Patient Registration Information

Please print and complete appropriate sections below Date: _____

*** PATIENT'S PERSONAL INFORMATION**

Last Name _____ First Name _____ M. ____ Date of Birth ____ / ____ / _____

Sex ____ Gender_____ How do you wish to be addressed? _____ Marital status ☐ M ☐ S ☐ W ☐ D

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____Cell Phone # _____

Email _____

PRIMARY INSURANCE INFORMATION

Insurance Cards Copied ☐ Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Policy Holder/Subscriber's Name (if self, skip) _____ Phone # _____

DOB ____ / ____ / _____

Address: ☐ Same as Patient, or _____ City _____ State ____ Zip _____

EMPLOYMENT INFORMATION

Patient Occupation _____ Date Hired _____ / _____ / _____ ☐ FT ☐ PT

Employer _____ Name of Employer Contact _____

Address _____ City _____ State _____ Zip _____

Employer Phone # _____ Fax # _____

ATTORNEY INFORMATION (must be filled out if involving auto accident or lawsuit)

Attorney's Name _____ Board # _____

Phone # _____ Fax # _____ Lien on File ☐ Date Sent ____ / ____ / _____

Address _____ City _____ State ____ Zip _____

REFERENCING PHYSICIAN INFORMATION

Name _____ UPIN # _____Specialty _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

*** EMERGENCY CONTACT**

Name _____ Relationship _____ Phone # _____

Address _____ City _____ State ____ Zip _____

*** Assignment of Benefits, Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made direct to (Gerry) Zhengjie Kuo, L.Ac., and any acupuncturists of Healing Remedies, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

* Your Signature _____ Date ____ / ____ / _____

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PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

* Present Complaint or Illness: _____

_____

_____

Duration of the Illness: _____

Events Preceding this Onset: _____

_____

_____

Western Medical Diagnosis (if known): _____

How long since you have been well? _____

Personal Health Goals: _____

_____

Any travel in the last 6 months and where? _____

_____

Vaccinations? _____

Special Diet? _____

_____

Allergic to Medication? _____

Drug Names and Reaction: _____

List of Current Medications and Dosages: _____

_____

_____

Have you had any of the following? If yes, please briefly describe:

☐ Chill ☐ Heat ☐ Day Sweat ☐ Night Sweat ☐ Headache ☐ Thirsty ☐ Vision ☐ Hearing ☐ Sleep

☐ Appetite ☐ Pain Status ☐ Bowel ☐ Urine ☐ Others: _____

Surgery: _____

Women Only:

Age of First Menstruation: _____ Age of Menopause: _____

How Many Days Each Cycle: _____ Duration of Menstruation Period: _____

Onset Date of the Most Recent Menstruation: _____

Cramping/Pain ☐ before ☐ during ☐ after the period

Color: _____ Clot: _____ Smell: _____

# of Children & Ages : _____ Complications: _____

# of Miscarriages: _____ C-Sections:_____

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NOTICE OF PRIVACY POLICIES

This notice describes our 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. This notice will remain in effect until it is replaced or amended by changes in the law.

We gather personal information and health information in several ways: information we receive, information we receive from other healthcare providers, and information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specially authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

This office may use or disclose your Protected Health Information when required by law.

Upon written request, you have the right to access, review or receive copies of your healthcare records. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information. Upon written request, you have the right to request that this office place additional restrictions on disclosure of you Protected Health Information. Upon written request, you have the right to request that we amend your Protected Health Information. You have the right to receive all notices in written.

If you have questions, complaints or want more information, please contact Zheng-jie "Gerry" Kuo L.Ac. at 415-636-7345.

You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH Building

Washington, DC 20201

Signature: _____ Date: _____

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. Bums 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.

Signature: _____ Date: _____

(Or Patient Representative, indicate relationship if signing for patient)

AAC-FED

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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 state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up \their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, 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 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	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	(Date)