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	
Soc. Security #	Dr. Lic#	
Employed By:	Work Phone:	
Employer Full Address:		
City:	State:	Zip:
Occupation:	Person responsible for Account?	
Spouse Name:	Spouse Phone:	
Primary Care Doctor:	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:	
UNION Registration # Union Local:	Vessel Name:	
ATTORNEY INFORMATION:		
Attorney Name:	Phone:	
Full Address:	City:	Zip:
PERSONAL HISTORY:		
Is condition due to a ? ( ) Auto Accident ( ) Work Injury ( ) Illness ( ) Unknown reason		
Are Symptoms ? ( ) Getting Worse ( ) Improving ( ) About the Same ( ) Intermittent (Come & Go)		
Have You Seen Someone Else for this Condition? If yes who ?		
Do you use any tranquilizers or sleeping medications? If yes which ones:		
List All Your Current Medications:		
List Any Surgeries:		
List Any Known Allergies:		

Health History Questionnaire

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**	
☐ swollen testes ☐ genital coldness/numbness ☐ testicular pain ☐ 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?	☐ Bleeding between periods? ☐ Clots Age of 1st menstruation: _____ Age of menopause: _____ Are you pregnant? Yes / No # children: _____ # pregnancies: _____

Additional comments:

_____

_____

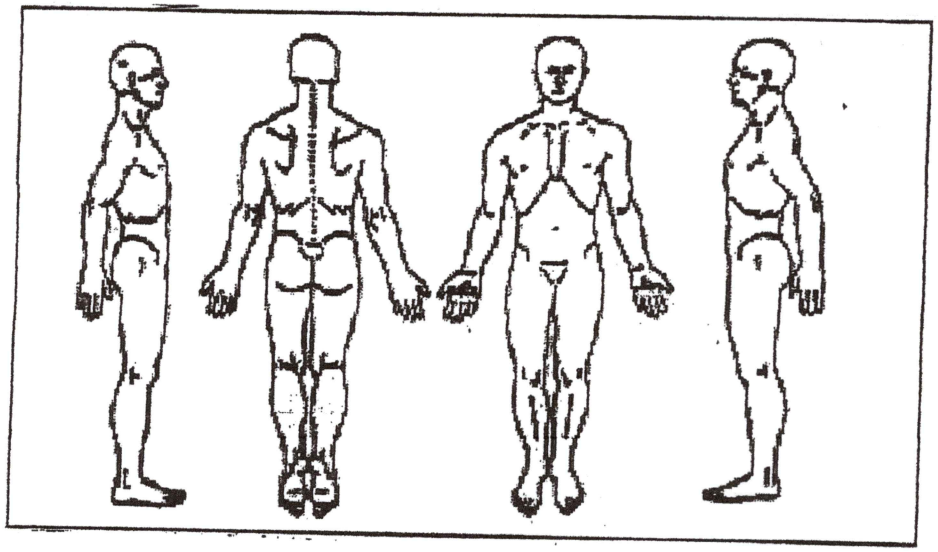
Your History

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis - *Type*_____	☐	☐	☐	☐	☐
Birth Trauma	☐	☐	☐	☐	☐
Blood Pressure Low/High	☐	☐	☐	☐	☐
Broken Bones/Factures	☐	☐	☐	☐	☐
Cancer -*Type*_____	☐	☐	☐	☐	☐
Cholesterol - High	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐
Eye Condition	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder Problems/Removal	☐	☐	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	☐	☐
Glasses/contacts	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐
Immune System - Weak	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐
Neuritis/Neuralgia	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Scarlet Fever	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Stroke/Hypertension	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐



Please draw location and type of pain on body outline.

Ache ^^^^^^ ^^^

Burning ====== ====

Numbness oooooo oooo

Pins and Needles ....

Stabbing //////// ////

Other xxxxxx xxx

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

Category I

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

Category II

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

Category III

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

Category IV

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

Category V

□ Large/low appetite □ Food sensitivities □ Cravings for salty/sweet □ Nausea/vomiting □ Sudden/unexplained weight gain or loss □ Heartburn/acid reflux	□ Burping/hiccups □ feeling of heaviness □ Abdominal bloating □ Gas/abdominal pain □ Noisy stomach □ Fatigue after eating □ Bruise easily	□ Over thinking/Worry □ Mentally sluggish or foggy □ Water retention □ Snoring □ Lack of thirst □ Bad breath □ Mouth or cold sores	□ Gums bleeding □ Loose stool/diarrhea □ Constipation/difficult stool □ Dry stool □ Incomplete feeling stool □ Bloody/Mucous Stool □ Undigested food in stool

Our Financial Policy

Thank you for choosing our office for your wellness care. We are committed to providing you with high quality health care. The services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. SELF PAY: If you are not insured by a plan we participate with OR choose to self-pay, payment in FULL is expected at each visit. INSURANCE: San Pedro Healing Arts participates in several insurance but knowing that your health insurance benefits is your responsibility. As a courtesy we verify your insurance information and benefits for medical services only. It is the policy of this office to extend to our clients the courtesy of assigning insurance benefits directly to you. We are happy to extend this credit to you so that you can follow through with all the care necessary. The following are important points of consideration to be aware of: **1. All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company, and we are required by law to collect co-payments and deductible payments at the time of service. Please assist us in compliance with our obligations by paying your co-payment and deductible payment at each visit. In the event that you do not pay your co-payment or deductible payment at the time of service, we will charge the credit card on file for such co-payment or deductible amount. 2. If you are seeing our doctors on an "out of network" basis, you will be subject to out of network rates. In this event, you may request a "Super bill" so that you may submit it to your insurance company for out-of-network reimbursement. 3. Patients whose treatment visitation schedule is once per month or less, may no longer be eligible for insurance assignment as this level of care is rarely covered by insurance.

Non-Covered Services: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

Patient Acknowledgment of Notice of Privacy Practices: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the

Release of Medical Information: to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Cancellation Policy (Missed, Forgotten, No-Show, and Late arrivals)
For your convenience, San Pedro Healing Arts Medical 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

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by 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)

(Or Patient Representative) (Indicate relationship if signing for patient) (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: _____