



Patient Confidential Information

Name: _____
First Middle Last

Address: _____
Street
City State Zip

Primary Phone : _____ Alternate Phone: _____
SELECT ONE: MOBILE HOME WORK MOBILE HOME WORK

Please provide an E-mail address at which you would like to receive appointment reminders:

E-mail: _____

May we send you a monthly E-mail newsletter? YES NO SSN: _____ - _____ - _____

Age: _____ Date of Birth: ____/____/____ Sex: M F Marital Status: S M D W

Place of Birth: _____ Occupation: _____ Employer: _____

If you would like us to bill your insurance company for services rendered, please furnish your insurance information at the front desk prior to treatment. We do not guarantee insurance benefits. Regardless of insurance coverage, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of the patient.

Whom may we thank for referring you to our office?: _____
(i.e. Patient name, Yelp, Google, other practitioner, walk-by, etc.)

In case of emergency, call: _____
Name Relation

Primary Phone: _____ Alternate Phone: _____

CANCELLATION POLICY

Out of respect for the practitioner's time and in order to maximize availability to patients, a minimum of 24 hours notice for cancellations is required. Not providing 24 hours notice, not showing, or being more than 20 minutes late for an appointment results in a charge of the standard fee to your account. If your appointment slot is filled after you cancel, this fee is waived.

Compliance with this policy enables better service to you and other patients. Thank you for your understanding.

Patient Signature Date

Medical History Questionnaire

Please complete the following as completely and accurately as possible.

Name: _____ Date: _____

Present Illness/Injury:

Please list your major symptoms that concern you in order of importance

Symptom When did this condition begin? What treatment have you received already?

- 1.
- 2.
- 3.
- 4.
- 5.

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had? When?

What allergies, if any, do you have?

What medications have you taken within the last 3 months (include dosages)?

What supplements are you taking (include dosages)?

Have any of your blood relatives had any of the following?

Stroke

Cancer

Heart Disease

Tuberculosis

Seizures

Bleeding disorder

Diabetes

High blood pressure

Thyroid Disorder

Allergies

Name: _____

When was your last physical exam? Were any abnormalities found? Please explain.

Please give a brief description of what you eat and drink on a typical day, including approximate times of consumption.

Morning

Afternoon

Evening

What types of exercise do you do during the week? How often and for what duration?

On average, how many hours do you sleep each night? Any difficulty falling or staying asleep?

How many hours per week do you work? What type of work do you do (desk, standing, labor, etc.)?

How many cigarettes do you smoke each day?

How much coffee, tea, cola or other caffeinated beverages do you drink per week?

How much alcohol do you drink per week?

Please list any use of drugs for non-medical purposes:

Check the symptoms that pertain to you:

Cold hands/feet

Fatigue

Feverish in the afternoon or flushes

Heat sensations in the hands, feet, chest

Night sweats

Catch colds easily

Sweat easily

Dizziness

See floating black spots

Palpitations

Sores on tip of tongue

Restlessness

Anxiety

Chest pain radiating to shoulder

Insomnia

Cough

Sinus congestion

Dry mouth, throat, nose or skin

Allergies

Chills alternating with fever

Stiff neck/shoulders

Sore throat

Difficulty breathing

Low appetite or Large appetite

Loose stools or Constipation

Abdominal bloating and/or gas after eating

Prolapsed organs (previously diagnosed)

Bruise easily

General feeling of heaviness in body

Mental heaviness, sluggishness or fogginess

Swollen hands/feet

Burning sensation after eating

Bad breath

Mouth sores/canker sores

Bleeding, swollen, painful gums

Heartburn and/ or Belching

Stomach pain

Check the symptoms that pertain to you:

Vomiting
Diarrhea alternating with constipation
Tight feeling in the chest
Bitter taste in the mouth
Blood shot/dry eyes
Anger easily
Skin rashes
Headache
Numbness of hands and feet
Muscles spasms, twitching, cramping
Seizures/convulsions
Sore, cold or weak knees
Low back pain
Frequent urination
Get up more than once per night to urinate
Lack of bladder control
Memory problems
Hair loss
Ringing in ears

Urine is:

Pale yellow
Clear
Dark yellow
Reddish
Cloudy
Scanty
Has odor
Burning
Painful
Difficult
Urgent

Libido (sex drive) is:

Normal
Low
High

Indicate if you currently have or have had any of the following:

Cold sores	Hemorrhoids
Genital herpes	Sexually transmitted diseases
Epstein Barr virus (EBV)	Disorder of the genitals
Fibromyalgia	Gynecological disorder
Heart disease	Congenital abnormalities
Rheumatic fever	Skin diseases
High blood pressure	Cardiac pacemaker
Stroke	Surgical implants
Epilepsy or convulsions	Change in bowel or bladder habits
Kidney disease	Sores that will not heal
Urinary bladder problems or infections	Unusual bleeding or discharge
Diabetes mellitus	Indigestion
Cancer	Colitis
Respiratory problems	Crohn's disease
Pneumonia	Irritable bowel syndrome/disease
Emphysema	Gallstones
Tuberculosis	Lupus Erythematosus
Asthma	Difficulty swallowing
Warts	Obvious change in a wart or mole
Peptic ulcer	Chronic Cough
Pancreatitis	Hoarseness
Anemia or other blood disorder	History of smoking
Bleeding disorder	History of smokeless tobacco use
Hepatitis	History of drinking alcohol
Jaundice	History of recreational drug use
Hernia	HIV/ AIDS
Thyroid disorder	

Name: _____

Women: Menstrual History

Age of your first period: _____

Length of flow (days): _____

Length of entire menstrual cycle, from day 1 of one period to day 1 of next period: _____

Date of your last period: _____

Any abnormal vaginal discharge? Yes No

Do you believe you are pregnant or that it may be possible? Yes No

Number of previous pregnancies: _____ Number of live births: _____

Date of last gynecological checkup: _____

Are you taking birth control pills/patch? Yes No

Have you taken birth control pills in the past? Yes No If yes, dates of use: _____

Do you have a history of any of the following?

- Menstrual cramps
- Menstrual blood clots
- Excessive bleeding
- PMS
- Breast swelling/tenderness
- Water gain
- Abnormal Pap smear
- Irregular cycle
- History of hormone therapy
- Breast cysts
- Ovarian cysts
- Endometriosis
- Pregnancy
- Infertility
- Difficulty getting/staying pregnant
- Emotional changes with period
- Hot flashes
- Vaginal yeast infections

Men: Urology History

Do you have a history of any of the following?

- Premature ejaculation
- Erectile Dysfunction
- Prostate problems
- Infertility

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, 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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X** (Or Patient Representative)

(Indicate relationship if signing for patient)

PATIENT NAME:

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 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, 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 or preceptorship 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.

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 non-economic 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 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.

PATIENT SIGNATURE **X**

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

Notice of Patient Privacy Health Insurance Portability and Accountability Act (HIPAA)

Stillpoint Acupuncture and Herbs is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or 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. We may revise our NOTICE from time to time. The Effective Date at the top right-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.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Stillpoint Acupuncture and Herbs at (310) 335-0073. You may also send a written complaint to the US Department of Health and Human Services.

Patient Signature

Date

Printed Name

CREDIT AND PAYMENT POLICIES

Thank you for choosing Stillpoint Acupuncture, Inc. as your holistic health care provider. Our goal is to provide the highest quality care at a reasonable cost.

- We bill all major carriers and most secondary carriers when all necessary information to do so is provided.
- We do not guarantee insurance benefits. Regardless of insurance coverage, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of the patient.
- Please note that your insurance coverage and benefit package is an arrangement between you and your insurance carrier. You are responsible to be aware of your benefits and to contact your carrier directly when issues arise regarding timely payment of claims, denials, rebilling, and other such issues.
- Many insurance plans have limitations on benefits, especially when it comes to holistic health care. Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions.
- Estimated copays will be assessed and collected at the time of service, and may not reflect exact amount due. Upon receipt of payments from your insurance carrier by our office, you will be notified of any overpayment that you have made, which will be credited or refunded to you at your discretion, and underpayments will be billed to your account and due immediately.
- We offer a "Prompt Pay" rate on all care when paid in full at time of service. The standard fee schedule applies to all services rendered that are not paid in full at time of service. Complete fee schedule is available upon request.
- Uninsured patients will be expected to pay for services in full at the time of service unless other prior arrangements have been made, and will receive our "Prompt Pay" rate.
- Quoted costs for services are based on our "Prompt Pay" fee schedule for a typical visit. If payment is not made at the time of service, our standard fee schedule applies.
- Additional charges may be assessed above and beyond quoted fees, for additional services such as myofascial release, cupping, electro-acupuncture, extensive consultation, etc. Your verbal approval will be obtained prior to rendering services that will incur charges above quoted fees.
- All balances are due within 30 days of receiving service. You may pay with cash, personal check, Mastercard or Visa credit card, or bank debit card. If you are unable to pay in full within 30 days please contact our office to set up a Payment Arrangement (P.A.) for regular monthly payments.
- Accounts may be assigned to an outside collection agency and reported to the credit bureaus for balances over 90 days old or missed P.A. payment. A patient whose account has been assigned to outside collections is thereafter on a cash basis with no extension of credit for future services and may be subject to dismissal.
- Additional Charges: 1.5% monthly finance charge (18% APR) added to accounts with personal balance over 90 days old, including those for which a payment arrangement has been established.
- Standard appointment rate are charged for no shows and added to account when the patient does not keep a scheduled appointment or does not cancel at least 24 hours or more prior to appointment time.
- \$50 - Collection. Added to accounts assigned to an outside collection agency.

I have read and received a copy of the Credit & Payment Policy for Stillpoint Acupuncture, Inc. I understand that authorization for treatment constitutes acceptance of the terms of said policy.

Signed: _____ Date: _____