Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

We're delighted you're here! Who can we thank?

Dr referral: _____ **Friend/Family name:** _____

Our Website: ____ **Facebook:** ___ **Yelp:** ___ **Twitter:** ___ **Pinterest:** ___ **GOOGLE:** ____ **Other:** _____

Patient #_____ **(Office Use Only)**

Date of Appointment: _____ **Time:** _____ **Appt w/**_____

Mr. Mrs. Miss Ms. Dr. **Preferred/Nickname:** _____ Birth Date: _____

(Please PRINT) Please Circle: Female / Male Marital Status: S M W D P

Name: _____

Address: _____ City, State, **Zip**: _____

Occupation: _____ Employer: _____

SS#: _____ E-Mail: _____

SS# optional for identification; ***ONLY required for VA*** **PLEASE PRINT** - *Email address required for email appt reminder*

Home Phone Number: (_____)_____ Cell Phone: (_____)_____

Cell Phone number required for text appt reminder

Work Phone Number: (_____)_____ ****Best Way to Reach You**: Home Cell Work

Emergency Contact: _____

(Name, relationship & phone number with area code)

Please Circle Your Appointment Reminder Preference: Text / Email / None

Primary Physician's Name: _____ PCP's Phone: _____

Referring Doctor's Name: _____ Dr.'s Phone #: _____

Doctor's Address: _____ Dr.'s FAX #: _____

MY PAYMENT METHOD: (Please circle ONE)

Acupuncture - **CASH** **or** **Veterans Administration**

Cash Payment will be made when treatment is rendered. Detailed receipts are available.
Cash; Check; FSA/HSA cards *or* Credit/Debit cards (Visa; Master Card; American Express or Discover)

Privacy Statement: Your information will be shared only with your doctors and other healthcare practitioners directly involved in your care. If using FSA/HSA cards, information will be sent to insurers as requested. Full HIPAA forms available upon request. Rev. 8.1.19

If you have arranged for a treatment package, please be sure to complete and sign our Evolution Medical Associates Financial Policy.

NAME: _____

Have you had acupuncture before? _____ Chinese herbal medicine? _____

Issue of greatest concern for you today: _____

How does this issue interfere with your daily activities (work, sleep, diet, etc)?

_____

How long has it been since you first noticed symptoms: _____

Is it getting worse? _____ Or is it simply persistent? _____

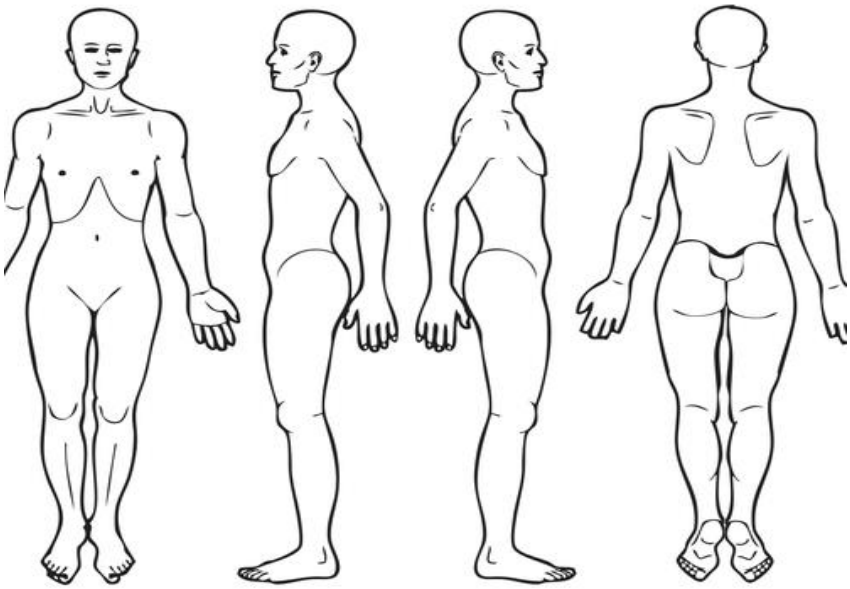
What seemed to be the initial cause? _____

What makes it better? _____ Worse? _____

If you've been given a diagnosis by your family physician, what is it? _____

What treatments or therapies have you tried? _____

PLEASE CIRCLE OR "X" AREAS OF PAIN OR DISTRESS:



Please circle pain level today: **10 9 8 7 6 5 4 3 2 1 0**

(10 = Worst imaginable 5 = Barely tolerable without medicine 1 = No problem)

FAMILY MEDICAL HISTORY: (Please circle)

Allergies _____	_____	_____
Arteriosclerosis	Asthma	Alcoholism
Cancer _____	_____	_____
Depression	Diabetes _____	Heart Disease
High Blood Pressure	Seizures	Stroke

NAME: _____

YOUR PAST MEDICAL HISTORY: (Please circle. Please note dates)

Alcoholism	Allergies	Appendicitis	Arteriosclerosis
Asthma	Birth Trauma (your birth)		Cancer
Chicken Pox	Diabetes	Emphysema	Epilepsy
Goiter	Gout	Heart Disease	Hepatitis
Herpes (type)	High Blood Pressure	HIV/AIDS	Measles
Multiple Sclerosis	Mumps	Pacemaker (date)	Pleurisy
Pneumonia	Polio	Rheumatic fever	Scarlet fever
Seizures	Stroke	Thyroid Disease	Tuberculosis
Typhoid Fever	Ulcers	Venereal disease	Whooping Cough

Major illness, Accidents, surgeries, or significant trauma: _____

LIFESTYLE: (Please circle)

Current medication/supplements? _____

Please indicate usage per day/per week:

Alcohol	Caffeine	Cigarettes/Tobacco	Drugs
Marijuana	Sugar	Other_____	

Occupational Hazards: _____

Regular Exercise: _____ Frequency: _____

Are you on a special diet? _____ Please specify: _____

CIRCLE any condition(s) you have experienced within the last (3) three months. Indicate the length of time you have had this condition.

GENERAL:

Appetite/Changed	Appetite/Heavy	Appetite/Poor
Artificial Sweeteners	Bleed/bruise easily	Chills
Coffee/Tea	Cold hands/feet	Cravings
Disturbed sleep	Edema	Fatigue
Fever	Fruit Juices	Insomnia
Muscle cramps	Night Sweats	Poor Balance
Poor Circulation	Salty Foods	Shortness of breath
Soft Drinks	Sudden energy drop (time of day)	
Sugar	Sweat easily	Thirst
Tremors	Vertigo/Dizziness	Weakness/localized
Weight loss/gain		

NAME: _____

Peculiar taste _____ Protein Intake: Low _____ High _____
Thirst for water: # of glasses per day _____
Other unusual conditions: _____

SKIN AND HAIR (Please circle)

Acne	Dandruff	Eczema	Fungal Infections
Hair Loss	Hives	Itching	Moles
Psoriasis	Rashes	Ulcerations	

Changes in hair or skin texture, acne _____
Any other hair or skin problems: _____

HEAD, EYES, EARS, NOSE, THROAT (Please circle)

Change in taste	Concussions	Dizziness	Dry Mouth
Excessive Saliva	Facial Pain	Grinding teeth	Gum problems
Headaches	Jaw clicks	Migraines	Sinus problems
Swollen Glands	TMJ		

Blurred Vision	Cataracts	Dry eyes	Eye pain
Eye Strain	Glasses {age _____}		Glaucoma
Itchy Eyes	Night blindness	Poor vision	Red Eyes
Spots in eyes			

Earaches	Poor Hearing

Ear ringing, Hearing loss (where? _____ when? _____)

Nosebleeds

Excessive phlegm	Enlarged thyroid	Lumps in Throat	Recurrent sore throat
Sores on tongue/lips			

Any other head or neck problems: _____

NAME: _____

CARDIOVASCULAR AND RESPITORY (Please circle)

Asthma	Blood clots	Bronchitis
Chest pain	Cold hands/feet	Cough, blood
Cough, dry	Cough, wet	Difficulty breathing
Dizziness	Excessive phlegm (color: _____)	Fainting
Heart palpitations	High blood pressure	Irreg heartbeat/Afib
Low blood pressure	Phlebitis	Pneumonia
Shortness of breath	Swelling of feet	Swelling of hands
Tachycardia	Tight chest	Wheezing

GASTROINTESTINAL (Please circle)

Acid regurgitation	Abdominal Cramps	Abdominal Pain
Anal Burning	Anal Fissures	Anal itching
Bad Breath	Belching	Black Stools
Bloating	Blood in stool	Constipation
Diarrhea	Gas	Hemorrhoids
Hiccup	Indigestion	Nausea/Vomiting
Mucous in stools	Rectal Pain	Intestinal pain/cramps

Laxative use? _____ How often? _____ What kind?_____

Bowel movements: Frequency _____ Color _____

GENITOURINARY AND REPRODUCTIVE (Please circle)

Bedwetting	Blood in urine	Decrease in flow
Frequent urination	Incomplete Urination	Kidney stones
Pain on urination	Sores on genitals	Urgent urination
Unable to hold urine	Wake to urinate	*Other problems*?

Do you wake up at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____ Other problems? _____

Venereal disease: _____ Change in sex drive

Impotence	Premature ejaculation	Nocturnal emission

NAME: _____

GENITOURINARY AND REPRODUCTIVE (continued)

Length of cycle (day 1 – day 1) _____ Duration _____ days
First day of last menses _____ PMS _____
Premenstrual changes Heavy/Irregular/Light menses Miscarriages
Painful menses Unusual menses Abortions Clots
Are you pregnant, or trying?_____ Date of last PAP test _____
Age at first menses _____ Age at menopause _____
Breast lumps _____ Number of pregnancies _____
Number of live births_____ Number of premature births _____
Do you practice birth control? If so, what type? _____
For how long _____ Vaginal discharge _____ (color) _____
Vaginal sores _____ Vaginal odor _____

MUSCULOSKELETAL (Please circle)

Back pain	Foot/ankle pain	Hand/wrist pain	Hip pain
Joint pain	Knee pain	Muscle weakness	Neck pain
Numbness	Rib Pain	Shoulder pain	

Limited range of motion/use: _____
Any other problems: _____

NEUROPSYCHOLOGICAL (Please circle)

Abuse Survivor	Anxiety	Bad temper	Depression
Easily stressed	Irritability	Lack of coordination	
Numbness	Poor memory	Seeing a therapist	
Seizures	Sleep Problems	Tics	

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
_____

Please list any other problems you would like to discuss: _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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, 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(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. 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 damages 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, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

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 healthcare 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): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Evolution Medical Associates
604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

FINANCIAL POLICY

Payment is due when services are rendered.

The only insurance accepted for physical therapy and/or concierge medicine is Traditional Medicare. We do not accept insurance for acupuncture, massage or neurofeedback therapy.

If you have an insurance policy other than Medicare and you'd like to self-submit a request for reimbursement, we can give you a detailed receipt.

Any balance remaining after Medicare and/or your secondary insurance have processed your claim(s) is your (patient) financial responsibility. Payment is due upon billing.

We can accept cash, check, FSA/HSA cards or credit/debit cards (Visa; Master Card; American Express or Discover.)

Discounted Packages: We offer discounted prices when a treatment package is purchased and scheduled. The patient is responsible for paying the full amount of the package before the first scheduled applicable treatment. Unused visits may be refunded to the patient. The used visits will be adjusted to non-discount prices. If the patient misses an appointment without notification of cancellation, a treatment is forfeited from the package. Packages may be transferred to friend/family to use remaining treatments.

Cancellations: We kindly request that our patients cancel at least 24 hours before your appointment via telephone. (**Please note – text/email message reminders do not receive responses*.) This allows us to re-book the appointment time with another patient who is waiting. We understand special circumstances, but we ask that you be respectful of our time, as we are of yours. Thank you.

_____ _____

Patient Signature or Authorized Representative Date

Private Health Information (HIPAA Compliance)

Evolution Medical Associates is bound by HIPAA regulations. We will only share your information with other healthcare practitioners that you are under care of with your consent.

Who may we contact regarding your health information?

_____ _____ _____

Name Relationship Phone