

VIBRANT LIVING ACUPUNCTURE/ VIBRANT LIVING COMMUNITY ACUPUNCTURE
Chet Franklin EAMP

Legal Name: _____ Preferred Name: _____

Sex/Gender: _____ Pronoun: _____ Birthdate: _____ Age: _____

Address: _____

Phone number: _____ Is it okay to leave a message? _____ Text? _____

Email address: _____

How did you hear about Vibrant Living Acupuncture? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Insurance Information:

Insurance Carrier: _____ ID Number: _____

Insurance Phone Number: _____

Describe what brings you in today: _____

List and date any major surgeries, accidents, traumas:

- 1.) _____ Date _____
- 2.) _____ Date _____
- 3.) _____ Date _____
- 4.) _____ Date _____

List current medications and supplements: Please use back of page if more room is needed.

- 1.) _____ Dose _____
- 2.) _____ Dose _____
- 3.) _____ Dose _____
- 4.) _____ Dose _____

List other medical professionals who have treated you in the past year with relevant diagnosis:

- 1.) _____ Diagnosis _____
- 2.) _____ Diagnosis _____
- 3.) _____ Diagnosis _____

Patient Name: _____ DOB: _____

Office Use:

Practitioner Initials: _____ Date of visit: _____

Chet Franklin LAC 2402 Broadway St. Vancouver, WA 98663

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Please circle any conditions you are currently experiencing:

Gastrointestinal

Nausea	Pain/Cramps	Excess Gas	Vomiting
Excess Belching	Constipation	Bad Breath	Rectal Bleeding
Sensitive Abdomen	Hemorrhoids	Bloody Stool	Gastritis
Diarrhea	Black Stools	Peptic Ulcers	Heartburn

Genito-Urinary

Pain on urination	Frequent urination	Blood in Urine	Incontinence
Kidney Stones	Venereal Disease	Urgency to urinate	Impotency
Wake up to urinate? ____/night			

Neuropsychological

Seizures	Areas of numbness	Poor memory	Concussion
Depression	Anxiety	Mood Swings	Easily Stressed

Treated for emotional problems:

_____ Date: _____

Skin & Hair

Rashes	Ulcerations	Hives	Itching
Eczema	Acne	Dandruff	Loss of Hair

Change in skin/hair texture? ____ Yes ____ No

Other hair/skin problems? _____

Head, Eyes, Ears, Nose, Throat

Grinding teeth	Recurrent Sore Throat	Facial Pain
Eye Strain	Teeth problems	Sores on lips or tongue
Poor hearing	Night Blindness	Jaw Clicks
Sinus Problems	Ringings in Ears	Glasses/Contacts
Dry Mouth	Nose Bleeds	Earaches
Eye Pain	Dry throat	Excess Mucus
Blurry vision	Poor Vision	Excess saliva
Dizziness	Cataracts	Glaucoma
Gum problems	Migraines	Spots in eyes
Macular Degeneration		

Sleep

Cannot Fall Asleep	Excess Sleep	Tired Upon Waking
Wake up to easily ____ x/night	Cannot get back to sleep after waking	
Tossing and turning during sleep	Snoring	Lots of dreams

Appetite

Large	Average	None	Snacks between meals
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Patient Name: _____ DOB: _____

Office Use:

Practitioner Initials: _____ Date of visit: _____

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Sweat

Easily perspires

Rarely perspires

Night Sweats

Temperature

Feeling of heat? Where? _____

Feeling of Coldness? Where? _____

Alternating Chills and Feverishness? _____

	None	A little	Some	A Lot
Fruits & Veggies				
Meat				
Dairy				
Fast Food				
Soda/Caffeine				
Sugar				
Gluten				
Cigarettes				
Drugs				
Exercise				
Alcohol				

Patient Name: _____ DOB: _____

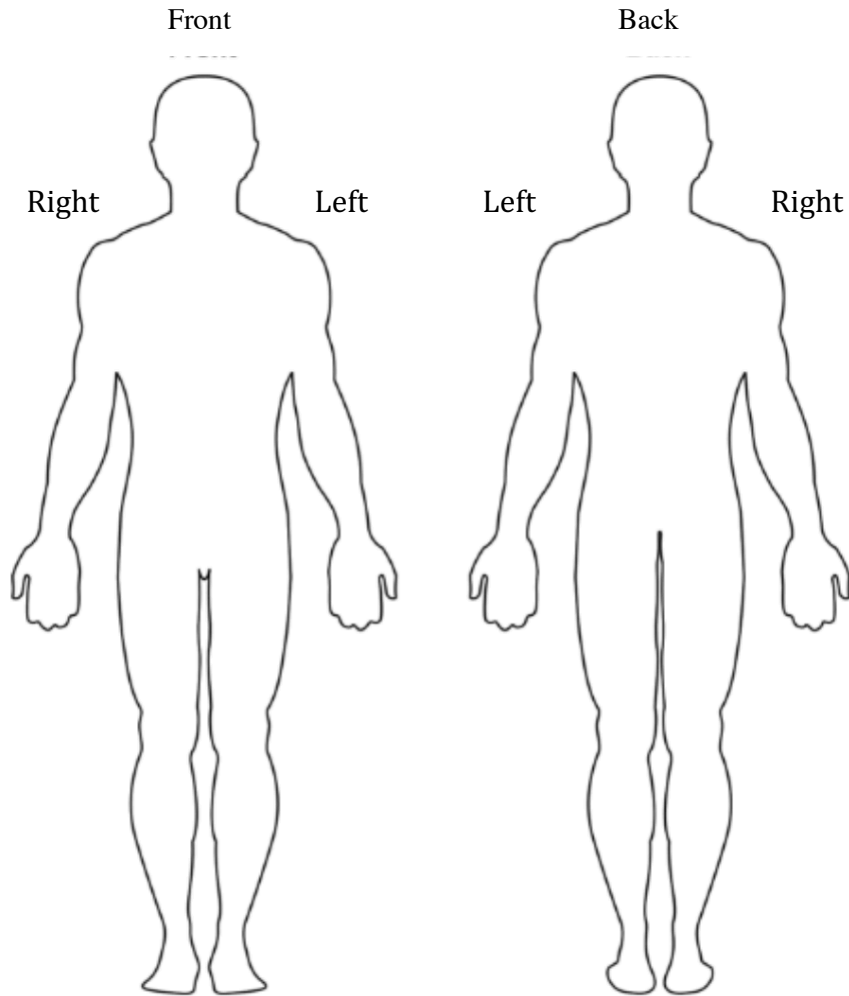
Office Use:

Practitioner Initials: _____ Date of visit: _____

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Indicate the areas you are feeling pain or discomfort:



Patient Signature: _____ Date: _____

Print Name: _____

Office Use:

Practitioner Initials: _____ Date of visit: _____

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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.

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

VIBRANT LIVING ACUPUNCTURE / VIBRANT LIVING COMMUNITY ACUPUNCTURE
Chet Franklin EAMP

Informed Consent:

I hereby voluntarily request and consent to the performance of acupuncture treatments and other Traditional Asian Medicine procedures, including various modes of physio- therapy on me (or on patient named below, for whom I am legally responsible) by Chet Franklin licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist at Vibrant Living Acupuncture LLC. I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Shiatsu (Japanese massage), gua sha, and Chinese herbs.

I have had the opportunity to discuss with Chet Franklin EAMP the nature and purpose or acupuncture treatments and other procedures. Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that there is no guarantee in the efficacy of the treatments. I understand that these treatments may result in certain side effects, not limited to local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, infection, and cellulitis. I have read the information on this page and understand the possible risk involved.

Collaboration with Just For The Health Of It: Vibrant Living Acupuncture LLC has a collaborative agreement with Just For The Health Of It. Patients of Vibrant Living Acupuncture LLC agree to release information not limited to patient charts and exams, intakes, and insurance information to and from Just For The Health Of It. Patient charts created at Vibrant Living Acupuncture LLC will be retained by both Vibrant Living Acupuncture LLC and Just For The Health Of It. Signing of this document will constitute releasing of records from Vibrant Living Acupuncture LLC to Just For The Health Of It.

Nondiscrimination: We embrace and we welcome all identities including those based on race, gender, socioeconomic status, gender-identity, ability, national origin, sexuality, relational status, education, veteran status, or age.

Payment of fees: Payment is due at time of service unless payment is being made with insurance. Patients are responsible for checking their own benefits/coverage and knowing their copay and deductibles. If your insurance fails to pay, you will be charge the full fee for service. Your acupuncturist may choose to reschedule your appointment if you are unable to pay. We do not accept 3rd party claims or put liens on 3rd party claims. If you run out of insurance benefits through medical or PIP, you are responsible for payment of fees.

No show/late cancel policy: A no show or late cancelation (less than 24 hours' notice) will be charged a \$25 fee. We understand there may be circumstances that arise that are not under your control and emergencies may come up. Those situations will be handled on a case-by-case basis and the fee may be waved.

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Services: I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me and are inserted according to clean procedures based on nationally prescribed standards. I understand I have the right to refuse any procedure.

The herbs and supplements that have been recommended are traditionally considered safe in Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any reactions to the herbs I will inform the acupuncturist. It is my decision whether or not to follow dietary or herbal supplement recommendations.

I understand Vibrant Living Acupuncture LLC and Just For The Health Of It have a collaborative agreement for release of medical records which makes it easier for patients to be seen by both business. I consent to release information including chart notes and medical records between both Vibrant Living Acupuncture LLC and Just For The Health Of It.	<div style="display: flex; justify-content: space-around; align-items: center;"><div style="text-align: center;"><hr style="width: 100px; border: 0; border-top: 1px solid black; margin-bottom: 5px;"/><div>Yes</div></div><div style="text-align: center;"><hr style="width: 100px; border: 0; border-top: 1px solid black; margin-bottom: 5px;"/><div>No</div></div></div> <p style="text-align: center;"><i>(Please Initial)</i></p>
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I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-name procedures. 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 Signature: _____ Date: _____

Office Signature: _____ Date: _____