The Axelrad Clinic

for Natural Hormonal and Reproductive Wellness

19 Briar Hollow Lane, Suite 240, Houston, TX 77027 / 4840 W. Panther Creek, Suite 208, The Woodlands, TX 77381
Tel: 713.527.9555 Fax: 713-422-2418 Web: www.axelradclinic.com

Welcome Letter

Dear New Patient,

I'd like to take a moment to welcome you as a new patient of The Axelrad Clinic. Thank you for choosing us. We look forward to partnering with you to address your health concerns, and we will do all we can to ensure you achieve the most successful result possible for you.

The trust and confidence you have placed in us is most appreciated. We see many patients which respond favorably to acupuncture care. Our mission is to help you achieve your treatment goals, and to maintain optimal health over the long-term using safe, natural and holistic acupuncture, herbal therapy (when appropriate), and nutritional guidance and support.

Traditional Chinese Medicine, the ancient health care system of which acupuncture is a part, definitely works.

1. It can help prevent illness and disease
2. It activates the self-healing and self-regulating abilities of the body.
3. It adjusts and balances the flow of vital life energy, called Qi.
4. It can help you achieve optimal health, vitality, and well-being.

The precious gift of health is an investment that takes both time and money. In order to help you to get the most out of this worthwhile investment I would like to share a few suggestions:

1. **Be on time and keep your appointments.** Each treatment builds upon previous ones. It is important to follow through with your future care plan in order to receive maximum benefit.
2. **Do your homework.** In many ways what you do at home, at work and at play affects your progress. We offer suggestions and self-care techniques to support you on the road to your treatment goals toward a life of increased wellness and vitality.
3. **Give it time.** As with any medical treatment, healing with acupuncture is a process, not a magic pill. It takes time and is influenced by many factors. Over time, things should improve and if necessary, we will adjust your treatment plan as we proceed. Changes to your condition can happen faster than anticipated, so enjoy them!
4. **Keep a positive attitude and EXPECT positive results**. As we follow through on your treatment plan, look for signs of improvement and take encouragement from them. Build an attitude that **expects** positive results and **knows** that profound healing is possible. Your belief and expectation has an **incredibly** strong influence on your body, and is a key factor in healing.

It is a great pleasure to welcome you to the clinic!

Yours in Health and Wellness,

Chris Axelrad, M.S.O.M., L. Ac., FABORM
Executive Director
The Axelrad Clinic for Natural Hormonal and Reproductive Wellness
www.axelradclinic.com
Houston, TX 77027

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Welcome Letter for Fertility Patients

Dear New Patient,

I want to salute your courage and dedication. The desire to have a child is one of the most optimistic things a person can do on this Earth. I understand and empathize with how difficult it can be when this incredibly optimistic and positive hope suddenly becomes mixed with desperation and disappointment. I want to encourage you to discuss your feelings about your situation during our visits. I promise I and my staff will listen with an attentive ear and will do whatever we can to ease your journey through what can be a very difficult time.

Your fertility quest is an investment that takes both time and money. In order to help you to get the most out of this worthwhile investment I would like to share a few additional suggestions not covered in the general welcome letter:

1. **Try to follow the program as closely as you can.** We try our best to keep the suggestions we make both practical and efficient. At the end of the day, your choices and priorities will guide you best. However, there will be certain changes we will suggest that will be very important. We will make sure you understand which ones these are, and we strongly encourage you to make sure you follow these important suggestions to the letter – they are born out of much study and experience working with many, many people such as yourself.
2. **Take a break from thinking about getting pregnant for six months.** I know that sounds strange, but I really do want you to let go of your pregnancy goal a little bit. This does not mean you will stop having intercourse, and it does not mean that you won't get pregnant soon. We will be doing targeted nutritional supplementation, herbal support, and Acupuncture therapy to balance and harmonize your endocrine system. I want you to have a simple trust that the positive changes in your mind and body are definite indicators that you are more fertile. Treat the sixth month like it is the first month. Do not think of the sixth month as a deadline. We will re-evaluate at the end of six months if you are still not pregnant to see what the next steps will be. Until that time, relax and enjoy the process of self-care that you will be undertaking.
3. **Plan fun things and enjoy life as much as possible.** Think of things you like to do, that are fun for you. It may help to think back to childhood to things that you enjoyed doing. Pick one or two things and make them regular occasions. For instance, if you really enjoyed playing tennis as a child or young adult, start playing tennis again. If you were an avid camper, plan a camping trip soon. Anything you can do to relieve stress and increase pleasure is good. Your body takes cues from your mind about what to do, and when you take time for enjoyment and fun, your body relaxes and feels safe. This can do nothing but help it express its reproductive intelligence.

It is a great pleasure to welcome you to the clinic!

Yours in Health and Wellness,

Chris Axelrad, M.S.O.M., L. Ac., FABORM
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PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:		
Street Address:		City:	State:	Zip:
Home Phone:	Business Phone:		Mobile Phone:	
Email Address:		Skype name (remote patients only):		

RECONFIRMATIONS: We will contact you one business day prior to your scheduled appointment with a reminder. Please check your preferred method of contact (choose one): ☐ Home Phone ☐ Business Phone ☐ Mobile Phone ☐ Email

Birth Date (mm/dd/yyyy):	Current Age:	Height:	Weight:	Gender: ☐ M ☐ F
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		Number of Children:	Ages of Children:	
Employer's Name and Address:		Occupation:		
Personal Physician's Name (and address if available):			Month/Year of last doctor visit:	

Emergency Contact Name:	Phone Number(s):	Relationship to You:

Have you ever had acupuncture before? ☐ Y ☐ N	Who can we thank for referring you? ☐ A friend ☐ A physician ☐ Another healthcare practitioner Name: _____

If you were not referred by someone you know, how did you find out about us?

☐ Printed advertisement (in: _____) ☐ Online search engine (name? _____)

☐ Printed brochure (from where: _____) ☐ Other: _____

I understand that I should be evaluated by a physician for the condition that I am currently seeking treatment for. Treatment at The Axelrad Clinic is done using the system of Traditional Chinese Medicine and its treatment methods Acupuncture, Chinese Herbs, Food Therapy, and Medical Qigong. The methods and advice offered at the clinic shall not be construed by the client to be a substitute for Western Medicine, nor shall they be construed or offered as a medical diagnosis or treatment of any disease or injury.

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders. I understand that complications may result from acupuncture treatment. Among these possible complications are: Areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. I further understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

I also understand that if I am currently under the care of or receiving concurrent treatment from a physician, it is my responsibility to inform said physician of any herbal products that I am taking as part of my treatment with this clinic.

Signed:_____ Date _____

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Medical History Form

Name (Last, First, Middle)	Date

How long have you been trying to conceive?
_____ ☐ days ☐ weeks ☐ months ☐ years

Who have you consulted with up to this point? (check all that apply)
☐ OB/GYN ☐ Fertility Specialist ☐ Acupuncturist ☐ Nutritionist
☐ Other: .....

Please check any medical diagnosis that has been given in relation to your fertility:

- ☐ Unexplained infertility
- ☐ Poor egg quality
- ☐ High FSH/Poor Ovarian Reserve
- ☐ Uterine fibroids
- ☐ Premature Ovarian Failure
- ☐ PCOS/Polycystic Ovaries
- ☐ Blocked tubes
- ☐ Uterine abnormalities
- ☐ No tubes
- ☐ Male factor
- ☐ Asherman's Syndrome
- ☐ Hormone insufficiency (hypogonadism)

Please check any treatments that have already been done: ☐ IVF ☐ IUI ☐ Natural cycle with clomid or injectables
If you checked any of the above, please note the number of treatments:

IVF: _____ cycles IUI: _____ cycles Natural w/medication: _____ cycles Month/year of last cycle: _____

Are you planning to do another IVF/IUI/medicated cycle? ☐ Yes ☐ No If yes, indicate month/year of anticipated start of cycle: _____

Name of fertility doctor (if applicable):

List any medications and supplements you are currently taking (use separate sheet if needed):

Name	Dosage	How often	Taking since

Please list any major surgeries, accidents, or injuries you have had:

Date	Description

Significant illnesses in your or your family's history (check all that apply):

- ☐ Allergies
- ☐ Asthma
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Blood clotting disorders
- ☐Autoimmune Disease
- ☐ Gallstones
- ☐ Cancer
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ Heart disease
- ☐ Herpes
- ☐ Connective Tissue Disease
- ☐ Pneumonia
- ☐ Eye disorders
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Drug addiction
- ☐ Liver Disease
- ☐ Ulcers
- ☐Hepatitis B or C
- ☐ HIV/AIDS
- ☐ Spinal injury/problem
- ☐ Neurological Disease
- ☐ Venereal Disease

☐ Other:

List all known food, drug, environmental allergies:

.....

.....

Please describe anything else you want us to know about your case:

.....

.....

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Current Symptom Profile

Last name First name Middle Initial

Please check any of the following symptoms that you currently have or have had recently:

Habits:
· Cigarettes · Soft Drinks
· Salt · Coffee · Alcohol
· Recreational Drugs
· Black Tea · Sugar · Stress
· Artificial Sweeteners
· Marijuana · Occupational Hazards
· Other: _____

Exercise:
☐ Never · Little · Moderate
· Heavy
Type of Exercise:
_____

How often:
_____

Emotional:
I would generally describe myself as (check all that apply):
· Happy · Easy going · Restless
· Irritable · Indecisive · Angry
· Cry easily · In a hurry
· Depressed · Stressed out
☐ Difficulty expressing emotion
☐ Short attention span
· Other: _____

Appetite:
· Up and down · Poor · Good
· Hungry all the time · Loss of taste
· Normal

Cravings:
· Sweets · Salty · Spicy · Sour
· None

Weight:
· Underweight · Overweight · Normal
· Recent gain · Recent loss
If recent gain or loss, how much?
_____
Since what date? month / year

Energy:
· Up and down · Low · Excessive
· Low after eating
· Tired in the afternoon · Normal
· Other _____

Body temperature:
· Warm natured · Flushed face
· Feel warm late afternoon and night
· Sweat Easily · Night Sweats
· Chill easily / feel cold / aversion to cold
· Feel hot / aversion to heat
· Warm Palms / Soles
· Cold hands and feet
· Normal
· Other _____

Digestion:
· Indigestion · Bloating · Heartburn
· Nausea · Vomiting · Full feeling
· Belch or burp · Gas
· Abdominal pain or cramps
· Difficulty digesting fatty or oily foods
· Bitter taste in mouth · Gallstones
· Normal
· Other _____

Bowels:
Frequency of Bowel movement:
_____ per ☐ day ☐ week
☐ Loose stool ☐ Diarrhea
☐ Hemorrhoids ☐ Constipation
☐ Colon problems ☐ Pain or cramps
☐ Use laxatives
· Normal
☐ Other _____

Urination:
Frequency of urination:
_____ times per day
Color:
☐ clear ☐ light yellow ☐yellow
☐ bright yellow ☐ dark
Symptoms:
☐ Burning · Bladder infections
· Urgency · Nighttime
· Incontinence
· Kidney stones or infections
· None

Thirst:
· Normal · Excessive
· Thirsty but do not drink
# of drinks (glasses) per day _____
I prefer my drinks:
☐ cold ☐ warm/hot ☐ room temperature

Sleep:
Falling asleep:
☐ Easy ☐ Avg ☐ Difficult
Staying asleep:
☐ Easy ☐ Avg ☐ Difficult
Waking up:
☐ Easy ☐ Avg ☐ Difficult
Sleep quality
(check all that apply):
· Restless
· Lots of dreams
· Easily awakened
· Nightmares
· Difficulty falling back to sleep
Bedtime _____
Wake time _____
# of times you wake up in middle of the night: _____

Cardiovascular
· Diagnosed heart problems
· Palpitations · Bleed easily
· Low blood pressure
· High blood pressure
· High cholesterol · Murmur
· Varicose veins · Ankle swelling
· Chest pain · Bruise easily
· Hand swelling
· Irregular heart beat
· Normal
· Other: _____

Headaches / dizziness:
· Headaches · Migraines
· Vertigo · Dizziness
· Motion sickness
· Poor balance
· Faint easily
· Poor memory
· None
· Other _____

Skin:
· Dry · Hives · Itching
· Oily · Acne · Rashes
· Bruise easily · Eczema
· Cuts heal slowly
· Normal
· Other _____

Hair:
· Dry · Oily · Dandruff
· Falling out · Early grey
· Normal
· Other _____

Nails:
· Soft · Spots · Ridges/ lines
· Grow slowly · Grow fast
· Purple · Pale
· Break easily
· Normal
· Other _____

Ears:
· Poor hearing
· Ringing (high pitch)
· Ringing (low pitch)
· Discharges · Ear aches
· Normal
· Other _____

Eyes:
· Wear glasses or contacts
· Eyelids swollen
· Dry · Itch · Twitch
· Poor night vision
· Light-sensitive
· Color blindness
· Tear easily · Normal
· Other _____

Nose:
· Stuffy nose · Hayfever
· Sneeze a lot · Bleeding
· Loss of smell
· Sinusitis · Rhinitis
· Normal
· Other _____

Mouth and throat:
· Dry · Gum problems
· Frequent colds · TMJ
· Feel lump in throat
· Thyroid problems
· Grind teeth · Normal
· Other _____

Respiratory:
· Shortness of breath
· Difficulty inhaling
· Sigh a lot · Dry cough
· Cough w/phlegm
· Asthma · Bronchitis
· Emphysema · Wheezing
· Cough with blood
· Tightness in chest
· Normal
· Other _____

Pain:
☐ Neck ☐ Back ☐ Shoulder
☐ Sciatica ☐ Hands ☐ Wrists
☐ Cramps ☐ Hips ☐ Knees
☐ Cold or Damp weather
☐ Foot/ankle ☐ Spine
☐ Arthritis ☐ Flank area
· None
☐ Other _____

Please enter any other relevant information that you think we need to know about:

.....

.....

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Gynecological History

Last name	First name	Middle initial

Are you or might you be pregnant? ☐ Yes ☐ No ☐ Not sure
If yes or not sure, approximate date of conception: _____

Do you currently use birth control? ☐ Yes ☐ No
If yes, what method are you currently using? _____
If no, have you used birth control in the past? ☐ Yes ☐ No
If yes, what method did you previously use? _____

Menstrual cycle history

Age started _____ Days of flow _____ Age stopped _____

Do you have IRREGULAR periods? ☐ Yes ☐ No
Number of days between periods? _____ days
Date your last period started __/__/_____

Premenstrual symptoms
Premenstrual symptoms usually start _____ days before my period.

Premenstrual symptoms include (check all that apply):
· Depression · Insomnia · Moodiness · Irritability · Cry easily
· Water Retention · Abdominal bloating · Cramping
· Painful or tender breasts · Breast lumps
· Feeling of lump in throat · Constipation and/or diarrhea
· Tightness in chest · Backache · Sigh a lot
☐ Cravings .....

☐ Other .....

.....

Menstruation (period)

Cramping:
Do you experience cramping during your period?
☐ Always ☐ Never ☐ Sometimes

If yes, how severe? ☐ Mild ☐ Moderate ☐ Severe
For how may days? _____

Flow/color:
Flow is generally: · Light ☐ Moderate · Heavy
Beginning of period: · Light ☐ Moderate · Heavy
Middle of period: · Light ☐ Moderate · Heavy
End of period: · Light ☐ Moderate · Heavy

The color is generally: ☐ Red ☐ Bright red ☐ Dark ☐ Pale red
Are there clots? ☐ Always ☐ Never ☐ Sometimes
Do you spot/bleed between periods? ☐ Always ☐ Never ☐ Sometimes

☐ Other .....

.....

Post menstruation

Are you tired after your period? ☐ Always ☐ Never ☐ Sometimes
Briefly describe any other symptoms you feel after your period ends:

.....

.....

Ovulation symptoms

Do you feel when you are ovulating? ☐ Yes ☐ No
Ovulation symptoms usually start _____ days after my period ends.
Describe ovulation symptoms:

.....

Vaginal discharge: ☐ None ☐ White ☐ Yellow

Current sex drive: ☐ Below normal ☐ Normal ☐ Above normal
Do you experience pain during intercourse? ☐ Yes ☐ No

Do you have regular PAP tests? ☐ Yes ☐ No
Last PAP test: month / year

Do you have regular breast exams? ☐ Yes ☐ No
Last breast exam: month / year

Do you have facial hair or excess body hair? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following:
☐ Polycystic Ovaries ☐ Premature Ovarian Failure ☐ Uterine abnormalities
☐ Endometriosis ☐ Pelvic Inflammatory Disease ☐ Uterine Fibroids

Pregnancies:
Total number _____ Number of miscarriages _____
Number of children _____ Number of therapeutic abortions _____

Pregnancy or childbirth complications (please describe):

.....

.....

Gynecological operations

Date	Operation
_____	_____
_____	_____
_____	_____
_____	_____

Gynecological medications taken within last year other than birth control

Date	Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Female Fertility Questionnaire

Last name	First name	Middle initial

Have you had any tests to check if your fallopian tubes are open? ☐ Yes ☐ No

If you answered Yes to the above, please indicate when test was performed: _____ (month/year or just year is OK)
Also, please indicate if the tubes were open or not: ☐ Open ☐ Blocked

If the tubes were blocked, was any treatment done? ☐ Yes ☐ No If treatment was done, please describe below:

……

Has a doctor ever found evidence of scarring or damage to the inside of your uterus or fallopian tubes? ☐ Yes ☐ No

On average, I have intercouse with my partner ____ times a ☐ month ☐ week.

Please check all methods you have used during your time trying to conceive:
☐ BBT (Basal Body Temperature) charting
☐ Ovulation predictor kits
☐ Electronic fertility monitor (i.e. Clear Blue, others)
☐ None
☐ Other: _____

Has your husband had a sperm analysis done? ☐ Yes ☐ No If analysis was done, please describe what you know about the results below:

……

……

Has your husband had a vasectomy reversal? ☐ Yes ☐ No

Please write out any other concerns related to your fertility that you feel are important:

……

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Eating Habits Profile

Please fill out this page as completely as possible.

Meals

Meal	Do you eat this meal on most days? (check one)	Approximate time of day	A general list of foods you eat at this meal
Breakfast	☐ Yes ☐ No		
Lunch	☐ Yes ☐ No		
Dinner	☐ Yes ☐ No		

Snacks

Approximate time	Types of foods eaten

Foods

Food type	**How often?**
Sodas (including diet sodas)	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Fried foods (french fries, fried chicken, etc…)	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Multiple cups of coffee in same day	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Donuts, ice cream, cookies, cake	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Milk and cheese	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Meat products (beef / chicken / pork (not fish))	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Shellfish (shrimp / crab / etc.)	☐ Every day ☐ Most days ☐ Occasionally ☐ Never
Deep-ocean fish (salmon / tuna / sea bass / etc.)	☐ Every day ☐ Most days ☐ Occasionally ☐ Never

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Clinic Policies

In order to maintain the quality of care at the clinic, we have instituted a number of policies, which are outlined below. Before becoming a new patient at the clinic, please initial each point and sign at the bottom. The cancellation policy is described in a separate document enclosed in this package:

_____ **Diversity**: The Axelrad Clinic does not discriminate based upon age, gender, race, religion, sexual orientation, health status or the ability to pay. We hope you will join us in honoring diversity.

_____ **Confidentiality**: I agree to maintain the confidentiality of all other patients of the clinic. Our staff will maintain your confidentiality by not acknowledging you outside of the clinic unless you first acknowledge them.

_____**Late Arrival**: As a courtesy to other patients, we regret that late arrivals will not receive an extension of the scheduled appointment time, thus your treatment will be shortened. If you arrive late by 20 minutes or more, we reserve the right to deny treatment and charge the 50% no show fee.

_____**Appropriate Dress**: Please wear or bring loose comfortable clothing, you will not need to undress. Most common points are located below the elbows and knees and on the abdomen, so access to those areas is crucial. Shorts or pants with leg opening that fit comfortable over the knee are recommended. One-piece dresses are not recommended.

_____ **Identifying Information**: I understand that any published research will not contain identifying information and that my medical record will not be released with out my written consent.

_____**Needle safety**: During acupuncture, I agree to remain lying down during treatment and not to remove or manipulate the acupuncture pins.

_____ **Etiquette**: I agree not to come into the clinic under the influence of alcohol or non-prescribed drugs. I agree to turn any cell phone/pager to silent mode. I agree to respect other patient's relaxation and will keep conversation to a minimum when in the treatment room. I understand that if my behavior does not comply with the policy of the clinic that I may be refused or released from treatment by The Axelrad Clinic until I agree to comply.

_____**Payment**: I understand payment is expected at time of visit. The Axelrad Clinic accepts cash, credit cards, or checks. We do not accept insurance, but will be happy to provide you with documentation of your treatment that you may file with your insurance company.

Please indicate your preference below:
I would like to receive, by mail and/or email, health information, newsletters and announcements from The Axelrad Clinic:
__ Yes __ No (check one)

I have read, or have had read to me, the above clinic policy. I have had an opportunity to ask questions and by signing below I agree to the above.

_____
Patient or Patient Representative (Print)

_____
Signature Date

_____
Relation to patient (if not patient)

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ACUPUNCTURE INFORMED CONSENT TO TREAT

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 acupuncturist named below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, 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, Tiu-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 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 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 the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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.

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 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 or Patient Representative (Print)

_____
Signature Date

_____
Relation to patient (if not patient)

The Axelrad Clinic

for Natural Hormonal and Reproductive Wellness

19 Briar Hollow Lane, Suite 240, Houston, TX 77027 / 4840 W. Panther Creek, Suite 208, The Woodlands, TX 77381

Tel: 713.527.9555 Fax: 713-422-2418 Web: www.axelradclinic.com

Patient Acknowledgement of Privacy Policy

I understand that I have the right to review the document "Axelrad Clinic, LLC – Notice of Privacy Policy" prior to signing this document. This notice has been provided to me in my intake packet.

The Notice of Privacy Policy (Notice) describes the types of uses and disclosures of my "protected health information (PHI)" that will occur in my treatment, payment of bills, or in the performance of healthcare operations of this clinic. My protected health information means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this clinic or its agents or employees. PHI is information that relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI.

By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Policy, and acknowledge receipt of the Notice.

PLEASE NOTE: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will NEVER be discussed, verbally or in writing, with anyone but you or your spouse. We will only disclose information to others (i.e. family members, other physicians, etc…) once we have obtained your express written permission. If you wish to keep your information private from your spouse as well, please indicate below.

___ I wish to keep my PHI (protected health information) private from my spouse.

_____

Patient or Patient Representative (Print)

_____

Signature Date

_____

Relation to patient (if not patient)

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Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of Licensee; Discipline of Licensee) and Texas Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the acupuncturist Christopher Axelrad of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

(check one) _____ Yes _____ No Initials of patient _____ Date _____

I have received a referral from my chiropractor within the last 30 days for acupuncture.

(check one) _____ Yes _____ No Initials of patient _____ Date _____

After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

_____
Patient or Patient Representative (Print)

_____
Signature Date

_____
Relation to patient (if not patient)

Exemptions according to rule **183.6 (e) Scope of Practice**

3) …an acupuncturist holding a current and valid license may without an evaluation or referral from a physician, dentist, or chiropractor perform acupuncture on a person for ***smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse***.

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Cancellation Policy

Please read this portion carefully. It outlines the scheduling and payment policy of The Axelrad Clinic. If you have questions or concerns about this policy, please feel free to contact us for clarification.

Why this policy exists: This policy ensures quality service and patient convenience at the clinic. By complying with this policy, you help our patient community enjoy professional, efficient, effective service.

All appointment cancellations must be made by 5pm one business day prior to your scheduled appointment time. Failure to do so results in the following:

Package Rate Missed Appointment Policy:

Package Rate appointments cancelled after 5pm one business day prior to a scheduled appointment will be forfeited and may not be rescheduled.

Per-Session Missed Appointment Policy

Per Session Rate appointments cancelled after 5pm one business day prior to a scheduled appointment will be billed at the full appointment fee.

How we charge for missed per-session appointments: The Axelrad Clinic sends notice via email of the charge. If no email address is on file for the patient, we attempt to contact the patient via phone to advise of the charge. Whether or not we successfully contact the patient, the charge is made to the patient's account on file.

How we collect the fees for missed appointments: The Axelrad Clinic uses reasonable means to collect any missed appointment fees, including contacting the patient via phone, email or regular U.S. Mail. Additionally, the clinic may use legal means of collecting a debt to obtain payment for the outstanding charge, such as hiring a collection agency to collect payment for delinquent accounts.

When we expect payment for missed appointments: Payments for missed appointments are expected within 30 days of the missed appointment, or at your next visit, whichever comes first. If not remitted after 30 days, collection action, as outlined in the previous paragraph, may be initiated.

By signing below, I acknowledge receipt of this Cancellation Policy. By signing this form, I acknowledge my agreement with all aspects of this policy and I authorize the Axelrad Clinic to bill me if I do not give appropriate cancellation notice as outlined in this Cancellation Policy.

Signature: _____ Date: _____

Patient Name (printed): _____

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Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your "protected health information (PHI)" including but not limited to, carrying out treatment, payment, healthcare operations and how you can gain access to such information. Your PHI is any of your written and oral health information that can be used to identify you, including demographic data. This is PHI that is created or received by Axelrad Clinic, LLC (ACCM). This notice is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA).

I. Uses and Disclosures of PHI

ACCM may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting healthcare operations. By applying to be treated by ACCM, you are implying consent to the use and disclosure of your PHI by our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing healthcare to you. The following are examples of the types of uses and disclosures of your protected healthcare information ACCM will make based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

A. Treatment

ACCM will use and disclose your protected healthcare information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party for treatment purposes. For example, we may disclose your PHI to another healthcare practitioner who may be treating you or consulting with your physician with respect to your care. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Furthermore, ACCM may from time-to-time disclose your PHI to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment

Your PHI will be used, as needed, to obtain payment for your healthcare services at ACCM. This may include certain communications to your health insurer to get approval for the treatment that ACCM recommends. ACCM may also disclose PHI to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered by your health plan. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations

ACCM may use or disclose, as needed, your PHI in order to support our business activities and to provide quality care to all patients. Healthcare operations include, but are not limited to, quality assessment activities, employee review activities and training in which students, trainees, or practitioners in healthcare learn under supervision, reviewing and auditing, including compliance reviews, medical reviews, legal services, business management and general administrative activities. As part of treatment, payment and healthcare operations, ACCM may also use or disclose your PHI including, but not limited to, reminders of appointments, with a third party "business associate" that performs various activities for the practice, to inform you of health-related benefits, products, or services that may be of interest to you, to contact you to raise funds for the practice or an institutional foundation related to the practice. ACCM may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you brochures or newsletters about our practice and the services that we offer. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that contains terms that will protect the privacy of your PHI. If you do not wish to be contacted regarding fundraising, or other such marketing practices, please contact our Privacy Officer, and include request in writing.

II. Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your PHI, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then ACCM may, using professional judgment, will determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your healthcare will be disclosed.

A. Others Involved In Your Healthcare

Unless you object, ACCM may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, ACCM may disclose such information as necessary based on our professional judgment and determined to be in your best interest. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of location, general condition, or death.

B. Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include,

1. Required By Law

ACCM may disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, worker's compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

2. Coroners, Funeral Directors, and Organ Donation

ACCM may disclose PHI to a coroner or medical examiner, funeral director, or organ procurement organization in limited circumstances.

3. Research

ACCM may use or disclose your PHI for research only in those limited circumstances not requiring your written authorization, such as those, which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

4. Military Activity and National Security

ACCM may disclose military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

III. Uses and Disclosures Which You Authorize

ACCM will not disclose your health information other than with your written consent. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

IV. Your Rights

The following are your rights regarding your protected health information.

A. The right to inspect and copy your PHI

In most cases you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Official. Please contact our Privacy Official regarding our copying fees.

B. The right to request a restriction on uses and disclosures on PHI

You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Official.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location

You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

D. The right to have ACCM amend your PHI

You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the written requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Official with any further questions about amending your medical record.

E. The right to receive accounting

You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Uses and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12- month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 14, 2003. If you request a disclosure accounting more than once in a 12 — month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Official regarding these fees.

V. Complaints

You have the right to express complaints to the practice and Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to ACCM by contacting the Privacy Official verbally or in writing using the contact information below. You will not be retaliated in any way for filing a complaint; hence we encourage you to express any concerns regarding the privacy of your information.

VI. Privacy Official

ACCM's contact person for all issues regarding patient/client privacy and your rights under the Federal privacy standards is the Privacy Official. Information regarding matters covered by this notice can be requested by contacting the Privacy Official. Complaints against ACCM can be mailed to the Privacy Official by sending it to:

Axelrad Clinic, LLC

4544 Post Oak Place, Suite 4544

Houston, TX 77027

ATTN: Privacy Official

713-527-9555

VII. Our Responsibilites

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment to you. ACCM is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions of reasonable desires. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. If ACCM changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in—person contact.