Bamboo Wisdom Acupuncture
148 Linden Street, Suite 105, Wellesley, MA 02482

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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

Bamboo Wisdom Acupuncture
148 Linden Street, Suite 105, Wellesley, MA 02482

CONSENT FORM

I hereby voluntarily consent to be treated with acupuncture by a licensed acupuncturist at Bamboo Wisdom Acupuncture. I understand that acupuncture is a generally safe method of treatment, but that it occasionally may have side effects, including bruising, numbness, tingling or pain near the needling site that may last a few days, and in rare cases, dizziness or fainting. Treatment may include but is not limited to the following:

1. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
2. Cupping treatments apply suction cups on the skin. These cups may produce a red or purple mark on the skin at the sight of the cup. Slight bruising or tenderness may persist after the treatment.
3. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.

I will notify my acupuncturist if I am, or become pregnant. I understand that if there is a worsening of my condition or if a new ailment or condition arises, or in the case of emergency, I should consult my personal physician or go to the local emergency room.

If applicable, I consent to Chinese herbal treatment. The herbal supplements that are 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. Possible side effects of taking herbs include nausea, and stomach ache. I understand that herbs must be consumed according to the instructions provided, and I will immediately notify my acupuncturist if any unanticipated or unpleasant side effects occur.

Acupuncture treatment is not a replacement for diagnostic medical procedures. If you have any concerns about what may be causing your symptoms you must see a medical doctor.

PRIVACY NOTICE FOR GROUP TREATMENT

I understand that it is possible for others to overhear conversation with my acupuncturist in a group setting. I understand that the acupuncturist will do all they can to minimize any compromise of privacy, and that my written health records are strictly confidential.

CANCELLATION POLICY

It is our intention to make acupuncture available to as many people as possible at the most affordable rates. In respect and support of that, **we ask for at least 24 hours notice to change or cancel an appointment. There is a $20 fee for appointments that are cancelled or changed with less than 24 yours notice.** If you are uncertain as to whether you can keep an appointment or give adequate notice, it may be better to call us on the day you'd like to come in, and we'll do our best to accommodate you. Thank you for your understanding.

_____ Date_____

Patient's name, printed

_____

Signature of patient or guardian

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NEW PATIENT FORM

CONTACT INFORMATION

First Name:		Gender: F ☐ M☐
Last Name		DOB: / / Age:
Address:		
City:	State	Zip
Occupation:	Employer	
Marital Status: M ☐ S ☐ D ☐ W ☐	Primary Care Physician:	
Home Tel:	Cell #	Work #
Email:		
Emergency Contact: Name, Relationship & Phone		
How did you learn about our clinic (Please circle)? Doctor's Referral Friend Web Event Business Other:		
Please let us know if someone referred you! We would like to thank them! Referred by:		

MAIN COMPLAINT(S)

1st:
How long ago did this begin:
Have you been given a diagnosis, if so,what:
2nd:
How long ago did this begin:
Have you been given a diagnosis, if so,what:
3rd :
How long ago did this begin:
Have you been given a diagnosis, if so,what:

HEALTH HISTORY

Past Medical History - Please circle all applicable to you: Cancer, Diabetes, Hepatitis, Heart Disease, High Blood Pressure, Stroke, Seizure, Thyroid, Asthma, Pacemaker, Osteoporosis, Herpes, Auto-immune Disease, AIDS/HIV, STD, Rheumatic Fever, Alcoholism, Mental Illness, Kidney Disease, Anemia, Glaucoma, Tuberculosis Others:
Significant Trauma, auto accidents, injuries and Surgeries:
Medications:(include prescription, OTC, vitamins, herbs etc)

General

☐Fever ☐Strange Tastes or Smells ☐Poor Sleep ☐Chills
☐Sweat Easily ☐Cravings ☐Fatigue ☐Night Sweats
☐Hair Loss ☐Weight Loss/Gain ☐Strong thirst ☐Hot flashes
☐Bruise easily

Head/ENT

☐Dizziness ☐Vertigo ☐Poor Concentration ☐Sore Throat
☐TMJ ☐Teeth Grinding ☐Sinus Congestion ☐Running Nose
☐Poor Vision ☐Red/Itchy Eyes ☐Poor Hearing ☐Earache
☐Floaters ☐Bleeding Gums ☐Toothache ☐Bad breath

Respiratory

☐Persistent cough ☐Chest congestion ☐Chest tightness
☐Nosebleeds ☐Chronic allergies ☐Sneezing
☐Wheezing ☐Shortness of breath ☐Frequent colds/flu

Gastrointestinal

☐Indigestion ☐Gurgling in intestines ☐Abdominal Fullness ☐Gas
☐Stomach ache ☐Nausea ☐Vomiting ☐Acid reflux
☐Belching ☐Heartburn ☐Hiccups ☐Diarrhea
☐Loose stools ☐Constipation ☐Mucous in stools ☐Hemorrhoids
☐Blood in stools How many BM daily:

Female Health

At what age did you get your first period: ___ First day of last menstrual period: ___
Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length: ___ Period length: ___
number of pregnancies: ___ number of live births: ___ miscarriages: ___
Are you currently using birth control? Y ☐ N ☐
If yes, what type and for how long? _____

Please indicate areas of pain