Access Acupuncture, Inc.

24619 Washington Ave. Ste. 206
Murrieta, CA 92562
951.698.0102

New Patient Health History

(In order for us to give you the best care possible, please print legibly)

Name: ____ Date: ____/____/____
(first) (middle) (last)

Address__________________________ City ______________ State______ Zip__________

Phone________________ Email____________________ Cell ______________

Emergency contact information Name ______________ Relation __________ Number ____________

Date of Birth: ____/____/____ Age: ______ Gender: M F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient, physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information legibly and indicate areas that might require further explanation with a question mark. Thank you.

1. When and where did you last receive health care? ________________________________

For what reason? ________________________________

Primary Physician's Name and Phone #________________________________

2. Have you had Acupuncture before? **Y** **N** Herbal Medicine? **Y** **N**

3. Chief Complaint ________________________________

________________________________ Date of onset________________

3a. Please tell us your motivation level, on a scale of 1-10, to actively participate in your treatment and healing process: ________

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

____

____

6. Do you have any reason to believe you may be pregnant? **Y** **N** If so, how far along are you?____________

7. Do you have any infectious diseases? **Y** **N** If yes, please identify: ________________

9. **Height:** ________ **Weight:** ________ Maximum: ________ When? ________________

8. **Family History:**

Women's Fertility History

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24619 Washington Ave Suite 206. Murrieta, CA 92562
Phone: 951-698-0102

Name:______________________________________ Age:______________

Successful fertility treatments are possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. If there are areas of confusion, please note with a question mark. This information is kept strictly confidential. Thank you.

Age at which menses began________ Date of last Menstrual Period________________
Are your menstrual cycles regular? Y N How many days? ________________
Are your periods painful? Y N How many days does the pain last? __________
How many days do you normally bleed? ________ Is there clotting? Y N
What color is the blood? Light Red Red Dark Red Purple Brown Black

Do you have PMS? Y N When does it begin? ____________________
Does your face break out before or during your period? Y N
Do your breasts become tender premenstrually? Y N
Do you get premenstrual low back pain? Y N
Do your bowel movements become loose at the beginning of your period? Y N
Do you bleed or spot between periods? Y N

	Number	Year(s)
How many pregnancies have you had?	________	____________________
How many children do you have?	________	____________________
How many Ceasarean sections?	________	____________________
How many abortions have you had?	________	____________________
How many miscarriages have you had?	________	____________________
How many times have you had a D & C?	________	____________________

Date of last PAP Smear?__________Have you ever had an abnormal PAP smear? Y N
Have you ever had a STD? Y N If yes, what was it and when? ______________
Do you get yeast infections regularly? Y N Urinary Tract Infections? Y N
Do you have chronic vaginal discharge? Y N Do you have genital sores? Y N
Have you ever had Pelvic Inflammatory Disease? Y N
Where you treated for it? Y N How______________________________

Have you ever been diagnosed with uterine fibroids or polyps? Y N
Have you ever been diagnosed with endometriosis? Y N
Have you ever been diagnosed with pelvic adhesions? Y N
Have you ever been diagnosed with any pelvic abnormalities? Y N

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long

Have your cycles changed since they began? Y N
How? ___________________________________
Do you ovulate on your own? Y N On what day of your cycle? ___________
Have you taken medication to help you ovulate? Y N
When ______________________ How long? ____________

How long have you been trying to conceive? ____________________
Have you had a diagnosis relating to infertility? Y N What was it? ___________
Have you had fertility treatments? Y N
If yes, when and where? ______________________________
By whom? ______________________________
What types? ______________________________

Have your fallopian tubes been evaluated medically? Y N
What were the results? ______________________________
Have you had any tubal operations? Y N
Have you had any hormone laboratory tests performed? Y N
What were the results? ______________________________

Do you have a single partner with whom you've been trying to conceive? Y N
How long have you been married or living together? ____________________
Has he had a fertility work up? Y N
What were the results? ______________________________
Is your partner supportive of your wish to conceive? Y N

Have you taken oral contraceptives? Y N
When ______________________ How long? ____________
Have you ever had an IUD? Y N
When ______________________ How long? ____________
Have you ever taken DepoProvera? Y N
When ______________________ How long? ____________

How is your sexual energy? Low Normal High
Do you douche regularly? Y N With what? ____________
Do you use vaginal lubricants? Y N

Are you more than 20% over your ideal body weight? Y N
Are you more then 20% below your ideal body weight? Y N

Do you have a stressful occupation? Y N What?______________________
Do you exercise regularly? Y N What form?________________________

Do you have excessive facial hair? Y N
Do you have excessively oily skin? Y N
Have you experienced excessive loss of head hair? Y N
Have you noticed discharge from your nipples? Y N

Was your mother exposed to diethylstilbestrol (DES) when she was
pregnant with you? Y N
Have you been exposed to any know environmental toxins or hormones? Y N
Are you presently taking steroids? Y N

Thank you for taking the time to fill out this health questionnaire. We look forward to working with you on your fertility journey.

I certify that the above information is complete and accurate to the best of my knowledge. I will notify my practitioner with any changes that may occur during the course of my treatment.

______________________________ ____________________
Name Date

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Privacy Policies

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorized.
Safeguards in place at our office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – e.g. your name, address, Social Security number, etc.).
We value our relationship, and respect your right to privacy.

By signing below I agree that I have read and acknowledge the above HIPAA regulations:

Signature: ______________________________ Date: ________________

Access Acupuncture, Inc.
Cancellation Policy

A missed appointment is a loss for everyone.

Should you need to cancel or reschedule an appointment, 24 HOURS NOTICE is required. If you fail to nitify us 24 hours in advance, YOU WILL BE CHARGED $40 FOR YOUR MISSED APPONTMENT.
For Monday cancellation, please call on Friday.

____

Patient Signature (or Patient Representative indicating relationship) Date

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** (Date)

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

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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, Tiu-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 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 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**	(Date)

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

AAC-CA

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER FROM PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the ____Insurance Company to pay by check made out and mailed directly to:

Access Acupuncture
24619 Washington Avenue
Suite 206
Murrieta, CA 92562

If my current policy prohibits direct payment to provider, then I hereby also and instruct and direct you to make out the check to me and Access Acupuncture and mail it to the above address.

For the professional or acupuncture expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid and the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Date____________________________________

____ ____

Signature of policyholder Signature of Claimant, if other than Policyholder