Mosaic Healing Arts
Dr. Brooke Baggett
DACM, MTCM, L.Ac

PERSONAL INFORMATION (PLEASE PRINT)

PATIENT NAME: (First/Last)	DOB:

Street Address:

City, ST, Zip:

Primary Phone:

Email:

Gender: ☐ M ☐ F | Marital Status: ☐ S ☐ M ☐ D ☐ W | Occupation:

Emergency Contact: Phone:

Who may we thank for referring you to our office?

POLICIES

You are important to us, and we appreciate the opportunity to serve in your healing process. To provide the best possible outcomes for all, we appreciate you reading and understanding our policies below:

Cancellations and Missed Appointment Policy: We are a small business with limited time and space. To serve potential patients and compensate for lost revenue, **we require a minimum of 48 hours' notice**. If you are unable to keep your appointment, we respectfully ask that you provide a minimum of 48 hours' notice. ***The full appointment fee will be assessed if there is failure to do so or if the appointment is missed.***

Insurance Policy: Mosaic Healing Arts does not participate in any HMO or PPO network plans. You are solely responsible for checking your medical plan for coverage. Please be sure to check if your plan covers our services. For acupuncture sessions, we can provide a superbill receipt that may be used to obtain reimbursement from insurance carriers.

Late arrival Policy: Late arrivals result in delayed treatment for other patients. If you arrive more than 10 minutes past your appointment time, but still wish to be treated, you will receive an abbreviated treatment, and will be charged the full amount.

Payment Policy: Payment is due at the time of service. To avoid processing fees, we prefer cash or check, however, we do accept the following forms of payment: Credit/Debit, HSA/FSA cards, and pay-over-time with AFFIRM (flexible payment plans, including options as low as 0% APR).

NOTICE: By signing below, I authorize that I have read, understood, and agreed to the terms and conditions contained in the above policies:

PATIENT SIGNATURE AND DATE **X**

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

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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 is 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT SIGNATURE AND DATE	**X**	
(Or Patient Representative)	(Indicate relationship if signing for patient)	(Date)

MOSAIC HEALING ARTS SIGNATURE AND DATE	**X**	
		(Date)

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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 licensed acupuncturists of Mosaic Healing Arts 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 Mosaic Healing Arts, 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME (PRINT)

PATIENT SIGNATURE: **X**

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

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HEALTH HISTORY

This confidential health history packet provides vital information and helps determine the best plan of care for you.
Please PRINT clearly and answer each question completely and to the best of your knowledge.

PATIENT NAME (PRINT):

Reason for your visit today:

STRESS LEVEL: Please indicate your current stress level.

0	1	2	3	4	5	6	7	8	9	10
(Low)										(High)

PAIN ASSESSMENT: Are you currently in any physical pain? Please indicate your current pain level.

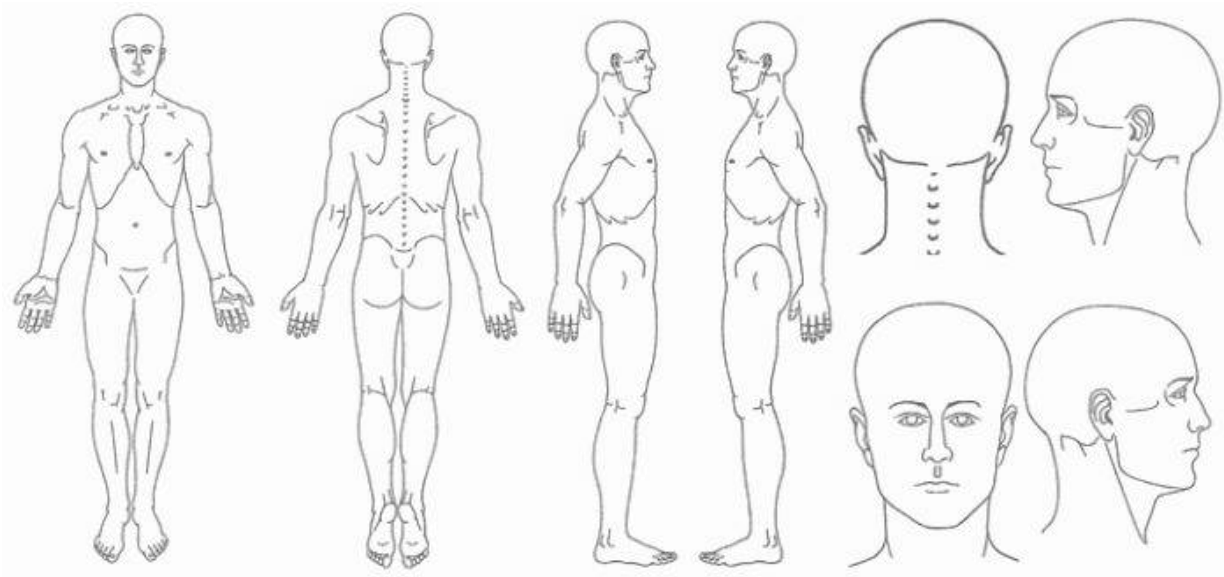
0	1	2	3	4	5	6	7	8	9	10
(Low)										(High)

How long have you been in pain?

What seems to make pain better and/or worse?

Please mark painful or distressed areas accordingly on the diagram below:

Pain Intensity			Swelling			Throbbing/Pulsing			Weakness/Temperature		Skin Issues
Slight	Moderate	Severe	Slight	Moderate	Severe	Slight	Moderate	Severe	Weak	Hot	
X	XX	XXX	^	^^	^^^	O	OO	OOO	~	+	*



CONDITIONS: Check the appropriate box if you have ever experienced any of the following conditions.

- ☐ Adrenal (fatigue, insufficiency)
- ☐ Adverse reaction to medical treatment
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis or rheumatism
- ☐ Artificial heart valves or joints
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Chemical dependency
- ☐ Dental Procedures (root canal, wisdom tooth extraction, etc.)
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Eye disorders
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver disorder
- ☐ Herpes
- ☐ High blood pressure
- ☐ Immune disorder (toxic exposures, vaccinations, etc.)
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Organ transplant
- ☐ Musculoskeletal disorder
- ☐ Pacemaker
- ☐ Respiratory disorder
- ☐ Rheumatic fever
- ☐ Scars or surgical sites
- ☐ Seizures/Epilepsy
- ☐ Skin disorders
- ☐ Special diet
- ☐ Stomach or intestinal disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Transfusion (before March 1985)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract disorder
- ☐ Venereal disease

Is there anything else we should know about your medical history?

MEDICATIONS & SUPPLEMENTS: Please check the box to indicate what you are currently taking.

- ☐ Antacids
- ☐ Aspirin
- ☐ Cold or Flu medications
- ☐ Diet pills
- ☐ Hay fever medication
- ☐ Herbs
- ☐ Ibuprofen
- ☐ Laxatives
- ☐ Oral contraceptives
- ☐ Sleeping pills
- ☐ Tranquilizers
- ☐ Vitamins

Please list any medication(s) you are currently taking that is/are not listed above:

Please list any allergies to medications you have:

HABITS: Please mark any of the habits listed below which apply to you. Mark an X for current habits. Mark a √ for past habits.

Tobacco use	☐ Yes	☐ No	If yes, # of cigarettes / day _____ Age started: _____
Alcohol use	☐ Yes	☐ No	If yes, # of drinks / week _____ Age started: _____
Caffeine use	☐ Yes	☐ No	If yes, # of soda / day _____ # of coffee / day _____ # of tea / day _____
Drug use	☐ Yes	☐ No	If yes, Type(s)/Amount _____ Age started: _____

EXERCISE: Please indicate your level of exercise activity.

☐ Sedentary	☐ Mild (climb stairs, walk 3 blocks, etc.)	☐ Occasional vigorous (workout, recreation less than 4x/week for 30 minutes)	☐ Reg Vigorous (workout/recreation 4x/week for 30 minutes)

OUTLOOK: How do you feel about the following areas of your life? Please indicate any problems you are experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Spouse/Significant other						
Family						
Diet						
Sex						
Self						
Work						

MAJOR HOSPITLIZATIONS: If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below. If you have had more than three (3) such hospitalizations check this box ☐. Do not include pregnancies.

1st Hospitalization_____
Year operation or illness hospital/city/state

2nd Hospitalization_____
Year operation or illness hospital/city/state

3rd Hospitalization_____
Year operation or illness hospital/city/state

WOMEN'S OBSTERIC HISTORY: Please fill in completely.

Total # of Pregnancies_____Living_____Ectopic(s)_____

Miscarriage(s)_____Induced Abortion(s): Nr and years_____

CURRENT CARE:

Are you currently under the care of a Medical Doctor? ☐ Yes ☐ No

Name of Medical Doctor:_____

Phone of Medical Doctor:_____

Date of Last Physical Exam:_____

Have you ever been treated with Acupuncture or Chinese Medicine? ☐ Yes ☐ No

Name of previous Acupuncturist:_____

What other forms of treatment have you sought for your current medical condition?_____

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SYMPTOMS: Please check the appropriate boxes below for any symptoms you have recently experienced.

HEAD & NECK
- ☐ Head
- ☐ Fainting
- ☐ Neck stiffness
- ☐ Enlarged lymph glands
- ☐ Headaches
- ☐ Other:

EARS
- ☐ Infection
- ☐ Pain
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Other:

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Spots
- ☐ Eye inflammation
- ☐ Other:

NOSE, THROAT, & MOUTH
- ☐ Bleeding
- ☐ Sinus infection
- ☐ Hay fever or allergies
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Changes in taste
- ☐ Changes in smell
- ☐ Oral ulcers
- ☐ Other:

SKIN
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Itching
- ☐ Night sweating
- ☐ Excessive sweating
- ☐ Dryness
- ☐ Bruise easily
- ☐ Changes in moles or lumps
- ☐ Other:

RESPIRATORY
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Difficulty breathing
- ☐ Wheezing/asthma
- ☐ Frequent colds
- ☐ Other:

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest pain or tightness
- ☐ Rapid heartbeat
- ☐ Irregular heartbeat
- ☐ Cold hands/feet
- ☐ Swelling of ankles
- ☐ Phlebitis
- ☐ Other:

GASTROINTESTINAL
- ☐ Indigestion
- ☐ Bloating
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Blood in stool or black stools
- ☐ Hemorrhoids
- ☐ Gall bladder disorder
- ☐ Recent change in weight
- ☐ Food cravings
- ☐ Other:

NEUROLOGICAL
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling of limbs
- ☐ Paralysis
- ☐ Other:

MUSCLE & JOINT
- ☐ Joint disorder
- ☐ Sore or painful muscles
- ☐ Weak muscles
- ☐ Difficulty walking
- ☐ Spinal curvature
- ☐ Backache or pain
- ☐ Other:

UROGENITAL
- ☐ Pain/itching of genitalia
- ☐ Genital lesions/discharge
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Excessive or scanty urination
- ☐ Blood in urine
- ☐ Diminished bladder control
- ☐ Other:

FEMALE
- ☐ Frequent urinary tract infections
- ☐ Frequent vaginal infections
- ☐ Pelvic inflammatory disease
- ☐ Abnormal Pap smear
- ☐ Uterine fibroids
- ☐ Irregular periods
- ☐ Painful menstrual periods
- ☐ Premenstrual Syndrome
- ☐ Abnormal bleeding
- ☐ Menopausal symptoms
- ☐ Breast pain
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Other:

- ☐ 1st day of last menstrual cycle:

- ☐ Date of last Pap smear:

- ☐ Are you pregnant? ☐ Yes ☐ No
- ☐ Are you nursing? ☐ Yes ☐ No
- ☐ Do you use birth control? ☐ Yes ☐ No

If yes, list type:

MALE
- ☐ Lumps in testicles
- ☐ Prostate problems
- ☐ Weak urinary stream
- ☐ Impotence
- ☐ Other:

OTHER
- ☐ Insomnia
- ☐ Frequent dreams/nightmares
- ☐ Anxiety
- ☐ Irritability
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Feel hot or cold
- ☐ Aversion to heat or cold
- ☐ Fever and or chills
- ☐ Thirst
- ☐ Psychiatric treatment
- ☐ Other:

Please list any other symptoms not covered above: