Vickery Health & Wellness

Dia Vickery, Doctor of Acupuncture and Chinese Medicine
Licensed Acupuncturist / Herbalist

PATIENT CONFIDENTIAL INFORMATION

PERSONAL INFORMATION

Legal Name:____
First Middle Last Suffix

Preferred Name:____
First Middle Last

Address:____
Street City State Zip

Home Phone: ______________________ **Business Phone:** ______________________________

Cell Phone: __________________________ **Email:** ____

Preferred communication method – cell phone ☐ email ☐

This authorization covers protected health information (PHI) disclosed by Vickery Health & Wellness personnel to a patient or a patient's representative through email communication. It expires when the need to communicate via email is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

Age ________ **Date of Birth** ______________ **Relationship Status** M S D W

Gender ________ **or Gender Identity** ______________ **Sexual Orientation**____________________

Preferred Language ______________________ **Race:** _____________________________________

Ethnicity ___________________________________ **Religion** ___________________________________

Smoking History: Start date: _____________ End date: ________________ Never Smoked ☐

Driver's License No ______________________ **Alternate Identification** _____________________

FOR MINORS:

List names and addresses of all responsible parties (parents, step-parents or other responsible person). Use back if necessary. Note that all responsible parties must also sign this form:

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EMPLOYMENT INFORMATION

Employer ______________________________ **Occupation** ____________________________

Employer's Address____

Street City State Zip

SPOUSE / DOMESTIC PARTNER OR RESPONSIBLE PARTY

Name ____ **Birthdate** ____________________

Address ____ **Phone** _______________________

Employer ____________________________________ **Occupation** ___________________

EMERGENCY CONTACT (If different from above)

In case of emergency, call: ____

Name

____

Relationship Phone

Do you have an advanced directive? Y N If so what type: ______________________________

Is someone other than your spouse or emergency contact named in your advanced directive? If so, please provide their name and contact information: ________________________________

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FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Circle one) Cash   Cheque   Credit Card

MasterCard, Visa, American Express, and Discover are accepted as well as cash and cheques.

A sliding scale is available upon request for annual income of less than $25,000 for a single person, $50,000 for a couple, $35,000 for a single parent with children or $70,000 for a family with children. Qualifying for the sliding scale requires documentation of income – either pay stubs or previous year's tax return. The sliding scale is 30% off the usual and customary billed charges.

INSURANCE INFORMATION

Will you be using your health insurance to pay for acupuncture treatments?   Y / N If yes please read the following and then provide your insurance information. If you will not be using your health insurance, you may skip this section.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner.

Payment Arrangements

We require that you pay your co-pay for today's charges. Your full portion of the bill is expected to be paid when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 1.5 % applied per month.

Assignment of Benefits

By signing this form, you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information

By signing this form, you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Company Name________________________________**Address**______________________________

Subscriber Name_____________________________________**Group Number**________________

Subscriber #____________________________**Subscriber Birthdate**________________________

Complaint result of: ◻ Auto Accident ◻ Injury ◻ Job Related ◻ Other

Date of Accident/Injury/Other _________ /____________/____________________

Have you seen any other doctor about this condition? Y / N
If yes, when? _______________

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Doctor's Name Address Phone Number

Is this a Personal Injury case? Y / N

CONSENT TO TREATMENT

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 Dia Vickery, PhD (Theology), Licensed Acupuncturist 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 Dia Vickery, PhD (Theology), Licensed Acupuncturist, 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, aroma acuppoint therapy (aromatherapy), moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counselling. 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. Moxibustion, cupping and treatments which involve heat lamps may cause burns and/or scarring. 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 this 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, stomach-ache, vomiting, headache, diarrhoea, 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.

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 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.

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 California 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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.

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.

OFFICE PROCEDURES AGREEMENT

Vickery Health & Wellness has my permission to send me appointment reminders and/or missed appointment correspondence by phone, email, via US Mail or other similar methods.

Vickery Health & Wellness has my permission to leave phone messages or verbal messages with whoever answers the provided phone numbers regarding appointment information.

I understand that patient health information will only be shared by phone with me as the patient or to legal guardians if the patient is a minor.

I authorize payment of insurance benefits directly to the acupuncturist or acupuncture office.

I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits

I understand that cash payments and insurance co-pays (and estimated insurance co-pays) are due at the time service is provided.

By signing below, I agree to the information above, services to be rendered, and responsibility of charges incurred at this office. If insurance does not cover filed charges, I understand that I will be fully responsible for payment of all services provided.

I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

By signing below, I understand that my appointment time is reserved specifically for me. In the event of a missed appointment, including arriving 15 or more minutes late for an appointment, or an appointment cancelled with less than 24 hours' notice I understand I will be charged a $50 fee. Insurance will not pay for a missed appointment.

DATED ____________ PATIENT'S SIGNATURE ____

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(All parents/responsible parties must sign if patient is minor, use back if necessary)

Referred by:

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