Patient Information Today's Date: _____/_____/_____

Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Phone: Home _____ Work _____ Mobile _____

Email Address: _____ Referred by: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Weight: _____ Height: _____

Marital status: Single Married Divorced Widowed Domestic Partner Other: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Employment status: Full-time Part-time Self-Employed Unemployed Student Retired Other: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____ Average hours of work/study: _____

Occupational Stress (Physical, Chemical or Psychological, if any): _____

Health Insurance Provider: _____ Phone _____ Fax _____

Insurance Address: _____

Policy Holder's Name: _____ Policy ID# _____ Group # _____

Primary Care Physician: _____ Phone _____ Fax _____

Address: _____

MISSED APPOINTMENT POLICY
If you need to change or cancel your appointment please do so within 24 hours notice. Failure to do so will result in being charged full price for missed appointment.
_____ I understand cancellation policy.

Patient Health History

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. Thank you.

What is your reason for today's visit? _____

When and how did the condition develop? _____

How does the condition affect your daily life? _____

Have you been treated for the condition? Yes/ No If Yes, how? _____

What makes it better? _____ Worse? _____

Please list current health diagnoses (if applicable) ie. HIV, hepatitis, diabetes, ulcers, high cholesterol, high blood pressure, cancer, arthritis, etc.

_____

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): _____

_____

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

_____

Please list any major hospitalization or surgery or injury: _____

_____

Habits: Please check any habits which apply to you now or in the past

Coffee: [ ] Yes [ ] No	_____ Cups per day/week	Age started:	Age quit:
Tobacco: [ ] Yes [ ] No	_____ Cigarettes per day/week	Age started:	Age quit:
Alcohol: [ ] Yes [ ] No	_____ Use per day/week	Age started:	Age quit:
Marijuana: [ ] Yes [ ] No	_____ Use per day/week	Age started:	Age quit:
Other: _____	_____ Use per day/week	Age started:	Age quit:

Please briefly describe your diet: _____

Do you exercise? ____ If yes, what and how many times a week? _____

How many hours do you sleep per night? _____ hours Do you feel rested when you wake up in the morning? Yes No

For Women: Menstrual/Birthing History

Are you currently pregnant? Yes No If yes, how far along? _____

Previous Pregnancies: Total _____ Living ____ Ectopic _____ Miscarriages _____ Induced abortions _____

Age of first period: _____ First Date of Last Menstral Period:_____ Duration of menses (Days of flow): _____

Current methods of contraception: _____ Pertinent contraception history: _____

Date of Menopause _____ Any bleeding since menopause? _____ If so, how often? _____

Please check any current or past symptoms:

GENERAL
Past Current Condition
[ ] [ ] Poor Appetite
[ ] [ ] Excessive Appetite
[ ] [ ] Easily Tired/Chronic Fatigue
[ ] [ ] Slow Wound Healing
[ ] [ ] Insomnia
[ ] [ ] Fevers
[ ] [ ] Night Sweats
[ ] [ ] Sweat Easily
[ ] [ ] Lack of Sweat
[ ] [ ] Chills
[ ] [ ] Strong Thirst
[ ] [ ] Frequent Colds
[ ] [ ] Cold Hands/Feet
[ ] [ ] Sudden Weight Change
[ ] [ ] Other: _____

SKIN & HAIR
Past Current Condition
[ ] [ ] Rashes
[ ] [ ] Hives
[ ] [ ] Itching
[ ] [ ] Eczema
[ ] [ ] Pimples
[ ] [ ] Dryness
[ ] [ ] Tumors, Lumps
[ ] [ ] Bruise Easily
[ ] [ ] Hair Falling Out

HEAD & NECK
Past Current Condition
[ ] [ ] Dizziness
[ ] [ ] Fainting
[ ] [ ] Neck Stiffness
[ ] [ ] Enlarged Lymph Glands
[ ] [ ] Headaches
[ ] [ ] Concussions
[ ] [ ] Other: _____

EARS
Past Current Condition
[ ] [ ] Infection
[ ] [ ] Ear Ringing
[ ] [ ] Decreased Hearing
[ ] [ ] Other: _____

EYES
Past Current Condition
[ ] [ ] Blurred Vision
[ ] [ ] Visual Changes
[ ] [ ] Poor Night Vision
[ ] [ ] Spots
[ ] [ ] Cataracts
[ ] [ ] Glasses/Contacts
[ ] [ ] Eye Inflammation
[ ] [ ] Other: _____

NOSE, THROAT, MOUTH
Past Current Condition
[ ] [ ] Nose Bleeds
[ ] [ ] Sinus Infections
[ ] [ ] Hay fever/Allergies
[ ] [ ] Recurring Sore Throat
[ ] [ ] Teeth Grinding/TMJ
[ ] [ ] Difficulty Swallowing

CARDIOVASCULAR
Past Current Condition
[ ] [ ] High/Low Blood Pressure
[ ] [ ] Heart Disease
[ ] [ ] Blood Clots
[ ] [ ] Palpitation
[ ] [ ] Fainting
[ ] [ ] Phlebitis
[ ] [ ] Chest Pain
[ ] [ ] Irregular Heart Beat
[ ] [ ] Heart Murmurs
[ ] [ ] Swelling of Hands/Feet
[ ] [ ] Other: _____

RESPIRATORY
Past Current Condition
[ ] [ ] Asthma
[ ] [ ] Bronchitis
[ ] [ ] Chronic Obstructive Pulmonary Disease (COPD)
[ ] [ ] Emphysema
[ ] [ ] Pneumonia
[ ] [ ] Cough
[ ] [ ] Coughing Blood
[ ] [ ] Production of Phlegm
[ ] [ ] Shortness of Breath
[ ] [ ] Other: _____

GASTRO-INTESTINAL
Past Current Condition
[ ] [ ] Nause
[ ] [ ] Vomiting
[ ] [ ] Diarrhea
[ ] [ ] Belching
[ ] [ ] Blood in Stool
[ ] [ ] Heart Burn/Reflux
[ ] [ ] Bad Breath
[ ] [ ] Rectal Pain
[ ] [ ] Hemorroids
[ ] [ ] Constipation
[ ] [ ] Stomachache
[ ] [ ] Indigestion
[ ] [ ] Ulcers
[ ] [ ] Gas/Bloating
[ ] [ ] Other: _____

GENITO-URINARY
Past Current Condition
[ ] [ ] Kidney Stones
[ ] [ ] Pain during Urination
[ ] [ ] Frequent Urination
[ ] [ ] Blood in Urine
[ ] [ ] Urgency to Urinate
[ ] [ ] Urinary Incontinence
[ ] [ ] Other: _____

MUSCULOSKELETAL: Pain, Weak or Numb
Past Current Condition
[ ] [ ] Arms, Hands
[ ] [ ] Legs, Ankles, Feet
[ ] [ ] Joints
[ ] [ ] Hips
[ ] [ ] Knees
[ ] [ ] Neck/Shoulder
[ ] [ ] Back: lower, middle, upper
[ ] [ ] Muscle Spasm/Cramps
[ ] [ ] General Lack of Strength

MALE
Past Current Condition
[ ] [ ] Genitalia Pain/Itching
[ ] [ ] Penile Discharge
[ ] [ ] Impotence
[ ] [ ] Low Sexual Energy
[ ] [ ] Nocturnal Emission
[ ] [ ] Seminal Emission
[ ] [ ] Weak Urinary Stream
[ ] [ ] Testicle Lumps or Swelling
[ ] [ ] Prostate Condition
[ ] [ ] Other: _____

FEMALE
Past Current Condition
[ ] [ ] Frequent UTI
[ ] [ ] Frequent Vaginal Infections
[ ] [ ] Genital pain/itching
[ ] [ ] Genital lesions/discharge
[ ] [ ] Pelvic Inflammatory Disease
[ ] [ ] Abnormal Pap Smear
[ ] [ ] Irregular Menstrual Periods
[ ] [ ] Painful Menstrual Periods
[ ] [ ] Premenstrual Syndrome
[ ] [ ] Abnormal Uterine Bleeding
[ ] [ ] Menopausal Syndrome
[ ] [ ] Breast Lumps
[ ] [ ] Breast discharge
[ ] [ ] Uterine Prolapse
[ ] [ ] Facial Hair
[ ] [ ] Difficulty Conceiving
[ ] [ ] Easily Miscarry
[ ] [ ] Other: _____

NEUROLOGICAL
Past Current Condition
[ ] [ ] Seizures
[ ] [ ] Tremors
[ ] [ ] Numbness or Tingling
[ ] [ ] Concussion
[ ] [ ] Paralysis
[ ] [ ] Stroke
[ ] [ ] Poor Coordination/Loss of Balance
[ ] [ ] Other: _____

PSYCHOLOGICAL
Past Current Condition
[ ] [ ] Depression
[ ] [ ] Anxiety
[ ] [ ] Stress/Irritability
[ ] [ ] Treated for Emotional or Psychological Conditions
[ ] [ ] Other: _____

INFECTION SCREENING
Past Current Condition
[ ] [ ] HIV
[ ] [ ] Tuberculosis
[ ] [ ] Hepatits
[ ] [ ] Gonorrhea
[ ] [ ] Chlamydia
[ ] [ ] Syphilis
[ ] [ ] Genital Warts
[ ] [ ] Herpes: Oral
[ ] [ ] Herpes: Genital
[ ] [ ] Human Papilloma Virus (HPV)
[ ] [ ] Other: _____

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Eunice Kan, L.Ac.. I have discussed the nature and purpose of my treatment with the above named practitioner. 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, physiotherapy exercises as well as lifestyle and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have 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. Infection is another possible risk. However, I understand that Eunice Kan, L.Ac., only uses sterile disposable single use needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and /or scarring are a potential risk of moxibustion. 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 understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Eunice Kan, L.Ac. of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Eunice Kan, L.Ac. if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgment during the course of treatment which she thinks at the time, based upon facts then known, is in my best interests.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

If I am unable to make a pre-scheduled appointment, I agree to cancel <u>at least 24 hours in advance</u>. I understand that failure to do so will result in my being **charged the full amount** of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my time-slot may be given to another client.

I understand that Eunice Kan, L.Ac. has the right to refuse treatment to any patient at anytime. Reasons for refusal of treatment include crude behavior or inappropriate conduct.

By voluntarily signing below, I show that I have read, or have had read to me, this 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.

_____	_____
PRINT NAME OF PATIENT (OR REPRESENTATIVE)	PRINT NAME OF PRACTITIONER
X_____	X_____
SIGNATURE OF PATIENT (OR REPRESENTATIVE)	Signature of Practitioner

<u>Confidentiality</u>: Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

NOTICE OF PRIVACY POLICY (HIPAA: Health Insurance Portability and Accountability Act)

Live Well Acupuncture & Herbal Medicine (hereinafter "Live Well") is dedicated to provide service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

You should be aware that during the course of our relationship, we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

You may specifically authorize us to use protected health information for any purpose or to disclose your 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.

Marketing
Live Well will not use your health information for marketing communications without your written authorization. However, we may send birthday cards, newsletters and appointment reminders, by telephone calls or email.

Disclosure
Live Well may use or disclose your Protected Health Information when required by law.

Patient Rights
- Upon written request, you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $15 and 10-days processing period.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I show that I have read, reviewed, understood and agreed to the statement of the Privacy Policy for healthcare services in Live Well.

Patient Signature _____ Date_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: lt 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: lt 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. lt 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider and/or the healthcare 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 circumstance 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 healthcare 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: lf patient intends this agreement to cover services rendered before the date it is signed (for example, Emergency treatment) patient should initial here. _____. Effective on the date of first professional service.

lf 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) (lndicate relationship if signing for patient)

OFFICE SIGNATURE X _____ (Date) _____

Insurance Information

At Live Well, we provide insurance billing as a courtesy to our patients. Currently, we accept most PPO insurance plans and are not currently "in-network" with any of them. Depending on your plan, you may still be covered, but this may result in a lower percentage of your claim being paid. Your financial responsibility depends on your specific health insurance plan.

If we are not able to verify your coverage before your first visit, you are responsible for the full payment at the time of service. We will issue a refund for your acupuncture charge when we receive payment from your insurance company. When we are able to verify coverage and get an estimate of what they will cover, you will be expected to pay a co-pay at the time of service. Amount due at time of service may need to be adjusted once we receive payments from your insurance company.

Please remember, the ultimate financial responsibility for payment lies with the patient, not the insurance company.

Release of information

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes our office to release medical information necessary to process your claim.
Your signature below acknowledges that you have read and agreed to the terms.

Patient Signature _____ Date: _____

Thank you. We look forward to working with you.