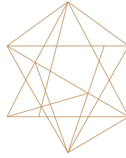

PRIYA
WELLNESS

Acupuncture | Feng Shui | Diet & Herbs

NEW YORK CITY • LOS ANGELES • REMOTE BY REQUEST • PRIYA@PRIYAWELLNESS.COM

CONTACT

Please print clearly. All records including email addresses are confidential.

Name ______________________________ Date ____________

Street Address ______________________________

City, State, Zip ______________________________

Phone Number(s) ______________________________

Email Address ______________________________

Emergency Contact Name and Phone Number ______________________________

____

Referred by ______________________________

REASON FOR CONSULTATION

Chief complaint or concern:

List all previous treatments for this condition, including medication:

Other health related concerns

PERSONAL MEDICAL

Birth Date ____________ Age______ Gender ____________ Ht.______ Wt.________

Past medical history, check all that apply:

{ } AIDS/HIV { } Diabetes Mellitus { } Herpes (Oral, Genital) { } Rheumatic Fever

{ } Stroke { } Tuberculosis { } Chest Pain { } Glaucoma { } Cancer _________

{ } Asthma { } Hepatitis _________ { } High Blood Pressure { } Pneumonia

{ } Seizures { } Thyroid disorder (type)_________ { } Ulcers { } Depression

List any previous surgery / major trauma (include dates)

FAMILY MEDICAL

Family history, list major medical conditions:

Father

Mother

Siblings

PRIYA WELLNESS

LIFESTYLE

Occupation(s)____

Are you under a lot of pressure at work? { } No { } Yes

If Yes, Please describe:

Do you smoke:

Cigarettes { } No { } Yes *If Yes,* Number of years ____ How much?__________

Pipe { } No { } Yes *If Yes,* Number of years ____ How much?__________

Cigars { } No { } Yes *If Yes,* Number of years ____ How much?__________

If you are a former smoker, when did you quit? ____________

Do you drink alcohol? { } No { } Yes

If Yes, What type(s)? ____

How much? __________ How often?__________

Do you use street drugs? { } No { } Yes

If Yes, What type(s)? __________________ How much? ________ How often? ________

Do you exercise? { } No { } Yes *If Yes,* Please list type and frequency:

Do you drink coffee? { } No { } Yes *If Yes,* How many cups per day? ____

Number of hours of sleep per night _____ Usual bedtime _____ Usual wake time _____

DIET

Diet, briefly describe what you may eat on a typical day:

Breakfast

Lunch

Dinner

Water consumption per day ______________

List dietary restrictions:

List food allergies:

List food cravings:

Supplements and/or vitamins:

Medication you are currently taking:

GOAL SETTING

Understanding and working to fulfill my client's health goals is very important to me. With that said, what are your expectations for your treatments with me?

Thank you!
PRIYA

(*Privacy and Payment Policies* attached—SIGNATURES ARE REQUIRED)

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. 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 SIGNATURE **X**	(Date)

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

OFFICE SIGNATURE **X**	(Date)

.

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED **A2004**

PRIVACY AND PAYMENT POLICIES

Federal laws effective April 14, 2003 require patients to be given a notice of privacy policy formulated in accordance with HIPAA (the Health Insurance Portability and Accountability Act), and to sign a consent form and payment agreement. New York State law requires all alternative health care practitioners to inform patients that they should consult Western medical practitioners in regard to the condition for which they seek acupuncture treatments.

I, ____ do affirm that I have been advised by Priya Ahuja L.Ac to consult aphysician regarding the condition or conditions for which I am seeking acupuncture treatment.

Initial: ___________

Informed Consent

Acupuncture is a technique in which sterile, stainless steel, disposable needles are inserted into specific points on the body to cause a desired healing effect via regulating the flow of Chi (vital energy) in the body. Techniques may include manual stimulation of the needles, cupping, and moxibustion. The benefits of acupuncture may include alleviation of pain or other symptoms, an overall sense of well being, improved sleep, and increased energy level. Risks may include feeling weak, nauseated, faint, bruising at the site of the needle insertion, and worsening of symptoms occasionally. Occasionally blood might exit or be let from needled sites. Moxibustion is a heat treatment using the herb mugwort placed on or near the body. There is possible risk of burning due to fallen ashes. With this knowledge, I voluntarily consent to have acupuncture treatments.

Initial: ___________

For New York State Patients

New York state law requires all alternative health care practitioners to inform patients that they should consult Western medical practitioners in regard to the condition for which they seek acupuncture treatments.

I, ____ do affirm that I have been advised by Priya Ahuja L.Ac to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment.

Initial: ___________

Payment

The discounted, out-of-pocket fee for acupuncture: First visit: 90 minutes detailed medical history/intake and acupuncture treatment: $185. Thereafter, consultation, follow-up examination and treatment 60 minutes: $155. There is no extra fee for moxibustion, cupping, double treatment (back and front), gua sha, seven star needle, or tui na. I agree to pay for my treatments at the time services are provided and I also agree to pay for any appointment cancelled or missed for which I did not give 24 hours notice. The fee for a missed/cancelled appointment without 24 hours notice is the price of a treatment in full.

Initial: ___________

Privacy Notice

I have received a copy of the practice's Notice of Privacy Practices, I am aware of the fee structure, and have given informed consent to treat.

____ ____________

Signature of Patient **Date**

____

Print Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to someone in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may se and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include acupuncture, cupping, tui na, etc.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your treatment.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED-HEALTH INFORMATION to public health authorities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding,, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of he request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

NOTICE OF PRIVACY PRACTICES, continued

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

- The right to request an amendment to your PROTECTED HEALTH INFORMAITON.

- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201