Morning Quail Health Care, PLLC

All your information will be confidential. If you have questions, please ask. Thank you.

Date: _____

Name: _____

Date of Birth_____ Age_____ Male☐ Female☐

Address:_____

City:_____ State:_____ Zip:_____

Phone#:_____ Insurance:_____

Email: _____

Occupation:_____

In Emergency Notify: _____

Phone#:_____

How did you find our clinic? Referred by_____

Web☐ Other (please specify) _____

Have you ever been treated by acupuncture before? Y☐ N☐

What is the main health problem for which you are seeking treatment for today?

_____

Have you been given a diagnosis for this problem? Y☐ N☐

If so, what? _____

What other health problems do you have?

_____

_____

Morning Quail Health Care, PLLC

Please list any accidents, surgeries or other periods of hospitalization.

_____

_____

Please list the medications and/or supplements , herbs you are currently taking?

_____

_____

_____

Allergies (drugs, chemicals, foods, etc)

_____

_____

_____

Any additional information that you feel is important:

_____

_____

_____

Signature:

_____

Adult Patient_☐__ **Parent or Guardian**_☐___ **Spouse**_☐___

Morning Quail Health Care, PLLC

REQUEST, CONSENT, AND PRIVACY POLICY

I hereby request Izumi Schutz, L.Ac, to treat me. I authorize her to perform on me the acupuncture treatment and other procedures whatever the methods she may see fit. I understand that methods of treatment may include, but are not limited to, acupuncture, electrical stimulation, elastin infusion therapy, Chinese herbal medicine, magnet therapy, intradermal needle therapy, kineshio taping therapy, cupping, moxibustion and nutritional counseling.

Izumi Schutz, L.Ac. has explained to me the nature and purpose of the treatment and the risks involved, including, but not limited to, mild bruises, infection, redness, allergic reaction, mild pain, pneumothorax, spontaneous miscarriage, weakness, fainting, burns, scarring. In giving my consent to the treatment, I have in mind her full and frank explanation. If any unforeseen condition arises in the course of the treatment, and in the judgment of the acupuncturist if it is advisable to use procedures in addition to

By singing this consent form, I understand and agree that Morning Quail Health Care reserves the right to charge for appointments canceled or missed without 24 hours advance notice.

or different from those now contemplated, I also request and authorize her to do whatever she deems advisable.

Please circle "yes" to confirm that Izumi Schutz, L.A., has shown you the disposable needles. YES

I understand that Morning Quail Health Care maintains the privacy of my records as governed by law. A copy of the privacy policies has been made available to me, and I understand that I may request a written copy of the policies.

I have been given no guarantee as to the results that may be obtained.

Signature:_____ Date:_____

Morning Quail Health Care, PLLC

ARBITRATION AGREEMENT

Article1: 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 proved 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.

Article2: 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 whether signatories to this form or not.

Article3: 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 third arbitrator(neutral arbitrator) shall be selected by the arbitrator, together with other expense 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 o entity that would otherwise be a proper additional person 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 payment, 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.

Article4: 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 stature of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article6: 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 Sighing 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 Article1 of this contract.

_____

Patient Signature (or Patient Representative) **Date**

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, MQHC is required to have you respond to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statement is no.
(Pursuant to the requirements of 22 TAC§183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann.,§205.351, governing the practice of acupuncture)

I (Patient's name)_____ am notifying the practitioners at Morning Quail Health Care of the following:

☐Yes ☐No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

☐Yes ☐No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two month or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.
It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___Chronic Pain
___Smoking addiction
___Weight loss
___Alcoholism
___Substance abuse
___ Facial Treatment

_____

Patient Signature Required **Date**