PATIENT INTAKE

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). You will notice that we ask questions about race/ethnic and social/lifestyle background. We ask this information as some health issues have a base in your genetic history. Your social history helps us tailor our care so you can successfully implement your treatment plan. Thank you for helping us to meet your needs.

PATIENT DEMOGRAPHICS		
Name: Last, First, MI:		Birth Date/Current Age:
SSN:	Race/Ethnicity:	Genetic Sex/Gender ID:
Mailing Address:		
Preferred Phone:	Cell Phone:	Work Phone:
Email:		
Emergency Contact Name/Phone:		
MEDICAL PRACITIONERS		
Primary Care:	Phone:	Fax:
Other, specify:	Phone:	Fax:
Other, specify:	Phone:	Fax:
SOCIAL HISTORY		
Occupation:		Hours Worked per Week:
Relationship Status:	Partner's Name/Phone:	

HEALTH HISTORY

Your health history is a valuable tool for both you and your provider. It will help us work together to see life-long health patterns and the impact of individual acute events (i.e., surgery, major illness). Please feel comfortable filling out the form completely and honestly. In our practice you are safe from judgment as we work to help you recover and maintain your health.

CURRENT CONCERNS

In order of importance, please identify the health concerns that brought you to the clinic today.

Condition	For How Long?	Successful past treatments?

ALLERGIES

List any foods, drugs, or medications you are hypersensitive or allergic to:

CURRENT MEDICATIONS & SUPPLEMENTS

List all medications (Prescribed & Over the Counter), herbs, vitamins and supplements you currently take:

MAJOR ILLNESSES, ACCIDENTS, HOSPITALIZATIONS & SURGERIES

Include incidents in childhood. Record from recent events working back to childhood.

Event: Date: Event: Date:

FAMILY MEDICAL HISTORY

Blood relatives including: siblings, parents, grandparents, aunts/uncles, 1st cousins. Mark with ***M*** for maternal Relatives and ***P*** for paternal relatives.

- □ Allergies_____
- □ Arteriosclerosis
- □ Cancer_____
- □ Heart Disease
- □ Diabetes
- □ Seizures
- □ Asthma
- □ Stroke
- □ Alcoholism
- □ High Blood Pressure
- □ Autoimmune disease_____
- □ Emotional/Psychological Disorder_____
- □ Other_____

LIFESTYLE

Current Weight: Current Height:

Which of the following is a part of your daily life?

- □ Exercise
  How many times a week?_____
- □ Relaxation/meditation
- □ Tobacco smoking/chewing
- □ Coffee/Caffeinated beverages
  How many cups per day?_____
- □ Alcohol
  How many drinks per week?_____
- □ Recreational drugs
- □ Dieting
- □ Stress
- □ Occupational hazards
- □ Other_____

SYMPTOM LIST

Please mark current symptoms with ***C*** and past symptoms with ***P***

Emotional & Mental

- □ Anxiety
- □ Depression
- □ Manic
- □ Bipolar
- □ Stress
  Rate stress level 1-10_____
- □ Frequent irritability
- □ Frequent anger
- □ Mood swings
- □ Anorexia
- □ Bulimia
- □ Frequent Worry
- □ Obsessive/Compulsive
- □ Chronic sadness/grief
- □ Overly fearful
- □ Addictions:
  (To what?):
  _____

SYMPTOM LIST continued…

Please mark current symptoms with ***C*** and past symptoms with ***P***

Immune & Inflammation

- □ Chronic Fatigue Syndrome
- □ Hashimoto's disease
- □ Grave's disease
- □ Arthritis_____
- □ Lupus
- □ Colitis
- □ Crohn's disease
- □ Fibromyalgia
- □ Frequent illness
- □ Frequent infection
- □ Hay fever
- □ Frequent swollen glands
- □ Cancer
- □ Hepatitis A, B or C
- □ Herpes (circle) Oral or Genital
- □ HPV
- □ HIV
- □ Chicken Pox
- □ Cold sores
- □ Mononucleosis
- □ Raynaud's Syndrome
- □ Connective tissue inflammation
- □ Food allergies
- □ Environmental allergies
- □ Seasonal allergies

Head, Eyes, Ears, Nose, Throat

- □ Impaired vision
- □ Blurry vision
- □ Eye pain/strain
- □ Glaucoma
- □ Dry eyes
- □ Red & painful eyes
- □ Watery eyes
- □ Impaired hearing
- □ Ear ringing/Tinnitus
- □ Earaches
- □ Nose bleeds
- □ Bleeding gums
- □ Runny nose
- □ Sinus problems
- □ Snoring
- □ Headaches
- □ Teeth grinding
- □ Toothache
- □ TMJ/Jaw problems
- □ Sore throat
- □ Dry mouth
- □ Dry throat

Gastrointestinal & Elimination

- □ Ulcers
- □ Increased appetite
- □ Decreased appetite
- □ Nausea/Vomiting
- □ Gas
- □ Abdominal pain
- □ Liver disease
- □ Heartburn/Acid reflux
- □ Belching
- □ Rectal bleeding
- □ Hemorrhoids
- □ Constipation
- □ Loose stools
- □ Diarrhea
- □ Irritable bowel
- □ Inflammatory bowel
- □ Polyps
- □ Leaky gut
- □ Indigestion
- □ Greasy foods upset
- □ Bloating after meals
- □ Discomfort after eating
- □ Discomfort relieved by eating
- □ Gallstones/ Gallbladder disease
- □ Undigested food in stools
- □ Urgency to defecate

___# of Bowel movements per day

Please circle type of BM: loose hard dry soft sticky (sticks to bowl) "normal"

Please circle color of BM: brown pale color green black bloody

Cardiovascular & Blood

- □ Irregular heartbeat
- □ Palpitations, Fluttering
- □ Chest pain
- □ Chest pressure or tightness
- □ Dizziness
- □ TIA/Stroke
- □ Heart murmurs
- □ Rheumatic Fever
- □ High LDL cholesterol
- □ Low HDL cholesterol
- □ High blood pressure
- □ Low blood pressure
- □ Cold hands/feet
- □ Hands & feet go to sleep easily
- □ Fast pulse (over 100 beats/min)
- □ Slow pulse (under 60 beats/min)
- □ Anemia
- □ Swelling of ankles
- □ Heart disease
- □ Heart attack
- □ Numbness
- □ Varicose veins

Endocrine

- □ Thyroid problems
- □ Diabetes Mellitus
- □ Hypoglycemia
- □ Feeling hot or cold
- □ Hypo adrenal

Neurological

- □ Seizures/Epilepsy
- □ Nerve pain
- □ Vertigo/Dizziness
- □ Paralysis
- □ Numbness/Tingling
- □ Loss of Balance

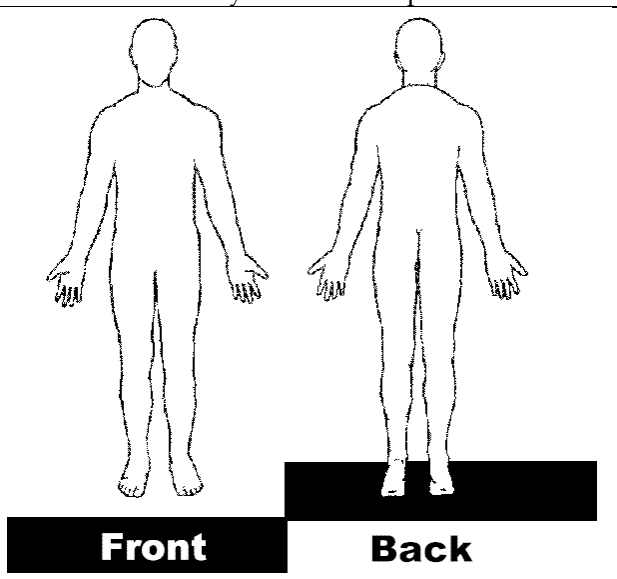
Respiratory

- □ Pneumonia
- □ Frequent colds & flu
- □ Wheezing
- □ Bronchitis
- □ Shortness of breath
- □ Persistent cough
- □ Pleurisy
- □ Asthma
- □ Tuberculosis
- □ Emphysema

Sleep & Energy	Skin	Urinary System	Blood Sugar Regulation
□ Insomnia □ Light sleeper/wake easily □ Can't fall back to sleep □ Fatigue □ Tired during day but awake at night □ Can't relax □ Poor memory □ Fuzzy thinking □ Sleep with pets (in room or in bed) □ Sleep Apnea □ Use a CPAP machine	□ Rashes □ Eczema □ Hives □ Rosacea □ Dandruff □ Fungal infections □ Warts □ Psoriasis □ Sweat easily during day □ Sweat easily at night □ Never sweat □ Itchy skin □ Dry skin □ Bruise easily □ Acne □ Boils	□ Kidney disease □ Painful urination □ Frequent urinary tract infection □ Frequent urination in general □ Frequent urination at night □ Impaired urination □ Urgency to urinate □ Lack of bladder control □ Kidney stones □ Blood in urine	□ Emotional eating □ Excessive appetite □ Hungry between meals □ Irritable before meals □ Get shaky if hungry □ Afternoon headaches □ Crave sweets in afternoon □ Compulsive eating □ Frequent dieting □ Frequent overeating

Musculoskeletal

Note any current bone, joint, muscle, tendon, or ligament problems. Please include: 1) Cause 2) Diagnosis 3) When problem started 4) Helpful Treatments: Shade areas of persistent pain on the diagram below.
Please circle here if you have osteoporosis.



ORAL HEALTH

Number of times you brush per day_____

Type of toothbrush: manual electric _____

Toothpaste:_____

Mouthwash:_____

Number of times you floss:_____

Date last dental cleaning:_____

Orthodontia dates:_____

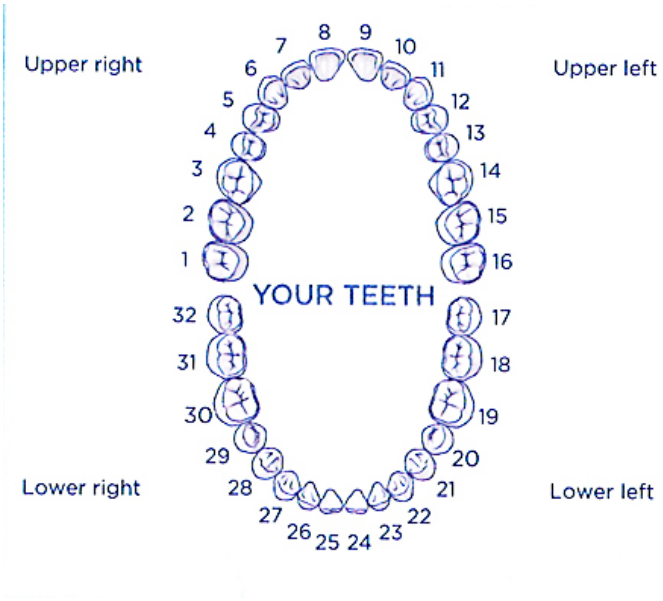
Dentures/Crown dates:_____

Oral Surgeries:_____

Tooth Sensitivities:_____

Wisdom Teeth: Intact Removed Failed to Form

On the diagram, mark fillings with an ***X.*** Mark crowns with a star. Mark root canals with ***RC***. Circle sore teeth or areas of concern.



VACCINATIONS

Please check the box and write the approximate year received next to each vaccination you have had:

- □ Hepatitis B (Hep B)
- □ Rotavirus (RV)
- □ Diphtheria, Tetanus, Pertussis (DTaP)
- □ Haemophilus Influenzae Type B (HIB)
- □ Pneumococcal
- □ Polio
- □ Influenza (Flu)
- □ Covid 'Vaccines' (circle manufacturer and list date(s) any injections were received, including boosters):
  Moderna, Pfizer, Johnson & Johnson; Dates:
  _____
  *Please note if you are aware of any adverse reactions your body had to ANY vaccines or injections you have received.
- □ Measles, Mumps Rubella (MMR)
- □ Varicella (VAR aka Chicken Pox)
- □ Hepatitis A (Hep A)
- □ Human Papillomavirus (HPV)
- □ Meningococcal
- □ Zoster (Shingles)
- □ Other (list):

FEEL FREE TO USE THIS SPACE (or a separate sheet) TO RECORD ANY ADDITIONAL INFORMATION YOU THINK SUMMER NEEDS TO KNOW:

SEX/GENDER SPECIFIC HISTORY

WOMEN'S HEALTH

- □ PMS symptoms
- □ Irregular/missed periods
- □ Painful periods
- □ Short cycles (<26 days)
- □ Long cycles (>35 days)
- □ Clots in menstrual blood
- □ Fatigue after menses
- □ Spotting between periods

Date of last period_____/_____

 # Days of bleeding _____

Color of blood:

bright dark pale

Type of blood:

light medium heavy

- □ Vaginal discharge
- □ Vaginal infections
- □ Uterine fibroids
- □ Endometriosis
- □ Ovarian Cyst
- □ Hysterectomy, when:

- □ Current or past sexual or physical abuse
- □ Sexually transmitted disease(s)
- □ Pain with intercourse
- □ Difficulty conceiving
- □ Pregnant now or trying to get pregnant

Current method of birth control:

_____

Past methods of birth control:

_____

_____

___# of Pregnancies, Dates: _____

___# of Births, Dates: _____

___# of Miscarriages, Dates: _____

___# of Abortions, Dates: _____

Note any complications during pregnancies, births, postpartum:

_____

_____

- □ Breast fibroids
- □ Breast lumps
- □ Breast pain
- □ Nipple discharge

Monthly breast exam?
Yes No

Last Pap Smear:

_____

Last mammogram or thermograph:

_____

(Note: Summer does not recommend mammograms based only on age

- □ Cancer:
  ovarian uterine
  breast cervical
- □ Menopause symptoms
- □ Hormone Replacement Therapy
- □ Decreased sexual energy
- □ Increased sexual energy

MEN'S HEALTH

- □ Prostate hypertrophy (BPH)
- □ Testicular pain/swelling
- □ Difficulty conceiving
- □ Penile discharge
- □ Cancer
  Prostate Testicular Breast
- □ Increased sexual energy
- □ Decreased sexual energy
- □ Sexual difficulties
- □ Current past sexual or physical abuse
- □ Sexually transmitted diseases

Thank you for providing us with your valuable health information. Taking the time to do a thorough health history is one of the first steps to reclaiming your health. If your health history changes from visit to visit, it is important to inform your provider.

Summer Waters, LAc, NTP, CGP

ACKOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

Name _____ Date _____

Address _____ Phone _____

I, _____, have received a copy of this office's HIPPA privacy notice.

Patient Signature _____

Patient Representative Name _____

Patient Representative Signature _____

* * * * * * * * * * * * * *

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Privacy Practices but acknowledgement could not be obtained because:

- □ Patient refused to sign
- □ Communication barriers prevented obtaining acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)

_____

PRICING and FINANCIAL POLICY

Service	*Fee*	*Hardship Scale*
Comprehensive Consultation for Chronic Conditions – includes initial 2-hour intake and 1-hr follow up consultation	$350	n/a
Initial New Patient/ Reinstatement Consultation (in-person or at-a-distance)	$240	n/a
Follow-up Consultation (in-person or at-a distance)	$120	$90 to $119

UNDERSTANDING THE HARDSHIP SLIDING FEE SCALE:

Summer recognizes that we are all governed to some extent by our personal economy. Unfortunately for many, one of the first areas to suffer is our healthcare. While cutting healthcare may reduce our budgets a little in the short term, in the long run it is very costly—we commonly develop chronic conditions and acute issues can worsen.

Summer wants you to take care of your health and to help you she developed a sliding fee scale. If you are under financial duress, you may choose to pay any amount between the lower sliding scale price listed on the fee schedule. If you feel you do not need the full hardship discount you may pay anywhere upwards of the base hardship fee. Unlike many medical practices, Summer does not require you provide documentation of your financial hardship. She trusts your integrity and knows you will only use the sliding fee scale if you need it. If a patient abuses the hardship sliding fee scale, Summer reserves the right to discontinue care.

MAKING PAYMENTS:

- *Payment for services and Wellness Shop items are due at or before time of service* (cash, check, credit or debit card)
- *Wellness Shop charges are separate from fees for service.*
- *No returns are allowed on compounded pharmacy items (tincture, creams, etc.), special orders, opened items, or potentially perishable items such as oils that may have been left in a hot car, at the sole discretion of Summer Waters.*
- *Please make all checks payable to Summer Waters, LLC.*
- *Visit www.SummerWaters.com/payments to make your payment online with Visa, Mastercard, American Express or Discover.*
- ***At-a-distance patients need to make their payment at least one day before their scheduled appointment** by visiting the link above and entering the required information. Proof of payment will be automatically received by our office.*

REINSTATEMENT CONSULTATION:

If a patient has not been seen by Summer for a consultation for one calendar year or is not currently enrolled in a SAVOR YOUR HEALTH program, the patient requires a reinstatement consultation. Our health is fluid and many aspects of it can change in a year. This reinstatement is to ensure Summer has the current health information necessary to optimize your treatment.

RETURNED CHECK AND OTHER FEES:

There is a $35 fee on all returned checks. This is to cover bank fees charged in the event of a returned check.

A $100.00 deposit is required to book an initial appointment. This nonrefundable deposit holds your scheduled appointment time and will be applied to your initial appointment rate. The initial appointment balance is due at the time of your initial appointment.

A valid credit card is required to be kept on file for any charges to be made for late cancellations, no-show appointments, and other approved charges. By signing below, you understand that it is your responsibility to notify us if your credit card information needs to be updated. Please see the section below for details.

LATE CANCELLATION AND NO-SHOW APPOINTMENT POLICY:

We require 36 business hours notice for cancellation or rescheduling of an appointment. Due to a limited number of available appointment spots for in-person patients, we require any Tuesday appointment cancellations be submitted by 4:00 p.m. Friday of the previous week. This allows us time to rebook for other patients who would like to get in sooner. Thank you for your understanding and cooperation. **All appointments cancelled with less than 36 business hours notice *are subject to a $50.00 fee.*** Out of consideration to other patients who would like to receive care, **all missed or "No-Show" appointments will be charged the full rate of the scheduled appointment.**
Call 541-326-8952 for any appointment cancelations or changes. **Do not cancel by email.** For information about cancellations or refunds on programs, please see the program materials.

I have read the above two-page PRICING AND FINANCIAL POLICY and understand, and hereby agree to the fee schedule and policy terms as stated.

Printed Name: _____

Signature Date

CREDIT CARD AUTHORIZATION FORM for Summer Waters, LLC

A valid credit card is required to be on file to receive care with Summer Waters, LLC.
Summer Waters, LLC, reserves the right to charge for late cancellation fees or missed appointments, as defined above. Please complete all fields in this form. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐Other Card #: _____
Cardholder Name (as shown on card): _____
Last 4 digits of Card Number: _____
Expiration Date (mm/yy): _____ CVV (3 Digit Code): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____,
authorize Summer Waters, LLC to charge my credit card, listed above, for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____
Customer Signature

_____
Date Signed

INFORMED CONSENT for TREATMENT

I, hereby request and consent to the performance of acupuncture treatments and other procedures that are within the scope of practice of acupuncture on me (or for the patient named below, for whom I am legally responsible) by Summer Waters, LAc., NTP, CGP. I understand that methods of treatment may include, but are not limited to, acupuncture, Far Infra-Red (FIR) heat therapy, Cranial Electrotherapy Stimulation (CES), Chinese herbal medicine, nutritional supplements, and lifestyle and nutritional counseling. I understand that I have the right to refuse any or all treatments recommended to me by Summer Waters, LAc, NTP, CGP.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Summer Waters, LAc, NTP, CGP, uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of heated lamp therapy. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

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 Summer Waters, LAc, NTP, CGP, of any unanticipated or unpleasant effects associated with the consumption of the herbs. 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 Summer Waters, LAc, NTP, CGP, if I am pregnant, become pregnant, or am trying to become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I agree to keep Summer Waters, LAc, NTP, CGP, informed of any changes in my medical condition. I do not expect Summer Waters, LAc, NTP, CGP, to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Summer Waters, LAc, NTP, CGP, to exercise judgment during the course of treatment she thinks at the time, based upon the facts then known, is in my best interest. I acknowledge that my condition and the potential benefits of acupuncture have been discussed with me. I have had the likelihood of success explained to me, and I understand that results are not guaranteed, and that my participation in my own treatment and quantity of treatments may significantly influence the outcome and results.

By voluntarily signing below, I show 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 also acknowledge that other treatment options have been presented to me. 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 or Patient Representative – including relationship if signing for patient — Date

BINDING 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 Oregon law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the health care practitioner, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care practitioner, and the practitioner's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care practitioner to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 parties within thirty days of a demand for a neutral arbitrator by either party. 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 counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately 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, which 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.

Article 4: **General Provisions**: 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 Oregon statute of limitations, or (2) the claimant fails to pursue the

BINDING ARBITRATION AGREEMENT Continued (pg. 2/2)

arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Oregon Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the health care practitioner within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____ Effective as of the date of first medical 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.

Patient Name Print

Patient Signature or Patient Representative – including relationship if signing for patient — Date

Practitioner Name Print

Practitioner Signature — Date