824 Main Avenue
701-232-2785
info@redriverhealth.com
R.A. Angotti, Lic. Ac., Herbalist

First Name ______________ Last Name ______________ Sex ______

Street Address ______________ City ______________ State ______ Zip Code ______

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email ______________ ☐ Clinic Newsletter Birthdate ______________

How did you find Red River Health ______________

Emergency Contact Name ______________ Relation ______________

Emergency Contact Phone Number ______________

Please put a check by those that apply, even if they appear more than once: ______

KD Y

- ○ Low back pain or soreness
- ○ Knee pain or soreness
- ○ Ringing in the ears
- ○ Dizziness
- ○ Early graying of hair
- ○ Vaginal dryness
- ○ Scanty cervical mucus with ovulation
- ○ Dark circles under the eyes
- ○ Night sweats
- ○ Hot flashes
- ○ Tendency towards being warm
- ○ Bladder disease or problems
- ○ Kidney disease or problems
- ○ Sugar in the urine
- ○ Blood in the urine
- ○ Frequent fears or phobias
- ○ Poor hearing
- ○ Ear infections
- ○ Bone disease or weakness
- ○ Teeth problems
- ○ Joint trouble
- ○ Neck pain
- ○ Weakness or pain of the legs
- ○ Excessive fears/phobias
- ○ Prior pregnancy
- ○ Miscarriages
- ○ Abortions
- ○ Contraception past or present
- ○ Infertility
- ○ Nocturnal emissions
- ○ Impotence

KD YA

- ○ Low back pain prior to menses
- ○ Cold feet, especially at night
- ○ Low libido
- ○ Morning urination
- ○ Frequent pale urination
- ○ Early morning BM loose and or urgent
- ○ Profuse vaginal discharge
- ○ Dull colored menstrual blood
- ○ Cold cramps with menstruation
- ○ Tendency towards being cold
- ○ Frequent fears or phobias

SP

- ○ Chronic fatigue
- ○ Poor appetite
- ○ Reduced energy after a meal
- ○ Distension after eating
- ○ Sugar cravings
- ○ Abdominal pains
- ○ Cold hands and feet
- ○ Cold nose
- ○ Feeling of heaviness or sluggishness
- ○ Bruise easily
- ○ Poor circulation
- ○ Varicose veins
- ○ Weakness in arms and legs
- ○ Insufficient exercise
- ○ Excessive worry
- ○ Low blood pressure
- ○ Spontaneous sweating
- ○ Dizziness or lightheadedness or visual changes when standing
- ○ Thin, watery menstruation with pink color

SP

- ○ Fatigue with ovulation and or menstruation
- ○ Spotting prior to period
- ○ Diagnosis of uterine prolapse
- ○ Bearing down sensation with menstrual cramps
- ○ Frequent colds or allergies
- ○ Diagnosis of hypothyroid or anemia
- ○ Frequent belching
- ○ Abdominal distension
- ○ Excess hunger
- ○ Frequent loose stools
- ○ Frequent constipation
- ○ Hemorrhoids
- ○ Diabetes
- ○ Weight changes and or eating disorders
- ○ Bleeding between periods
- ○ Heavy menstruation

LU

- ○ Tuberculosis
- ○ Emphysema
- ○ Asthma
- ○ Throat problems
- ○ Allergies
- ○ Sinus problems
- ○ Frequent colds
- ○ Tobacco use
- ○ Excessive sadness or crying
- ○ Spontaneous sweating

BLD

- ○ Scanty or late menstruation
- ○ Dryness or flakiness of the skin
- ○ Chapped lips
- ○ Brittle nails or hair

- ○ Loss of head hair
- ○ Poor nighttime vision
- ○ Dizziness or lightheadedness around period
- ○ Blurred vision
- ○ Floaters
- ○ Poor memory
- ○ Poor concentration

BL ST

- ○ Black or brown menstrual flow
- ○ Pain around ovaries during ovulation
- ○ Painful, unmovable breast lumps
- ○ Numbness of hands and feet at night
- ○ Varicose or spider veins
- ○ Red spots or cherry spots on skin
- ○ Chronic hemorrhoids
- ○ Clotted menses
- ○ Endometriosis or uterine fibroids
- ○ Abnormal lumps in abdomen
- ○ Piercing or stabbing pain with menses
- ○ Vascular abnormalities
- ○ Strokes
- ○ Rheumatism
- ○ Pain with intercourse
- ○ Convulsions

LV

- ○ Emotional depression
- ○ Anger or rage
- ○ Premenstrual irritability
- ○ Distension or bloating at ovulation
- ○ Prolonged ovulation
- ○ Breast tenderness during menstruation
- ○ Diagnosis of elevated prolactin levels
- ○ Premenstrual bloating or distension
- ○ Difficulty falling asleep
- ○ Heartburn or bitter taste in the mouth
- ○ Painful menstruation
- ○ Cramping of the external genitals with menstruation
- ○ Thick and dark menstrual blood with purple color
- ○ Gallbladder problems
- ○ Liver disease
- ○ Jaundice
- ○ Red or irritated eyes
- ○ Glaucoma or cataract
- ○ Alcoholism
- ○ Drug use or abuse
- ○ Pain or discomfort with stress
- ○ Difficulty making decisions
- ○ Missed periods
- ○ Frequent or severe headaches
- ○ Pain before menstruation
- ○ Leg cramps while walking
- ○ Breast swelling
- ○ Painful breasts
- ○ Prostate trouble
- ○ Painful testicles

HT

- ○ Wake early in am with difficulty falling asleep
- ○ Heart palpitations especially when anxious
- ○ Nightmares
- ○ Low in spirit or vitality
- ○ Agitated or restless
- ○ Fidgety
- ○ Chronic hemorrhoids
- ○ Excessive sweating
- ○ Heart disease
- ○ High blood pressure
- ○ Low blood pressure
- ○ Shortness of breath after mild exercise
- ○ Irregular or rapid heartbeat
- ○ Awareness of heartbeat or palpitations
- ○ Pain in the chest
- ○ Abnormal EKG
- ○ Swelling in ankles and feet
- ○ Shortness of breath at night
- ○ Mental illness
- ○ Anxiety or nervousness
- ○ Insomnia, excessive dreams
- ○ Dry mouth or throat
- ○ Thirst for cold fluids
- ○ Warmer than those around you
- ○ Wake sweating or with hot flashes
- ○ Premenstrual acne which is red
- ○ Vaginal irritation or rashes
- ○ Pain or burning sensation with urination

DP

- ○ Tired or sluggish after a meal
- ○ Fibrocystic breasts
- ○ Cystic or pustular acne
- ○ Urgent, bright or strong smelling stools
- ○ Stringy tissue or mucus in menses
- ○ Yeast infections and vaginal itching
- ○ Achy joints
- ○ Excess weight
- ○ Leucorrhea

DP HT

- ○ Fowl smelling, yellow or green vaginal discharge
- ○ Vaginal or rectal itching during premenstrual phase
- ○ Syphilis
- ○ Gonorrhea
- ○ Gout
- ○ Goiter

- ○ Current Pregnancy
- ○ Family member with diabetes
- ○ Family member with cancer/tumor
- ○ Family member with high blood pressure
- ○ Family member with tuberculosis
- ○ Family member with heart disease

Chief Complaints:

Western Medical Diagnosis

Occupation:

Members in Household:

Medications: *(Name, dosage, frequency)*

Supplements: *(Name, dosage frequency)*

Surgeries: *Type, date, doctor*

Informed Consent to Treat and Arbitration Agreement (page 1 of 2)

Patient Name:________________________________

I consent to acupuncture and other procedures associated with Traditional Chinese Medicine by Licensed acupuncturist Robert Angotti of Red River Health. I have discussed the nature and purpose of my treatment with Robert Angotti.

I understand that methods of treatment include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needle sites that may last for a few days, and dizziness or fainting. I understand that bruising is a common side effect of cupping. I understand that the unusual risks of acupuncture include spontaneous miscarriage, nerve damage or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although I understand that Red River Health uses needles contained in sterile bubble wrap until the time of use, and all needles are disposed of in biohazard waste containers never to be reused. I understand that burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I understand that the herbal and nutritional supplements (from plant, animal and mineral sources) which are prescribed have traditionally been considered safe in the practice of Traditional Chinese Medicine, although some can be toxic in large doses. I understand that Red River Health uses manufactured herbal products from reputable companies dedicated to maintaining standards in accordance with the Good Manufacturing Practice certification of the Department of Health, Republic of China and the Commonwealth Department of Health, Australia. I understand that Red River Health maintains a pharmacy of raw herbs of which the 50 most commonly prescribed herbs have been tested for heavy metals, pesticides, and fungicides prior to shipping.

I understand that some herbs may be inappropriate during pregnancy, and that some possible side effects of herbs may include nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. I understand the herbs may have an unpleasant smell or taste. I will immediately notify Red River Health of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Red River Health if I become pregnant.

I do not expect Red River Health to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Robert Angotti L. Ac. to exercise judgment during the course of treatment as to what best suits my interests.

I understand that all my records will be kept confidential and will not be released without my written consent unless the release is specifically authorized by law. I also understand that I may receive a copy of my records from Red River Health at any time assuming a reasonable cost.

By voluntarily signing below I show that I have read, or have had read to me, this 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 intend this consent form to cover the entire course or treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or by patient's representative if the patient is a minor or is physically or legally incapacitated).

____
PRINT NAME OF PATIENT

____
SIGNATURE OF PRACTITIONER

____
PRINT NAME OF PATIENT REPRESENTATIVE (if applicable)

____
DATE OF SIGNATURE

____
SIGNATURE OF PATIENT OR REPRESENTATIVE

Arbitration Agreement (page 2 of 2)

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 or arbitration proceedings. Both parties to his 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 are instead accepting the use of arbitration.

ARTICLE 2: All Claims Must be Arbitrated – It is 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 these 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 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 healthcare 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.

ARTICLE 3: Procedure 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 thirties 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 issue of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in the 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 partiers 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 preceding. A claim shall be waived and forever barred if (1) on the date notice therof is received, the claim, if asserted in 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 their 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 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 effected 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 OR 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 SIGNATURE______________________________________ DATE _________________________

(Or patient representative) (Indicate relationship if you are signing for patient)

Patient's Consent For The Purposes of Treatment, Payment And HealthCare Operations

I ______________________________give consent to Red River Health to use and disclosure of my Individual Identifiable Health Information or Protected Health Information for only these specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:

Protected Health Information is any information that includes;

1. Demographic Information
2. Information gathered by this practice as it relates to my past, present and future.
3. Information gathered by this office for past, present or future payments for providing the healthcare services.
4. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

Signature of Patient or Personal Representative date______________________________

Description of Personal Representative's Authority _______________ date ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. Red River Health has attempted to provide each patient with a statement of Privacy Policies.

Patient's Signature__________________________________Date_________________

Cancelation and Missed Appointment Policy

Our goal is to provide you with our highest quality of care. We want you to benefit fully from your treatment plan. This requires a commitment from both you and us to schedule the recommended treatments and to be fully present during these treatments. We understand that at times, appointments will need to be cancelled, due to a variety of reasons. Because we accept this reality, we need a **minimal** notice of 24 hours for all cancelled appointments. A 48-hour notice is preferred as it gives us time to utilize our wait list and help other patients get the treatments they need.

Without adequate notice on cancelled appointments, we cannot run an efficient and effective practice. For this reason, we uphold a strict policy that **all appointments cancelled less than 24-hour in advance will be charged a $39.00 fee***. This includes missed appointments.

By signing this form, I agree to pay $39.00 for any appointments cancelled less than 24-hours in advance of the scheduled appointment, as well as for missed appointments.

____

Print Name

____ _______________

Signature Date

*This policy does not apply to treatment package gift certificates. Appointments that are part of a gift certificate package are prepaid, thus are not refundable.