): _____

FEEDING

Breastfed? ☐ yes ☐ no How long?_____ Formula? ☐yes☐ no If Yes☐cow's milk☐ soy☐ other

Child's sleep patterns _____

How would you describe your child's temperament?_____

_____

Food or environmental sensitivities or allergies (if known)

_____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Age began solids _____Which foods?_____

Typical daily diet:

- Morning _____
- Afternoon _____
- Evening _____
- Between Meals _____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

SYMPTOMS (mark Y if current, P significant past symptom)

___Hives	___Burning of urine	___Bloody urine	___Eczema
___Frequent urination		___Cries easily	___Bleeding gums
___Heart murmur	___Nervous	___Nose bleeds	___Vomiting
___Sleep problems	___Acne	___Anemia	___Night sweats
___ High fevers	___Stomach aches	___Sensitive to light	___Chronic rash
___Jaundice	___Body/breath odor	___Hearing loss	___Easy bruising
___Motion/car sickness		___Diarrhea	___Earaches/Infections
___No appetite	___Sore throats	___Constipation	___Nightmares
___Headaches	___Gas	___Canker sores	___Frequent colds
___Bleeding tendency		___Unusual fears	___Wheezing
___Joint pains	___Excessive fatigue	___Cough	___Dizzy spells
___Hair loss	___seizures	___Reflux	___diabetes
___hyperactivity	___bed-wetting	___emotional concerns	___allergies
___behavioral concerns			

Other:_____

Please explain briefly what you would like to see as a result of acupuncture treatments?

_____

HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Invigortae Acupuncture, PLLC maintain my records confidentially in accordance with the law. I agree to inform Invigorate Acupuncture, PLLC if I need any special arrangements pertaining to this issue.

Signature:	**Date:**
Printed Name:	

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily 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 above 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 above 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, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine , nutritional counseling and lifestyle coaching.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records 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 conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alteratives, including treatment offered by a licensed physician, as Invigorate Acupuncture, PLLC is not a primary care physician.

I have read and understand all of the above information and am fully aware of what I am signing. I undertstand that I may ask my practioner for a more detailed explaination. I give my consent and permission for treatment.

Patient name:	**Date:**
Patient signature:	**Guardian signature:**

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 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 SIGNATURE X (Date)

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

OFFICE SIGNATURE X (Date)

Notice and Authorization for Insurance Billing

I _____ *(print name)* do hereby give full permission and authorize Invigorate Acupuncture, PLLC, to bill my insurance for services rendered by Kate Campos, LAc. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Kate Campos LAc

6416 E. Tanque Verde, Suite B

Tucson, AZ 85715

As a courtesy, my insurance will be billed directly by Invigorate Acupuncture, PLLC. When possible, Invigorate Acupuncture, PLLC will call my insurance to verify my benefits, although benefits quoted by my insurance company are not a guarantee of payment. I am responsible for knowing the benefits my insurance policy covers. Payments will be due at the time of service for any non-covered services, deductibles or co-pays.

I understand if I do not have insurance coverage, I will receive a cash discount. If I do have insurance that covers acupuncture treatment or other modalities, Invigorate Acupuncture, PLLC will bill my insurance for me at the full insurance fee rate. **I understand a full fee rate for services rendered is available upon request. I will be required to pay my insurance policies stated copay or coinsurance fee if required by my insurance, and/or the difference of the full insurance reimbursement and cash based fees.**

I understand the aforementioned office fees, insurance and billing policy. If my insurance is billed by this office, my billing statement will show "signature on file."

Please check one of the following:

____ I authorize Invigorate Acupuncture, PLLC to bill my insurance.

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service.

*Please note Invigorate Acupuncture, PLLC has a 24-hour appointment cancellation policy. Unless due to an emergency, any cancellations made with less than 24 hours notice prior to their scheduled appointment time will be charged a $30.00 fee.

_____ _____

Signature Date