

MEDICAL HISTORY

Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No

How long have you had your current symptoms? _____

Are you under the care of a physician now? Yes No If yes, for what? _____
 Physician name: _____ Physician's phone: _____

Family Medical History (circle any that apply)

Allergies: (list)	Asthma	Cancer (type)	Heart Disease
_____	Alcoholism	_____	High Blood Pressure
_____	Depression	Diabetes (Type: _____)	Stroke

Your Medical History

(circle any of the following conditions you currently have, or have had in the past.)

AIDs/HIV	Diabetes (Type: _____)	Multiple Sclerosis	Surgery (List)
Alcoholism	Emphysema	Mumps	_____
Allergies	Epilepsy	Pacemaker (Date: _____)	_____
Appendicitis	Goiter	Pneumonia	_____
Arteriosclerosis	Gout	Polio	Thyroid disorders
Asthma	Heart disease	Rheumatic fever	Major trauma
Birth Trauma	Hepatitis (Type: _____)	Scarlet fever	(car accident, fall,...-list)
(your own birth)	Herpes (Type: _____)	Seizures	_____
Cancer	High Blood Pressure	Stroke	_____
Chicken pox	Measles		_____

Your Diet (circle all that apply)

Appetite: Low	Coffee/Tea	Sugar	Thirst for fluids
Normal	Soft Drinks/Fruit Juices	Protein Low	# glasses per day:
High	Artificial Sweeteners	Intake: High	_____

Average Daily Menu

Morning	Noon	Evening	Snack
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications/Supplements

(Please list all prescription medications and vitamins/supplements that you are currently taking)

Your Lifestyle

Alcohol	Marijuana	Regular Exercise	Frequency: _____
Tobacco	Drugs	Type: _____	Frequency: _____
		Type: _____	Frequency: _____

INFORMED CONSENT FOR TREATMENT
PLEASE READ BEFORE SIGNING

I hereby request and consent to be treated with Chinese herbal medicine by a practitioner who is a Licensed and Board Certified Acupuncturist in the state of Florida. If I wish to decline any form of treatment recommended by the practitioner, I have the right to do so.

I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may be 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 accept the fact that **no guarantee** is made concerning the outcome of my treatments with herbal medicine. I accept the fact that each combination of herbs is designed for my needs and my needs only, **and therefore I cannot receive a refund on any herbs or any services rendered.** I also understand that I may stop treatment at any time.

I have the right to refuse treatment; however, I must communicate this to the clinical staff **before** any herbal prescription has been filled for me; otherwise I will be obligated to pay for the herbs prescribed.

I will notify the practitioner if I am or become pregnant.

By signing below I show that I have read, or have had read to me, this consent to treatment, 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.

Patient's Name _____

Patient's Signature _____

Date Signed _____

To be completed by the patient's Guardian if the patient is a minor or is physically or legally incapacitated. The person who is given Power of Attorney over the patient, must sign these documents, be present at all appointments and must provide a copy of the Power of Attorney.

Print Name of Patient Guardian _____

Signature of Patient Guardian _____

Relationship or Authority of Patient _____

Payment must be made in full when service is rendered.

We accept Cash, Mastercard, Visa, and Discover

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. This notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature of patient or patient's Guardian

Date

Relationship to patient (if signed by a personal representative of patient)

OFFICE USE ONLY

I attempted to obtain the patient's signature on this HIPPA Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Ni's Chinese Medical Center
1250 W. Eau Gallie Blvd., Ste L, Melbourne (321) 757-9731
922 Lake Baldwin Lane, Ste C, Orlando (407) 237-0088

www.drboni.com
Email: office.drboni@gmail.com
Email: ORLOffice.drboni@gmail.com

FEES

INITIAL (NEW PATIENT) PHONE/SKYPE CONSULT	\$90
FOLLOWUP PHONE/SKYPE CONSULT	\$40

HERBS ARE AN ADDITIONAL COST. PRICES VARY AND WILL BE GIVEN TO YOU BEFORE THE RX IS FILLED. HERBS RANGE FROM \$30-\$300/WEEK. CREDIT CARD PAYMENT MUST BE MADE BEFORE HERBS ARE SHIPPED. SHIPPING & HANDLING CHARGES ARE BASED UPON WEIGHT OF SHIPMENT AND ARE NOT INCLUDED IN THE PRICE OF HERBS.

THERE ARE NO REFUNDS ON HERBS.

NI'S CHINESE MEDICAL CENTER RESERVES THE RIGHT TO REVISE THEIR FEES AT ANY TIME.

PLEASE SEND A PHOTO ID ALONG WITH YOUR FORMS.

Patient Signature

SKYPE/VIDEO/PHONE AGREEMENT & CONSENT

It is important that you understand the following limitations of Skype/video/phone contact, as well as expectations in using it for your consultations.

1. Any internet-based communication is not guaranteed to be secure/confidential. I agree that Dr. Bo-Shih Ni and Ni's Chinese Medical Center should not be held responsible in the event that any outside party passes Skype's security and discovers personal or confidential information.
2. There are precautions that you can take to increase security including:
 - a. Ensuring that you are online in a private area.
 - b. If possible, connect to the internet directly (as opposed to using Wi-Fi).
 - c. Make sure to turn Skype off, not just disconnect from the call when the session is over.
3. Make the same commitment to your online session that you would to an in-office appointment.
 - a. Don't be late. A courtesy reminder call will be made to you the day before.
 - b. Limit distractions – turn off cell phone, explain to others that you are unavailable for the next 10-15 minutes.
 - c. Check the audio/visual in the 'preferences' each time before a session so that you can see what Dr. Ni is seeing (and vice versa).
 - d. For Skype consultations, send a friend request to hantangni so Dr. Ni can accept and be prepared to make the Skype call as scheduled.
4. A Skype or phone session is subject to a 24-hour cancellation policy. You will be billed at full rate if you miss an appointment or you cancel without providing at least 24 hour notice.
5. Payment for each session is to be made prior to the scheduled session. When you schedule your appointment, the receptionist will request a credit card # to put on file to use for each session. MasterCard, Visa, and Discover are accepted. Health Insurance will not cover online/phone consultations. Your consultation will be charged to your credit card the day your appointment reminder call is made.
6. Before a session can begin, it is necessary to complete and email or mail the Skype/video/phone Agreement & Consent form.

Melbourne – 1250 W. Eau Gallie Blvd., Ste L, Melbourne, FL 32935
Email – office.drboni@gmail.com
7. Skype isn't right for everyone. Dr. Ni prefers to have patients, with severe internal disease, physically visit the office at least twice before conducting Skype/video/phone consultations. If you are experiencing an emergency, call 911 for help.

My signature below indicates that I have read the Skype, video & phone agreement and consent for Dr. Ni to conduct my health consultations via this form of media. I understand and agree to comply with the policies as they are described and acknowledge receipt of this agreement. I also understand that there is no guarantee on the outcome of my treatment using this form of consultation.

Patient Signature and Date

Skype Name or Phone #

