



**INITIAL PATIENT VISIT FORM**

P1

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please provide the following medical information to the best of your ability.

<b>What problems are you here for today?</b>	<b>List any allergies to medications:</b>

**Past Medical History:**

1. Please check the "Yes" or No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease/cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. Please list any operations (and dates) you have ever had (including tonsils and adenoids):


3. Please list any current medications:


4. Please check any of the treatment you have had for your current problem(s):

Physical Therapy     Chiropractic     Nerve Block     Massage     Traction     Others: \_\_\_\_\_

**Social History:**

Yes No

**Please list details below**

Do you smoke? List how much?      \_\_\_\_\_  
 If no, did you smoke previously?      \_\_\_\_\_  
 Do you drink alcohol? List how often?      \_\_\_\_\_

**Family History:**

1. Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.

If yes, please indicate which relative(s) have the problems.

	<u>Yes</u>	<u>No</u>	
Heart problems/murmurs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Review of Systems:**

1. Please check the "Yes" or "No" box to indicate if you have any of the following symptoms.

2. For any "Yes" response, please check the "current" box if this symptom relates to the reason for your visit today.

		<u>Yes</u>	<u>No</u>	<u>Current</u>		<u>Yes</u>	<u>No</u>	<u>Current</u>
GENERAL	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain/ loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	Environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**INITIAL PATIENT VISIT FORM**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

		<u>Yes</u>	<u>No</u>	<u>Current</u>		<u>Yes</u>	<u>No</u>	<u>Current</u>
EYES	Eye pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problem snoring, apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stomachache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adnominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty/drink lots of water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URINARY	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGY/ LYMPHATIC	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night/Daytime Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINOLOGY	Feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Inching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GYNECOLOGY (FEMALE ONLY)	Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Early/Late/No Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHOLOGY	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have any pain and related condition(s), please check the appropriate boxes below and mark on the figure.

Location of Pain	Level (1-10)	Constant/ intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/ Tingling	Spasms	Weakness	Please mark your conditions on the figure below Pain: X, Spasm: S, Numbness: N, Weakness: W
Headache		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Jaw		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Upper back		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Middle back		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lower back		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulders		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Upper Arm		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Elbows		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Forearm		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wrists		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hands		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Buttocks		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thighs		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Knees		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legs		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ankles		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foot		<input type="checkbox"/> / <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reviewed by: _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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I have received a copy of this office's Notice of Privacy Practices.

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{Please Print Name}

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{Signature}

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{Date}

# Dragon Acupuncture & Herb Center, Inc.

## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice 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 health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**Change of Ownership.** In the event that our business is sold or merged with another organization, your health information/record will become the property of the new owner.

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.2 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Min Shi, Ph.D., L.Ac.  
Telephone: (949)727-0898 Fax: (888)682-8119  
E-mail: dragonacupuncture@hotmail.com  
Address: 18 Endeavor, Ste 301, Irvine, CA 92618

PATIENT NAME

**ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES**

**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  
(Or Patient Representative)

X

(Date)

(Indicate relationship if signing for patient)

**PLEASE SIGN REVERSE SIDE ALSO**

**ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES**

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, Tiu-Na (Oriental massage), Oriental 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 be 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 effect 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 Oriental 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.

<b>PATIENT SIGNATURE</b> X (Or Patient Representative)	Date
	(Indicate relationship if signing for patient)

<b>OFFICE SIGNATURE</b>	Date
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**PLEASE SIGN REVERSE SIDE ALSO**

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ALL DISPUTES OR COURT TRIAL RESOLVED BY NEUTRAL ARBITRATION AND TO WAIVE YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 FOR THE CONTRACT.