



Valencie Exceus, AP, DOM

Acupuncture Physician, Doctor of Oriental Medicine
3500 N. State Road 7, Suite 440 Lauderdale Lakes, FL 33319
954.390.0411

This is a CONFIDENTIAL questionnaire to help determine the best treatment for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition.

PERSONAL INFORMATION

First Name _____ Last Name _____ Age ____ Today's Date _____

Home Address _____

City _____ State _____ Zip Code _____

Email _____ Date of Birth _____ Social Security _____

Cell Phone _____ Home Phone _____ Work Phone _____

Occupation _____ How did you hear about us? _____

Emergency Contact: Name _____ Contact Phone _____

Have you been treated with acupuncture before? ____ Yes ____ No If Yes, Where and When? _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):

____ Hepatitis ____ HIV ____ High Blood Pressure ____ Seizures ____ Pacemaker ____ Blood-Thinning Medications ____ Pregnant

Please describe the reason for the visit today (The Chief Complaint) _____

How long have you had this condition? _____

What seems to be the initial cause? _____

What seems to make it worse? _____

What seems to make it better? _____

Does it affect your ____ Sleep ____ Work ____ Other (please list) _____

What is your health goal? _____

INSURANCE

Insurance company _____ Contact # _____

ID or Subscriber # _____

List any past or future surgeries. _____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in: _____

Signs/Symptoms

- | | | | | |
|---|---|---|---|---|
| <input type="radio"/> Abdominal pain/distention | <input type="radio"/> Coughing blood | <input type="radio"/> Hemorrhoids | <input type="radio"/> Mucous in stools | <input type="radio"/> Seizures |
| <input type="radio"/> Abuse survivor | <input type="radio"/> Dark stools | <input type="radio"/> Heart palpitations | <input type="radio"/> Muscle cramps/pain | <input type="radio"/> Seeing a therapist |
| <input type="radio"/> Acid regurgitation | <input type="radio"/> Decreased libido | <input type="radio"/> Hiccup | <input type="radio"/> Nasal congestion | <input type="radio"/> Short temper |
| <input type="radio"/> Acne | <input type="radio"/> Depression | <input type="radio"/> High blood pressure | <input type="radio"/> Neck/shoulder pain | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Asthma | <input type="radio"/> Dizziness/vertigo | <input type="radio"/> Impotence | <input type="radio"/> Night sweat | <input type="radio"/> Sinus pressure |
| <input type="radio"/> Bad breath | <input type="radio"/> Dry throat/mouth | <input type="radio"/> Increased libido | <input type="radio"/> Nocturnal emission | <input type="radio"/> Skin fungal infection |
| <input type="radio"/> Blood in stools | <input type="radio"/> Diarrhea | <input type="radio"/> Indigestion | <input type="radio"/> Nose bleeds | <input type="radio"/> Spots in eyes |
| <input type="radio"/> Blood in urine | <input type="radio"/> Ear aches | <input type="radio"/> Intestinal pain/cramps | <input type="radio"/> Numbness | <input type="radio"/> Sweat easily |
| <input type="radio"/> Blurry vision | <input type="radio"/> Enlarged thyroid | <input type="radio"/> Irritable | <input type="radio"/> Odorous stools | <input type="radio"/> Sore throat |
| <input type="radio"/> Breast lump/pain | <input type="radio"/> Eye pain/strain/tension | <input type="radio"/> Itchy eyes | <input type="radio"/> Pain upon urination | <input type="radio"/> Sudden energy drop |
| <input type="radio"/> Bruise easily | <input type="radio"/> Excessive phlegm | <input type="radio"/> Itchy skin | <input type="radio"/> Peculiar tastes | <input type="radio"/> Swollen glands |
| <input type="radio"/> Chest pains | <input type="radio"/> Color of | <input type="radio"/> Joint pain | <input type="radio"/> Poor appetite | <input type="radio"/> Teeth/gum problems |
| <input type="radio"/> Chills | <input type="radio"/> Excessive saliva | <input type="radio"/> Kidney stones | <input type="radio"/> Poor circulation | <input type="radio"/> Ulcerations |
| <input type="radio"/> Cold hands/feet | <input type="radio"/> Fatigue | <input type="radio"/> Laxative use | <input type="radio"/> Poor memory | <input type="radio"/> Upper back pain |
| <input type="radio"/> Concussion | <input type="radio"/> Fever | <input type="radio"/> Limited range of motion | <input type="radio"/> Poor sleep | <input type="radio"/> Urgent urination |
| <input type="radio"/> Confusion | <input type="radio"/> Frequent urination | <input type="radio"/> Loss of hair | <input type="radio"/> Premature ejaculation | <input type="radio"/> Vomiting |
| <input type="radio"/> Constipation | <input type="radio"/> Gas/belching | <input type="radio"/> Low back pain | <input type="radio"/> Psoriasis | <input type="radio"/> Wake to urinate |
| <input type="radio"/> Cough | <input type="radio"/> Grinding teeth | <input type="radio"/> Migraine | <input type="radio"/> Rash | <input type="radio"/> Weight loss/gain |
| | <input type="radio"/> Headache | <input type="radio"/> Mouth sores | <input type="radio"/> Redness of eyes | <input type="radio"/> Wheezing |

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No
Have you ever been pregnant? Yes No Birth control? Yes No How long? _____
 PMS Clotting Vaginal sores Vaginal pain Discharge

Medical History

Do you have any allergies? Yes No If so, to what? _____
Do you take medication? Yes No If so what types and how often _____
Do you take supplements? Yes No If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

<input type="radio"/> Pneumonia	<input type="radio"/> Drug reaction	<input type="radio"/> Mental breakdown	<input type="radio"/> Gonorrhea/Herpes	<input type="radio"/> Cancer
<input type="radio"/> Tuberculosis	<input type="radio"/> Heart attack	<input type="radio"/> Jaundice	<input type="radio"/> HIV/Aids	<input type="radio"/> Mental illness
<input type="radio"/> Hepatitis	<input type="radio"/> Blood transfusion	<input type="radio"/> Parasites	<input type="radio"/> High/low blood pressure	<input type="radio"/> Hypo/hyper thyroid
<input type="radio"/> Diabetes	<input type="radio"/> Anemia	<input type="radio"/> Measles	<input type="radio"/> Heart disease	<input type="radio"/> Premature graying
<input type="radio"/> Epilepsy	<input type="radio"/> Arthritis	<input type="radio"/> Mumps	<input type="radio"/> Gout	<input type="radio"/> Seizures
<input type="radio"/> Kidney Stone	<input type="radio"/> Obesity	<input type="radio"/> Syphilis		<input type="radio"/> Multiple Sclerosis

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____ Do you have a low point during the day? Yes No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

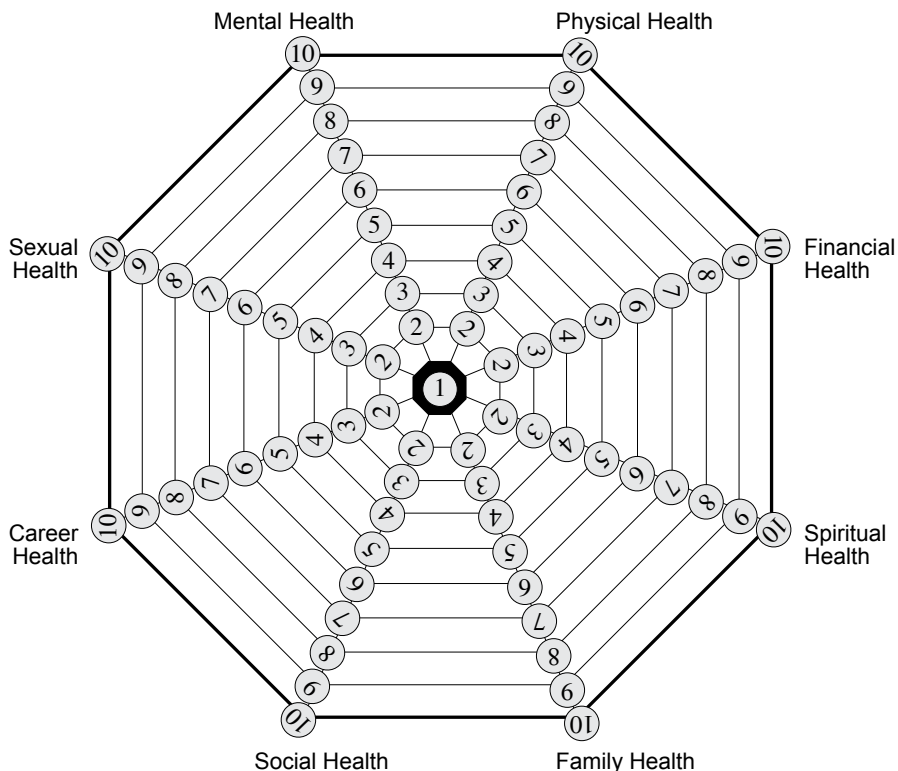
Web of Wellness

Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

- 1 = Not happy
- 10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work - Can do:

Usual work 25% of work 50% of Work No work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem on long trips Moderate pain on trips Severe pain

Recreation - Can do:

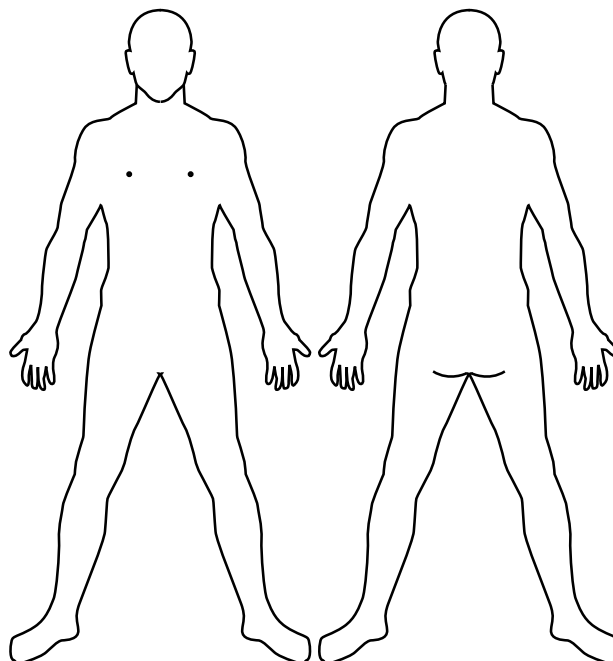
All activities Some activities No activities

Walking

Can walk any distance Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



Acute Care

Obvious symptoms and signs

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care

Symptom and signs disappear

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care

You feel great

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) _____ (date) _____

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Highpoint Healing and Wellness, Inc.

As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your, protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare providers providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we may provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you \$0.83 per page for the first 30 pages and \$0.63 per page for every page after that plus \$19.00 for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Valencie Exceus, AP
Telephone: (954) 390-0411
Address: 3500 North State Road 7, Suite 440
City, State, Zip: Lauderdale Lakes, FL 33319

I have read and understood the HIPPA privacy policies of Highpoint Healing and Wellness, Inc.

Patient's Name (printed)

Patient's Signature

Date

(If under 18)

Parent or legal guardian (printed) Representative's Signature

Relationship

HIGHPOINT HEALING AND WELLNESS, INC, 954-390-0411, WWW.HIGHPOINTHEALING.COM
3500 NORTH STATE ROAD 7, SUITE 440, LAUDERDALE LAKES, FL 33319

INFORMED CONSENT TO CARE AND TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine (Traditional Chinese Medicine) procedures, including various physical modalities, on me (or, on the patient named below, for whom I am legally responsible) by licensed acupuncturists who now or in the future treat me while employed by or associated with or serving as a back-up in the offices of Highpoint Healing and Wellness, Inc.

Nature of Treatment: I understand that methods of treatment may include, but not limited to, acupuncture, moxibustion (moxa), cupping, electrical or magnetic stimulation, acupressure, Tuina (Chinese medical massage), dermal friction (Gua Sha), infra-red (heat lamps), sonopuncture (sound stimulation), cold laser, herbal therapy, Biopuncture injections with vitamins and homeopathic solutions, therapeutic exercises, food therapy and dietary counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: I understand that the purpose of the treatment is to resolve my complaint, i.e. the reason I am seeking treatment. Traditional Chinese Medicine is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment: I understand that acupuncture, moxibustion, electrical stimulation, cupping, pricking, and injections are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage, organ puncture, including lung puncture (pneumothorax). Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and guasha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I understand that this document describes the major risks of treatment, other side effects and risks may occur.

I understand that herbs and nutritional supplements (which are from plant, animal, and mineral sources) recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process. Additionally, I will inform my acupuncturist if I have severe bleeding disorders or if I am wearing a pacemaker or other electronic medical device.

HIGHPOINT HEALING AND WELLNESS, INC, 954-390-0411, www.AcupunctureFortLauderdale.com

3500 NORTH STATE ROAD 7, SUITE 440, LAUDERDALE LAKES, FL 33319

Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I recognized that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. The second time and each time thereafter that I fail to give the required 24 hours notice of cancellation, I will be responsible for the full fee of the missed appointment. I understand that insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge that any inherent risks, or give my consent for treatment and healthcare operations received, incurred or carried out at this practice.

Consent

I request and consent to the performance of acupuncture and Oriental Medicine procedure. I consent to receive treatment that involves the above procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read or have read to me this consent form, and understand the preceding information regarding my treatment. I understand the possible risks and complications involved. I have had the opportunity to discuss the consent form with my Acupuncture Physician. I understand that I can request more information at any time if desired. I understand that if I have any questions about this information, I should ask my acupuncturist. I hereby release my acupuncturist and Highpoint Healing and Wellness, Inc. any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I have the right to refuse or discontinue any treatment at any time. I understand that refusal or discontinuation of treatment should be done in writing and will be kept in my medical file. I understand this refusal may affect the expected results. I intend for 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 (printed)	Patient's Signature	Date

<i>(If under 18)</i> _____	_____	_____
Parent or legal guardian (printed)	Representative's Signature	Relationship

DIRECTIONS

We are located at 3500 North State Road 7, Suite 440 in Lauderdale Lakes, on the east side of State Road 7 (also called 441, the sign may say SR7) between Oakland Park Boulevard and Commercial Boulevard, much closer to Oakland Park Blvd. Our building is called the World Executive Center, it is a four story building.
We are on the fourth floor.

From I-95 Northbound: Take the Oakland Park Blvd. WEST exit (31B) to State Road 7 (SR7). Make a right on State Road 7. After you cross the 34th Street light, look for the four stories 3500 building on the right side.
It's called the World Executive Center.

From I-95 Southbound: Take the Oakland Park Blvd Exit (31), stay on the right lane to head west. Make a right on State Road 7. After you cross the 34th Street light, look for the four stories 3500 building. It's called the World Executive Center.

From the Turnpike Southbound: Take the Commercial Blvd. exit. Head east to State Road 7. Make a right on State Road 7. On 36th Street, make a U-turn. Look for the four stories 3500 building on the right side. It's called the World Executive Center.

From the Turnpike Northbound: Take the Commercial Blvd. exit. Stay on the left lanes to head east. After you turn left to head east, stay on the right. Make a right on State Road 7. On 36th Street, make a U-turn.
Look for the four stories 3500 building on the right side. It's called the World Executive Center.

PARKING

You may park on all four sides of the building and the parallel parking spaces on the north side of the building. There is ample parking. Refrain from parking in the plaza to the north of the building to avoid getting towed.

BUILDING ENTRANCE

Once you parked, you may enter the building through the main entrance facing west, or the back of the building facing east. There is also a side door on the north side of the building. The main entrance of the building automatically locks at 6pm M-F and at 2pm on Saturdays. Please arrive before these times if your appointment is around those times. If the door downstairs is locked, please call 954-390-0411.

Office Policies and Procedures

Initial Appointments:

- The initial visit usually last 90 minutes. Please allow up to 2 hours for your initial visit.
- Please arrive 5 minutes early, with your forms completed
- If the forms are not completed, please arrive 20 minutes early to complete the forms
- Any scheduling changes for initial appointments must be made at least 2 business days in advance.

Cancellations and Changes:

- If you need to reschedule an appointment, please notify us a minimum of 1 business day prior to your scheduled time, so we have time to schedule someone else that is waiting for an appointment slot. Our scheduler automatically sends you an e-mail; you can reschedule or cancel your appointment directly from the e-mail.
- If your appointment is on Monday, please notify our office of changes no later than noon on the previous Friday.
- Please be respectful to our time and to other patients we might have turned away for this time slot that was reserved for you, and kindly give us as much advance notice as possible if you need to reschedule.
- Once a patient is a no-show for an appointment or cancels at the last minute, prepayment of services is required for the following appointments. We will send you a Paypal invoice or you can pay the office over the phone with a credit card.

Your visits:

- We value our patient's time. In order to keep on schedule, we request that you arrive on time for your appointments. If you arrive more than 15 minutes late for your appointment, it does not allow the necessary time to effectively conduct a treatment and we will need to reschedule you, and will treat it as a missed appointment. We will make every effort possible to reschedule you ASAP, and if at all possible we will work you into our schedule for that day, contingent on space availability. Please allow sufficient travel time and take traffic conditions into consideration.
- There are occasions where extenuating circumstances arise and we may be delayed for a brief time. This will not affect the length of your visit. Please accept our apologies for any inconvenience.
- Please allow enough time for your complete visit. If you know you need to leave the office by a specific time, please let us know when you first arrive and we will do our best to accommodate you.

Herbs, Supplements & Prescriptions:

- If for any reason you are unable to take your prescribed herbs and supplements as directed or have questions, please call our office as soon as possible.
- Unopened bottles in a resalable condition can be returned for office credit or refund within 30 days of purchase.
- The following items cannot be returned: refrigerated items, special order items, custom formulas, and perishable items.

Payment

- Payment is due at the time of your appointment.
- Payment for the ordering of herbs is due at the time of the order.
- Accepted methods of payments are: Visa, Mastercard, Discover, American Express, Paypal Card, Check and Cash.

Insurance

If your insurance plan covers our services, we will bill your insurance at the rate of the usual and customary fees. The cash fees are discounted from the usual and customary fees for paying at the time of office visit.

HIGHPOINT HEALING AND WELLNESS, INC, 954-390-0411, www.AcupunctureFortLauderdale.com

3500 NORTH STATE ROAD 7, SUITE 440, LAUDERDALE LAKES, FL 33319

About Valencie Exceus, AP, DOM

Valencie Exceus, AP, DOM (Dr. Vie) is an Acupuncture Physician / Doctor of Oriental Medicine licensed by the state of Florida and board certified, Diplomate in Acupuncture through the NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine). Dr. Vie is a graduate of the Atlantic Institute of Oriental Medicine in Fort Lauderdale, Florida. She is also certified in NADA (National Acupuncture Detoxification Association), an Auricular Therapy Protocol for Drug Detoxification completed at the Lincoln Recovery Center in Bronx, NY, and is certified in Biopuncture – administering homeopathic and vitamin injections in the acupuncture points.

Growing up in Haiti and being so free and close to nature, Dr. Vie developed her interest in natural medicine very early on. She would carefully observe the elders and adapt their ancient knowledge. When she came to the United States at the age of 12, she was unaware of natural medicine being an option as a degree in college. She went on to study the Social Sciences with the goal of becoming a Lawyer. During her junior year at Florida Atlantic University, she started feeling a pull to continue exploring her childhood interests in natural medicine and provide true healing to people. She took a semester off to find her true calling, and by the end of the semester, she was enrolled at the Atlantic Institute of Oriental Medicine.

She graduated in 2006 and went into private practice within two months of graduation. In her practice, Dr. Vie strongly believes that healing is achieved by treating the root cause of the condition while addressing the manifesting symptoms. Having worked as a Health Advisor for the Life Extension Foundation, a leader in the field of Nutraceuticals and Functional Medicine, and having had completed an extensive study in Ayurvedic Medicine, Dr. Vie has in-depth knowledge and understanding of other forms of medicine and healing modalities. Over the years, she has worked collaboratively with other physicians to best meet the health needs of her patients.

Over the years, Dr. Vie has noticed that a great percentage of her patients viewed Oriental Medicine as a last resort and even so, Oriental Medicine has been able to help them turn their health around. This observation has been the catalyst that drove her into becoming a pioneer in educating the community in making Oriental Medicine one of their first options rather than their last resorts. Dr. Vie has lectured on several topics including Women's Health, Natural Solutions to Pain, Natural Solutions to Digestive Health, Stress, Insomnia, and Anxiety. She has been a regular contributor on various health-related radio programs as well.