ALOHA ACUPUNCTURE

510 Hacienda Dr.

Suite 107

Vista, Ca 92081

760.630.0683

Consent to Acupuncture Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substance from the Oriental Materia Medica by **Kimberley Feig, L.Ac.**

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat the bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunctions or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include but are not limited to: changes in bowel movements, abdominal pain/discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the practitioner as soon as possible.*

Cupping/Acupressure/Tui-Na: I understand that I may also be given cupping/acupressure/tui-na as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered in the treatment. I am aware that certain adverse effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanation. I give my permission and consent to treatment.

_____ _____

Signature of Patient/Patient Representative | Today's Date

_____ _____

Print Name | Relationship to Patient

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PATIENT INFORMATION

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Mobile) _____ Email _____

Birthdate, including year _____ Age _____ Height _____ Weight _____ Sex M / F

Occupation _____ Employer _____

How did you hear about us? _____ Is this your first time getting acupuncture? Y / N

Emergency Contact: Name _____ Phone _____

Primary Care Practitioner _____ Phone _____

MEDICAL HISTORY

Successful health care and preventative care are only possible when the practitioner has a complete understanding of the patient's physical, mental, and emotional state. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank You.

Please list any allergies/hypersensitivities _____

_____

Please list any medications and/or supplements you are currently taking, including the associated condition(s) _____

_____

_____

Please list any surgeries or major injuries, including dates _____

_____

_____

Are you pregnant? Y / N If yes, how many weeks _____

Do you have a pacemaker or any metal devices in your body? Y / N

NAME: _____

CHIEF COMPLAINT

Symptom(s) for which you are seeking acupuncture (If more than one, list in order of most concerning to least)

_____

_____

_____

_____

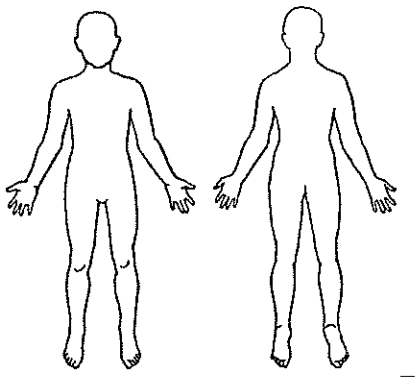
What aggravates your symptom(s)? _____

What alleviates your symptom(s)? _____

How often is/are your symptom(s) present? 0-25% 26-50% 51-75% 76-100%

Have you sought other therapies or treatments for the stated condition(s)? Y / N List _____

Are you experiencing pain/discomfort in any area of your body? Y / N If YES, use the illustration below to mark areas of pain/distress. Also, rate your discomfort level (0-10 with 10 being most painful/debilitating).



What would you most like to achieve with acupuncture treatments? _____

_____

_____

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, and 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 or preceptorship interns who now or in the future treat 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 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

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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, Tui-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.

PATIENT SIGNATURE X Date
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE Date

PLEASE SIGN REVERSE SIDE ALSO

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules, different treatment techniques and patient management. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Please consult with our office manager before your treatment if you have any questions.

CONSENT TO TREAT MINOR

I, _____ the parent or legal guardian, who has permission to make decisions for _____, a minor child, authorize any necessary treatment at propel physical therapy for my minor child and fully agree to the above terms.

_____ _____

Printed Name of Patient | Patient's Signature or that of Legal Representative

_____ _____

Today's Date | If Legal Representative, Indicate Relationship

Aloha Acupuncture

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

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

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Aloha Acupuncture.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Aloha Acupuncture** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

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