

CONFIDENTIAL PATIENT INFORMATION

Full Name:			
Home Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
Email:			
Date of Birth:	Age:	Sex:	Marital Status: M S W
Last Four of Yours Soc. Security #		Dr. Lic#	
Employed By:		Work Phone:	
Employer Full Address:			
City:		State:	Zip:
Occupation:		Person responsible for Account?	
Spouse Name:		Spouse Contact Phone:	
Your Doctor's Name:		Phone:	
Who can we thank for Referring you to our office:			

INSURANCE INFORMATION

Primary Insurance Name:		Phone:
Policy#	Grp#	
Insured Name:		Insured Date of Birth:
Registration #	Union Local:	Relationship to Insured?:

ATTORNEY INFORMATION:

Attorney Name:		Phone:
Full Address:		City: Zip:
Is condition due to a? () Slip & Fall () Illness () Auto Accident () Injury at Work () Other		

What is your chief concern today? _____

How long have you been experiencing this? _____

What other treatments have you tried? _____

Doctor's name that you are seeing for this condition: _____

May we contact your doctor? _____

Medications	Vitamins / Supplements	Fluid Intake
		Water (oz/day):
		Coffee (oz/day):
		Tea (oz/day):
		Alcohol (#/week):
		Soda (#/week)
Men's Questions	Women's Questions	
<input type="checkbox"/> swollen testes <input type="checkbox"/> genital coldness/numbness <input type="checkbox"/> testicular pain <input type="checkbox"/> Sexual dysfunction Describe: _____ Date of last PSA: _____ Date of last DRE: _____	Regular menstrual cycle? Yes / No Date of last period: _____ # days of flow: _____ # days in cycle: (day 1 to _____ Color: _____ Heavy flow / normal / light flow Pain / cramping during flow? Before flow? After flow?	<input type="checkbox"/> Bleeding between periods? <input type="checkbox"/> Clots Age of 1 st menstruation: _____ Age of menopause: _____ Are you pregnant? Yes / No # children: _____ # pregnancies: _____

Additional comments: _____

Directions: Please check any symptoms you are experiencing, even if it may seem unrelated to your condition.

Category I

<input type="checkbox"/> Chest congestion <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sore throat	<input type="checkbox"/> Puffy face <input type="checkbox"/> Allergies <input type="checkbox"/> Cough <input type="checkbox"/> Do you easily cough up sputum? Y N Color: _____	<input type="checkbox"/> Nasal/sinus congestion <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Sneezing <input type="checkbox"/> Frequent colds How many per year? <input type="checkbox"/> Dry throat/nose/skin	<input type="checkbox"/> Sadness/grief <input type="checkbox"/> Rashes Where? _____ <input type="checkbox"/> Do you smoke cigarettes or cigars? How many per day? _____
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Category II

<input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Anxiety Does it travel to Depression shoulder? Y N <input type="checkbox"/> Mental confusion <input type="checkbox"/>	Restlessness What time do the <input type="checkbox"/> Sores on <input type="checkbox"/> Difficulty falling or Frequent/vivid dreams	you go to bed tongue/mouth and what up? _____ staying asleep	time do you wake <input type="checkbox"/>
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Category III

<input type="checkbox"/> Cold hand feet <input type="checkbox"/> Sweaty hands/feet <input type="checkbox"/> Feeling hot/cold <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Lack of sweating <input type="checkbox"/> General fatigue <input type="checkbox"/> Low energy	<input type="checkbox"/> Morning fatigue <input type="checkbox"/> Wake un-refreshed <input type="checkbox"/> Ear ringing <input type="checkbox"/> Hearing loss <input type="checkbox"/> Heat in hands/feet/chest <input type="checkbox"/> Dizziness <input type="checkbox"/> Thirsty	<input type="checkbox"/> Tooth problems/cavities <input type="checkbox"/> Easily broken bones <input type="checkbox"/> Sore/cold/weak knees <input type="checkbox"/> Lower back pain <input type="checkbox"/> Fear/easily startled <input type="checkbox"/> Memory problems <input type="checkbox"/> Hair loss <input type="checkbox"/> High/ low sex drive	<input type="checkbox"/> Kidney/bladder stones <input type="checkbox"/> Frequent UTI's <input type="checkbox"/> Wake at night to urinate How often? _____ <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Slow, dribbling, difficult Urination
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Category IV

Stress level 0 1 2 3 4 5 6 7 8 9 10 What causes stress? _____ <input type="checkbox"/> Headaches/migraines Frequency? Duration? _____ <input type="checkbox"/> STD What? _____ When? _____	<input type="checkbox"/> Muscle spasm/twitching <input type="checkbox"/> Muscle cramping Where? _____ <input type="checkbox"/> Numbness/tingling Where? _____ <input type="checkbox"/> Neck/shoulder tension or stiffness <input type="checkbox"/> Limited range of motion? Where? _____ <input type="checkbox"/> Sciatica <input type="checkbox"/> Hip pain	<input type="checkbox"/> Feeling of lump in throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> PMS/emotional <input type="checkbox"/> Irritable/anger/frustration <input type="checkbox"/> Breast swelling/tenderness <input type="checkbox"/> Painful periods <input type="checkbox"/> Bloating/ fatigue/ cravings <input type="checkbox"/> Hormonal imbalances <input type="checkbox"/> Gallstones When? _____	<input type="checkbox"/> Near/far sighted <input type="checkbox"/> Blurry vision <input type="checkbox"/> Bloodshot eyes/Eye Pain <input type="checkbox"/> Hot/dry/itchy/gritty eyes <input type="checkbox"/> Watery eyes <input type="checkbox"/> Decreased night vision <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Spots or floaters in vision <input type="checkbox"/> Do you drink alcohol? How often? _____ <input type="checkbox"/> Recreational drug use?
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Category V

<input type="checkbox"/> Large/low appetite <input type="checkbox"/> Food sensitivities <input type="checkbox"/> Cravings for salty/sweet <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Sudden/unexplained weight gain or loss <input type="checkbox"/> Heartburn/acid reflux	<input type="checkbox"/> Burping/hiccups <input type="checkbox"/> feeling of heaviness <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Gas/abdominal pain <input type="checkbox"/> Noisy stomach <input type="checkbox"/> Fatigue after eating <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Over thinking/Worry <input type="checkbox"/> Mentally sluggish or foggy <input type="checkbox"/> Water retention <input type="checkbox"/> Snoring <input type="checkbox"/> Lack of thirst <input type="checkbox"/> Bad breath <input type="checkbox"/> Mouth or cold sores	<input type="checkbox"/> Gums bleeding <input type="checkbox"/> Loose stool/diarrhea <input type="checkbox"/> Constipation/difficult stool <input type="checkbox"/> Dry stool <input type="checkbox"/> Incomplete feeling stool <input type="checkbox"/> Bloody/Mucous Stool <input type="checkbox"/> Undigested food in stool
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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 California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the 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 any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or 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 health care 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 healthcare 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. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty 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 issues of liability and damage upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this 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 parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for noneconomic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable 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 other 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 of 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 affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

OFFICE SIGNATURE	(Date)
PATIENT SIGNATURE X	(Date)

ARBITRATION AGREEMENT

Payment Responsibility and Authorization

Welcome to the San Pedro Healing Arts Medical Clinic. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask if you have any questions about our fees, financial policy, or your responsibility in this matter.

1. All patients must complete our 'Patient Information' form before seeing the Acupuncturist. It is the patients' responsibility to inform us of any changes in this information, including address, telephone number, employment, insurance coverage, etc.
2. Payment is collected at the time services are rendered.
3. We accept cash, checks and credit cards as methods of payment.
4. Balances older than 30 days will be subject to additional collection fees and charges at a rate of \$25.00 per month until the balance is paid in full, unless other arrangements have been made beforehand and upheld.
5. Returned checks will be charged a \$25.00 service charge.
6. A fee, equal to the amount of 50% of our full fee, will be charged for any missed appointments or appointments cancelled with less than 24 hours' notice.
7. **Unaccompanied Minors:** Parents or guardians are responsible for full payment.

I agree to pay in full for services at the time services are rendered.

I understand and agree that there will be a late fee added to my account if I fail to pay within thirty (30) day. The late fee charge will be \$25.00 per month. I understand that I am solely responsible for this late fee.

If I fail to pay the balance of my account to San Pedro Healing Arts Medical Clinic within sixty(60)days of the date of service, my account will be turned to collection. If it is necessary to turn my account over to collection, I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

It is our intention and hope that this written policy will eliminate any future misunderstandings between our office and our patients.

I understand that I am responsible for all fees incurred for services rendered and that full payment is expected at the time these services are rendered, unless advance arrangements are made with our clinic director before services are rendered in office.

Responsible Party's Signature _____ Date _____

Insurance

We accept most insurance upon approval. Insurance claims will be billed at our Usual and Customary Rates and differ for those who pay in full at the time services are rendered. Please speak with a Front Desk Staff Member who can help verify your Insurance Benefits.

Cancellation Policy

(Missed, Forgotten, No-Show, and Late arrivals)

For your convenience, San Pedro Healing Arts schedules by appointment only. Walk in appointments are not generally available at our practice; however, we attempt to accommodate acute injuries/conditions as quickly as possible. Should you be unable to keep a scheduled appointment, we would like 48-hour notice, but we require 24 hours' notice for cancellations. Failure to cancel 24 hours prior to your scheduled appointment will result in a Missed Appointment Fee, equal to half the appointment cost, placed on your account. No-show and forgotten appointments are considered cancellations. Also, if you are more than 15 minutes late to your appointment, your appointment may be shortened or rescheduled to a different day. Missed appointments prevent us from seeing patients with acute conditions.

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

If required, I hereby authorize payment directly to the acupuncturist responsible for my care. I understand that I am financially responsible to my acupuncturist for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third-party payor in order to obtain payment. I hereby authorize the acupuncturist to release any medical information required for my examination or treatment. I understand that payment is expected at rendering of services unless other arrangements have been made. I understand that even if I have some type of insurance coverage, I am responsible for payment of services.

Consent: I hereby, also, consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested.

Signature of Responsible Party (relationship)

Date

Notice of Patient Privacy Practices

We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC). *Treatment includes activities performed by a practitioner, assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. *Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*Health Care Operations includes the necessary administrative and business functions of our office. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect. You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

Complaints: Complaints about your privacy rights or how the clinic handled your health information should be directed to the office manager by calling (310)547-2197. If the manager is not available, you can schedule a personal conference in person or by phone within two business days. If you are not satisfied with this matter in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave SW Room 509F HHH Building Washington DC 20201.

I have read the privacy notice and understand my rights contained in this notice:

By way of my signature I have provided San Pedro Healing Arts Medical Clinic Inc with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment and healthcare operations as described in the privacy notice.

Print Patient Name: _____

Signature: _____ Date: _____

Witness Signature: _____

Information about Acupuncture Treatment

What is Acupuncture? Acupuncture is a practice that involves the stimulation of specific points on the body. It has the effect of normalizing physiological function, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. The stimulation may be produced by needles, heat, digital pressure, electrical currents, or other means, but most frequently by needling. Herbs and nutritional supplements may be recommended and are considered safe in the practice of Chinese Medicine.

What are the side effects or complications? Acupuncture is considered a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been extremely rare instances reported in which a patient fainted, developed a scar or infection, experienced a spontaneous miscarriage, or sustained a pneumothorax (air in the chest cavity that can cause a collapsed lung).

What are the contraindications for Acupuncture or use of Chinese Herbal Medicine? Contraindications for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy.

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 indicated 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, TuiNa (Chinese massage), Chinese herbal medicine, heat therapy, 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 have 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects 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.**

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during 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.

San Pedro Healing Arts Medical-Maria E. Baez, OMD, LAC

PATIENT SIGNATURE **X**

(Or Patient Representative)

Date:

(Indicate relationship if signing for patient)