Please print out, complete and sign the following paperwork to bring with you on your first visit.

Print your Name and/or Sign Highlighted areas.

Patient Information

Patient Name: _____ Birthdate: _____/____/_____ Gender: M / F / _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Cell _____ Home: _____ Work:_____

Email Address: _____ Drivers License #: _____

Employer: _____ Occupation: _____

In Case of Emergency Call: Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Health Plan: _____ Patient/Member #: _____

Subscriber Name: _____ Subscriber ID # _____ Group #: _____

Secondary Plan: _____ Patient/Member #: _____

Subscriber Name: _____ Subscriber ID # _____ Group #: _____

If using insurance please sign here for signature on file: _____

Healthcare Practitioner Information:

Primary Care Physician:_____ Phone: _____

Specialist: _____ Phone: _____

Other: Chiropractor/Naturopath/Other _____ Phone: _____

Are you under the care of a physician? (Circle) No or Yes, For what conditions?_____

_____

Allergies: _____

Medications/Supplements/Herbs:

Name of Medication	Taking medication for:	Dosage:	How long been taking?

Surgeries:

Type of Surgery (Please include dental and elective surgery)	Date

Sign up for our email newsletters. Email only Specials, Information, and Events.

☐ **Yes, please add me to your mailing list** ☐ **No, please do not add me to your mailing list**

Whom may we thank for referring you to us? Insurance List Current or Past Patient _____

Dr. _____ Other :_____

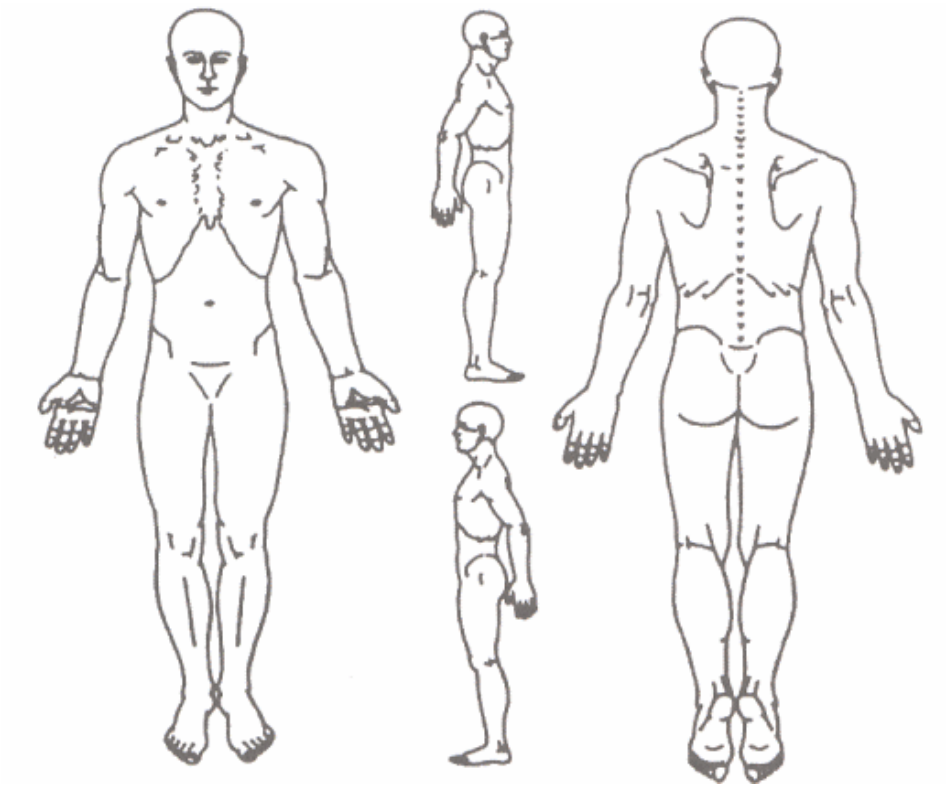
Do you use tobacco products or smoke tobacco? Yes No Have you in the past? Yes No

Does your family have a history of: (please indicate whom)

Heart Disease Y N _____ High Blood Pressure Y N _____
Cancer Y N _____ High Cholesterol Y N _____
Diabetes Y N _____ Other_____ _____

Chief Complaint/ Other Complaints:	**When Began?**	**Pain 1-10**	**Auto/Work Related?**
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____

Please mark the diagram where there is pain or discomfort.



What areas of your life have been impacted by your condition(s)? **Which is/are most impacted?**
Circle all that apply: If not on the list, please write in.

Exercise Sleep Walking Enjoyment of Life Quality of Life Intimacy Relationship

Ability to Concentrate/Focus Work Ability to care for self

Have you had Acupuncture before? Yes No If so, for what condition(s)?
_____

What was your experience with Acupuncture? Great Good OK Poor

Do you have any questions or other concerns you would like to address? If so, please list them below.

Dr. Jocelyn Joy, DAOM, L.Ac.

4420 Hotel Circle Court, Suite 265 SD, CA 92108 - 5252 Balboa Ave. Suite 901 SD, CA 92117

Prompt Pay Fee Schedule and Financial Agreement

Acupuncture Treatments

New Patient Appointment (80 min) (intake, exam, and treatment) **$ 105/ $90**

Return Sessions (50 min) **$ 90/$70**

Senior 60+, Student, Military

Add-on modalities:

Deep Tissue Massage (Site-Specific) up to 10 min, **$ 25 each**

Celluma™ LED Light Therapy 15 min

Mobile Appointments **$160/$125**

Herbal Consultation (30 minutes) **$60 initial/$30 re-exam**

Herbal Prescriptions/Supplements avg. **$25-50/ 1weeks supply**

Smoking Cessation Package 10 Sessions-30 min. each **$449**

Acupuncture Treatment Packages

Joyful Acupuncture Package of 6 Sessions **(use w/in 2 months) $459*** ($540 Value)

Joyful Acupuncture Package of 10 Sessions **(use w/in 4 months) $759*** ($900 Value)

(*Must use packages within specified timeframe or $75 additional fee applies)

Club Joy Wellness Maintenance Program

After you have finished your Acute and Corrective Care Treatment Phases

Pay automatically each month for a Wellness/Maintenance Visit ($60). Extras visits per month only $50

New! LED Light Therapy by Celluma™

An additional healing modality using specific light frequencies to reduce pain, help with healing wounds and injuries, reduce inflammation, reduce wrinkles, and more! $40 – 30 min

Package of 6 treatments $200 Package of 10 $320

Cancel with less than 24 hours' notice: $50

No Show-No Call: You will be charged the full amount of cash price for session or will forfeit One Treatment in Package or Offer.

Late Arrivals: Please call and let us know!

If you are late 10 minutes or less your treatment time will be shortened accordingly.

If you arrive more than 10 minutes late you will be rescheduled.

Insurance coverage must be verified prior to your initial visit, otherwise our cash rates apply.

Payment is expected at time of service:

Visa – MasterCard – Discover – American Express- Cash – Checks

Many Insurances Accepted, please inquire, Select Personal Injury Cases, MedPay

I understand and accept the terms of this financial agreement.

Signature **Date**

Notice of Information Practices and Privacy Statement

Joy Acupuncture Healing Arts, Inc.
4420 Hotel Circle Court, Suite 265, SD, CA 92108
619-322-4492

San Diego Chiropractic Group
5252 Balboa Avenue, Suite 901, SD, CA 92117
858-560-5022

Privacy Practices and Information Sharing

How We Collect Information About You: We collect information through phone calls, emails, voice mails, and Patient Information and Health History forms.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients that is considered patient confidential or is restricted by law.

How We Do Use Your Information: Under normal circumstances information is only used as is reasonably necessary to set up your Patient Medical Record or verify insurance coverage. The minimal amount of information may be shared with other health care providers to assist with treatment coordination with your express written consent.

Exclusions: Dr. Joy is considered a 'mandatory reporter' and if you seem to be a danger to yourself or others, are a suspected victim or perpetrator of child or elder abuse, or you are suspected of having an active contagious disease such as Tuberculosis or a MRSA, information can be shared without your approval to appropriate authorities and institutions as required by law. If you have any questions about our Privacy Policy or wish to view the entire HIPAA Policy please contact:

Dr. Jocelyn Joy, DAOM L.Ac. 619-322-4492

Notice of Privacy Practices (HIPPA) received.

I, _____, **have received a copy and understand The Notice of Privacy Practices for Joy Acupuncture Healing Arts, Inc.**

_____ _____
Signature Date

Patient Name Printed:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

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 health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one 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.

(Date)

PATIENT SIGNATURE X _____ _____

Acupuncturist Signature : Dr. Jocelyn Joy, DAOM, L.Ac. Date: _____

Patient Name Printed: _____ X

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, Tui-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 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 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

(Date)

PATIENT SIGNATURE X _____ _____

Guardian's signature if patient under 18 years of age.

Acupuncturist Signature: Dr. Jocelyn Joy, DAOM, L.Ac.

Insurance: Covered, Non-Covered Services and Charges

Covered Conditions

Treatment for acute musculoskeletal conditions or limited flare-ups of a chronic musculoskeletal condition, PAIN, and sometimes nausea from chemo or pregnancy.

Limited to medical necessity: an approved complaint; limited to visits that demonstrate progress. Visits denied if no progress or if progress plateaus.

You may need a referral (Kaiser, Sharp) or authorization to have your insurance pay for your acupuncture care.

Check your coverage, by calling Member Services on the back of your insurance card!

NOT Covered Conditions

1. **Treatment for a chronic condition when the therapeutic goals of the treatment plan have been achieved and no progress is apparent or expected to occur.**

2. **Maintenance/Preventive/Wellness care**, defined as care in the absence of symptoms or care to promote better health or to enhance performance in sporting activities, elective care.

3**. Treatment for "internal medicine**", i.e. anything not neuromusculoskeletal pain, or defined as medically unnecessary.

4. **Treatment over the allowed number of visits per your insurance plan where an extension has not been approved.**

You may elect to pay additional fees to treat conditions not covered (each visit):

You will pay an additional $35, limited to 1-2 additional areas/issues per treatment.

In addition, you can pay for optional add-on or additional services not covered by your insurance:

1. **Herbal Prescriptions (price varies)**
2. **Healing Touch, Energy Medicine – up to 10 min ($25) (for full session $130 for 45 min)**
3. **LED Light Therapy by Celluma™– (15 min. for $25; or full 30 min session for $40)**
4. **Kinesio Taping 1-2 areas ($10 single application)**

You may pay for non-covered issues after your referral or medical necessity is complete at normal cash prices or join the *Club Joy Wellness Program (Please see fee schedule).*

☐ **I elect to receive additional care over what is covered by my insurance carrier**, including herbs, healing touch, LED light therapy, etc. I choose to pay the additional charges out of pocket at the time or service and have been informed of such fees prior to receiving care. _____ (please initial)

☐ **I would like to bill my insurance and pay my copay only** (if any) for acupuncture care, which is limited to certain conditions and modalities. _____ (Please Initial to acknowledge)

By signing this agreement, I acknowledge I am responsible for all charges incurred to me according to my insurance plan and fee schedule and agree to pay all uncovered charges and have been informed of said charges prior to care.

Signature of Patient_____ **Date:** _____

I acknowledge patient has been informed of uncovered charges prior to receiving care. Provider Initial_____