Patient Data Sheet

Patient: _____ Date: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____ Age: _____

Employed: ☐Full Time ☐Part Time ☐Retired ☐None Student: ☐Full time ☐Part time

Occupation: _____ Work Phone: _____

Employer: _____

Emergency Contact: _____ Relation: _____

Phone: _____ Alternate Phone: _____

Referred by: _____

Please indicate if you have any of the following:

☐ Cardiac Pacemaker	☐ Seizure disorder	☐ High Blood Pressure	☐ HIV
☐ Fainting Disorder	☐ Hepatitis B	☐ Diabetes	☐ TB
☐ Bleeding Disorder	☐ Hepatitis C	☐ Herpes	☐ Possibly Pregnant

☐ other: _____

Have you had any surgeries, please explain: _____

_____

_____

Main reason for your visit today: _____

_____

_____

_____

Patient signature: _____ Date: _____

***If patient is a minor please print name and signature of legal guardian:**

Name: _____ Signature: _____

Address: _____ Date: _____

Patient Data Sheet

Has this condition/injury been addressed by another physician? ☐Yes ☐No

When: _____ What was the result? _____

Physician's name: _____ Phone: _____

Please list any prescribed medications you are currently taking:

	Medication	Dosage	Purpose
1.			
2.			
3.			
4.			
5.			

Please list any vitamins, supplements and/or herbal products you currently take:

	Medication	Dosage	Purpose
1.			
2.			
3.			
4.			
5.			

***If patient is a minor please list parent information:**

Mother's name: _____ Phone: _____

Mother's address (if different from minor) _____

_____

Father's name: _____ Phone: _____

Father's address (if different from minor) _____

_____

Patient Data Sheet

Please check all that apply to you:

☐ Cold hand/feet
☐ Fatigue
☐ Feverish or flushed in the afternoon
☐ Heat sensations in hands, feet or chest
☐ Night sweats
☐ Catches colds easily
☐ Dizziness
☐ See floating black spots in vision

☐ Palpitations
☐ Sore on the tip of the tongue
☐ Restlessness
☐ Anxiety
☐ Chest pain radiating to the 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
☐ Loose stools
☐ Constipation
☐ Abdominal bloating and/or gas after eating
☐ Feeling tired after eating
☐ Prolapsed organs (formally diagnosed)
☐ Bruises easily
☐ General feeling of heaviness in body
☐ Mental heaviness, sluggishness or fogginess
☐ Swollen hands/feet

☐ Burning sensation after eating
☐ Bad breathe
☐ Large appetite
☐ Mouth (canker) sores
☐ Bleeding, swollen painful gums
☐ Heartburn/reflux/belching
☐ Stomach pains
☐ Vomiting/dry heaves

☐ Diarrhea alternating with constipation
☐ Tight feeling in chest
☐ Bitter taste in mouth
☐ Blood shot eyes/dry eyes
☐ Angers easily
☐ Skin rashes
☐ Headaches/migraines
☐ Numbness of hands and/or feet
☐ Muscle spasms, twitching, cramping
☐ Seizures/convulsions

☐ Sore, cold or weak knees
☐ Low back pain
☐ Frequent urination
☐ Wake more than once a night to urinate
☐ Lack of bladder control
☐ Memory problems
☐ Hair loss
☐ Ringing in the ears: high/low pitch

Urine is:

☐ Normal color
☐ Dark Yellow
☐ Cloudy
☐ Bad odor
☐ Difficult
☐ Burning
☐ Clear
☐ Reddish
☐ Scanty
☐ Painful
☐ Urgent
☐ _____

Libido (sex drive) is:

☐ Normal ☐ Low ☐ High

Patient Data Sheet

Has anyone in your family been diagnosed with:

☐ Diabetes ☐ Cancer ☐ High blood pressure ☐ Heart disease ☐ Stroke
☐ Seizures ☐ Asthma ☐ Allergies ☐ other: _____

Which family members:

Mother's family: _____

Father's family: _____

Occupational stresses (chemical, physical, psychological, etc.):

_____

Do you have a regular exercise program: ☐ Yes ☐ No

If so, please describe briefly: _____

_____

Have you ever been on a restricted diet: ☐ Yes ☐ No

If so, what type**?** _____

Please describe your average daily diet:

Morning Afternoon Evening

_____

_____

_____

_____

Do you smoke tobacco products: ☐ Yes ☐ No What type/how much: _____

Do you drink alcohol? ☐ Yes ☐ No Type/how much per week: _____

How much: ☐ Coffee ☐ Tea ☐ Soda do you drink per week: _____

Do you use any cannabis products (including CBD) for medicinal purposes: ☐ Yes ☐ No

What type: _____ Purpose: _____ How often: _____

Do you use any substances for non-medical or recreational use: ☐ Yes ☐ No

What type & how often per week: _____

Patient Data Sheet

Women Only:

1. Are you currently pregnant?
   ☐ Yes ☐ No
2. Number of children _____
3. Number of pregnancies _____
4. Age of first period _____
5. Age of menopause: _____
6. Is your menstrual cycle regular?
   ☐ Yes ☐ No

a. Average number of days per flow: ____

b. Menstrual flow is:

☐ Normal ☐ Heavy ☐ Light

c. The color is:

☐ Normal ☐ Dark ☐ Purple

☐ Light Brown ☐ Brown

d. Do you have any of the following menstrual related signs/symptoms:

☐ Blood clots

☐ Cramps

☐ Nausea

☐ Breast Distention

☐ PMS

☐ Bleeding between periods

☐ Heavy vaginal discharge between periods

e. Method of contraception (if any):

_____

Men Only:

☐ Feeling coldness or numbness in the external genitalia

☐ Pain or swelling in the testicles

☐ Premature ejaculation

☐ Impotence/erectile dysfunction

_____

Women and Men:

Please list any uro-genital injuries/disease you have ever ben diagnosed with.

_____

_____

_____

_____

_____

_____

_____

Informed Consent Form

Acupuncture is part of a larger medical system called Chinese Medicine that includes other therapeutic modalities. This medical system relies on your body's innate healing capacity and requires each person to take responsibility for their own health by participating in the healing process. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relieve is sustained. Every patient participates with the acupuncturist in a healing partnership. The statements below describe some of the therapeutic modalities which may be employed during treatment, and assist in patient understanding and participation in the treatment process.

Acupuncture is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used in this clinic. The location of the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the needling site or fainting. Momentary euphoria or light-headedness may occur after acupuncture treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause of concern.

Electrical stimulation (e-stim) of the acupuncture needles involves using a small, battery-powered stimulator attached by wires to the acupuncture needles. A slight throbbing or tingling sensation may be felt during and for a few hours after the use of this stimulator. This modality is usually employed for pain management and other specific conditions.

Moxibustion is the application of indirect heat supplied by burning the herb *Folium Artimesiae Vulgaris*, (commonly known as mugwort) over a single acupuncture point or a group of points. This generally produces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidents, a minor burn may occur at the site of moxibustion. The attending acupunctures can readily address this.

Cupping uses round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to several days. These marks may resolve on their own and are not indications of complications or injury.

Qi Gong, Chinese for "energy work," is a non-invasive healing modality that predates the use of acupuncture needles, and incorporates the same therapeutic basis as acupuncture.

Herbal supplements are used to facilitate the body's own restorative process. These herbs are usually taken in tea form by boiling dried plants in their natural forms. Chinese herbal teas tend to taste bitter because they are made mostly from roots and barks. As an alternative to natural herb form we also utilize powdered extracts to create herbal prescriptions, as well as ready made formulas in pill or capsule form that are referred to as "patent" formulas. On rare occasions, temporary gastric upset may occur. If any discomfort persists, and is accompanied by hives or shortness of breath, contact our attending acupuncturist immediately.

Signature: _____ Date: _____

Signature of Patient's Representative and Relation: _____

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language, the notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses are disclosures that will be made only with my written authorization and that may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these right in relation to:
    - The right to complaint to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice current Notice of Privacy Practices on request

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient) _____

Payment Policy

Payment is due at the time of service unless special arrangements have been authorized by the clinic manager in advance.

Due to the high demand for appointments, **the following fee of $70 will be applied for all "no shows" and cancellations made less that 24 hours in advance. This is your financial liability & responsibility. Know that your insurance will not cover this fee.**

A return check charge of $35 will also apply to any checks returned by the bank unpaid.

Insurance deductibles must be met before insurance benefits can apply towards treatment. Until that deductible is met, regular cash prices will apply. In the event that the insurance policy covers a treatment already paid by the patient, a refund will be given to that patient in the amount he or she has paid for that treatment.

Co-pays are the responsibility of the patient to pay at the time of service. It is illegal to receive treatment without paying it when billing the patients insurance.

Some insurance companies will send treatment payments to the patients directly via super bill. In this event, the patient is responsible for full payment in advance for the treatment and the insurance payment will be considered a reimbursement for that payment. If the amount to be paid by the insurance is unknown, the cash amount will be paid for that treatment and any remaining balance will be billed to the patient. If there is an overpayment, the patient will be refunded the difference. Refunds will be mailed to the patient in the form of a check within 10 business days upon verification of overpayment.

Herbal Policy:

Herbal formulas and products are not covered by insurance. They are billed to the patient as a charge separate from treatment received by the patient that is billed to the patient's insurance. These are two separate transactions.

Herbal formulas must be paid for with payment for treatment and are not returnable for refund or credit.

I have read and understand the above policies. I am aware that I will be personally responsible for any of the above charges/fees incurred.

Signature: _____ Date: _____

Signature of Patient's Representative and Relation to Patient _____

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 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 or 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 of 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:

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 indicated 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 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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 conditions(s) for which I seek treatment.

ACUPUNCTURIST NAME: Jose L. Bermudez, Dipl. OM., DAOM, L. Ac. Eastern Medical Health Group

PATIENT SIGNATURE: X DATE:

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