WE LOVE ACUPUNCTURE, INC.

NEW PATIENT INFORMATION FORM

Name: _____
First M.I. Last

Today's Date: _____ **Date of Birth:** _____

Referred By: _____

Please complete the following information as thoroughly and honestly as possible. Know that all answers are confidential. Please print clearly. Thank you.

Reason for Today's Visit: _____

_____

Is this issue the result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other**:** _____

Date of Injury/Accident/Onset: _____

Has your case been referred to an attorney? ☐ Yes ☐ No **Who?** _____

Have you seen other health care providers for this issue? ☐ Yes ☐ No

If Yes: When? _____ **With Whom?** _____

Results of Treatment: _____

Other problems: _____

_____

Have you tried acupuncture for the current issue or any past issues? ☐ Yes ☐ No

If Yes: When? _____ **With Whom?** _____

Results of Treatment: _____

What do you want from your acupuncture treatment? _____

_____

If applicable, please list any allergies or hypersensitivities (please include reaction):

_____

_____

Please list any medications (prescribed or OTC), vitamins, or supplements you are currently taking:

_____

_____

_____

Do you have any infectious diseases? ☐ Yes ☐ No **If yes, please identify:** _____

_____

WE LOVE ACUPUNCTURE, INC.

PREVIOUS HEALTH HISTORY (INCLUDE YEARS)

Injuries /Accidents / Major Illnesses: _____

_____

Surgeries and Hospitalizations: _____

_____

X-Rays / MRI's / CAT Scans: _____

_____

LIFESTYLE

List any exercise activities. Include frequency: _____

_____

Spiritual Practice: _____

List frequency & amount of nicotine/alcohol/caffeine/drug use: _____

_____

Amount of water consumed daily: _____

CONFIDENTIAL / PERSONAL INFORMATION

Name: _____
First Middle Last

Street: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Mobile Phone:** _____

Email: _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ **M** ☐ **F** **Marital:** ☐ **M** ☐ **S** ☐ **D** ☐ **W**

Occupation: _____ **Work Phone:** _____

Employer: _____ **Address:** _____

Do you enjoy work? ☐ **Yes** ☐ **No** **Why or Why Not?** _____

Level of Education Completed: ☐ **High School** ☐ **Bachelors** ☐ **Masters** ☐ **Doctorate** ☐ **Other**

Emergency Contact Name & Phone _____

Financial arrangement on your account: ☐ **Cash** ☐ **Check** ☐ **Credit Card**
We Love Acupuncture ***does not bill insurance directly****, but we can provide you with a Super-Bill and advise you how to seek reimbursement from your health insurance carrier for any fees related to your care with us.*

WE LOVE ACUPUNCTURE, INC.

FOR MINORS

Parent/Gaurdian #1 – Name: _____

Relation to Minor: _____ **Phone No:** _____

Address: _____

Parent/Gaurdian #2 – Name: _____

Relation to Minor: _____ **Phone No:** _____

Address: _____

WOMEN ONLY

Mark any you are ***currently*** experience or ***frequently*** experience

Women Only

__ Are you pregnant? □ Yes □ No
# of weeks along ____
# of pregnancies____
# of live births____
# of miscarriages____
# of abortions____
Date of last menstrual period_____
Duration of flow_____
Length of cycle_____
__ Irregular cycle/Missed periods
__ Blood clots
__ Heavy bleeding
__ Light/Scanty bleeding
__ Cramping
__ Pain before cycle
__ Pain during cycle
__ Pain after cycle
__ PMS
__ Painful breasts
__ Hot flashes
__ Vaginal infection
__ Vaginal discharge
__ Fibroids
__ Endometriosis
__ Ovarian Cysts
__ Other_____

PATIENT CERTIFICATION

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with California state statutes, for the care and management of this complaint

Patient's (or Guardian's) Signature: _____ **Dated:** _____

WE LOVE ACUPUNCTURE, INC.

EXPLANATION OF PAYMENT AUTHORIZATION FORM AND POLICY

To provide more efficient service to you as a patient of We Love Acupuncture, Inc. or Brent Keime, LAc, MSTOM, Dipl. O.M., DBA We Love Acupuncture ("We Love Acupuncture"), we are requesting that you authorize this Payment Authorization Form for future payments for our services.

By submitting your payment information, you authorize We Love Acupuncture, Inc. to charge the card provided here for any and all charges associated with your treatment and/or product purchases.

Additionally, by submitting this Form, you agree to the following Cancellation Policy:

> **Failure to provide twenty-four (24) hour notice of cancellation of appointment to We Love Acupuncture, Inc. by telephone (619-800-2287) or email (brent@weloveacupuncture.com), will result in a charge equal to the full amount of a single visit to the card provided under the Payment Authorization Form. This policy will only be waived in limited emergency circumstances, and any single waiver does not void this policy.**

Please know this Policy hopes to establish mutual respect between our patients and our business. As you may know, routine attendance is the best way to gain the greatest benefit from acupuncture treatment. We aim to keep the cost for treatment reasonable because we want to ensure that our patients can benefit from acupuncture treatment by being able to come on a frequent and regular basis. Last minute cancellations or no-shows cause other patients to miss out on an opportunity for treatment. This also makes it harder for We Love Acupuncture, Inc. to maintain the reasonable treatment cost. We appreciate you as a patient, and value our time with you. We hope this policy will encourage you to maintain your appointment.

If you have any questions regarding the Cancellation Policy or this Payment Authorization Form, please inquire with our staff.

Thank you and we look forward to continuing to provide the best service possible.

All the best,

We Love Acupuncture, Inc.

PAYMENT AUTHORIZATION FORM

I, _____, authorize We Love Acupuncture, Inc., to initiate payment regarding my treatment by charging my:

☐ **Debit** ☐ **Visa** ☐ **Master Card** ☐ **Discover** ☐ **American Express**

Credit Card Number: _____

Expiration Date: _____ CVV/CVC Number or Card Identification Number: _____

Name as it appears on the Card: _____

Billing Address – Street: _____

City: _____ State: _____ Zip: _____

I understand and acknowledge that this authorization will remain in effect until I have cancelled by providing written notice to We Love Acupuncture, Inc.

Patient Name (Print): _____

Patient Signature: _____ Date: _____
(Guardian or Legal Representative)

WE LOVE ACUPUNCTURE, INC.

CONSENT TO TREATMENT AND THE USE AND DISCLOSURE OF HEALTH INFORMATION

Please review the following items and provide your informed consent. By initialing beside each statement you acknowledge that you have read, understand, and agree.

I understand 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. _____ **(initials)**

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, gua sha, ultrasound 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 have an unpleasant smell or taste. I further agree to immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. _____ **(initials)**

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 or radiating from the needling sites that may last a few days, and dizziness or fainting. Burns, blistering, or scarring are a potential risk of moxibustion, ultrasound and cupping, or when treatment involves the use of heat lamps or hot packs. Bruising and tenderness is a common side effect of Tui-Na, gua sha, acupuncture and cupping. _____ **(initials)**

I have been informed that 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 single-use, sterile, disposable needles and maintains a clean and safe environment. _____ **(initials)**

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. _____ **(initials)**

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. _____ **(initials)**

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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. _____ **(initials)**

I understand that as part of my healthcare, We Love Acupuncture, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. _____ **(initials)**

I understand that this information serves as a basis for planning my care and treatment, as a means of communication among the many healthcare professionals who contribute to my care, as a source of information for applying my diagnosis and surgical information to my bill, a mechanism by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals. _____ **(initials)**

(Continued on Next Page)

WE LOVE ACUPUNCTURE, INC.

I understand that I have the right to object to the use of my health information for directory purposes, to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that We Love Acupuncture, Inc. is not required to agree to the restrictions requested. _____ **(initials)**

I understand that I have the right to revoke this consent in writing, except to the extent that We Love Acupuncture, Inc. has already taken action in reliance thereupon. _____ **(initials)**

I request the following restrictions to the use of disclosure of my health information: _____

_____

_____

_____

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. _____ **(initials)**

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 regarding the use and disclosure of my health information.

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.

Acupuncturist's Name: BRENT KEIME, LAc

Patient Name (Print): _____

Signature: _____ Date: _____
(Guardian or Legal Representative)

Indicate relationship to patient: _____

WE LOVE ACUPUNCTURE, INC.

ARBITRATION AGREEMENT

Section 1: Definitions. The Parties are defined as _____ ("Patient or Legal Representative") and We Love Acupuncture, Inc. ("Healthcare Provider").

Section 2: Initial Dispute Notice and Resolution. In the event of any dispute between the Parties including but not limited to: (i) those arising out of or relating to the healthcare treatment of Patient, (ii) 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, and (iii) any other disputes regarded as such by only one of the Parties, the aggrieved Party shall promptly notify in writing the other Party of the dispute within ten (10) calendar days after such dispute arises.

Section 3: Agreement to Arbitrate. If the Parties shall have failed to resolve the dispute within fourteen (14) calendar days after delivery of such notice, each Party shall have the right to enforce any and all rights available and defined in the proceeding sections of this Agreement.

The Parties agree that any such dispute or claims 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. Further, the Parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis.

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, as to whether this Agreement is unconscionable, and any 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 Health Care Provider including any heirs or past, present or future spouse(s) of Patient in relation to all claims, including loss of consortium.

Section 4: Additional Binding Effects. This Agreement is also intended to bind any children of Patient whether born or unborn at the time of the occurrence giving rise to any claim. This Agreement is intended to bind Patient and Health Care Provider and/or other licensed health care providers, preceptors, or 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 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.

Section 5: Procedure for Arbitration Demand. 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.

Section 6: Cost Allocation. 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.

(continued on next page)

Section 7: Applicable Law. 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 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.

Section 8: 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.

Section 9: Revocation: This Agreement may be revoked by written notice delivered to Health Care Provider within 30 days of signature and, if not revoked, will govern all professional services received by Patient and all other disputes between the Parties.

Section 10: 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.

Section 11: Severability. 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 and I agree in full to all terms of this Agreement.

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 SECTION 3 OF THIS CONTRACT.

Patient Name (Print): _____

Signature: _____ Date: _____
(Guardian or Legal Representative)

Indicate relationship to patient: _____

Office Representative Name (Print): _____

Signature: _____ Date: _____

WE LOVE ACUPUNCTURE, INC.

RECORDS RELEASE PURSUANT TO *HIPAA*

I, _____ hereby authorize the disclosure and release of any of my individually identifiable health information and any other medical records to my healthcare provider, We Love Acupuncture, Inc.

This Authorization is intended to satisfy the requirements of the ***Health Insurance Portability and Accountability Act*** (*42 U.S.C. § 1320d*) (***HIPAA***) and the California Confidentiality of Medical Information Act (Civil Code § 56 *et seq*.) (CMIA) for the disclosure of information to my healthcare provider.

The entities who are authorized to disclose and release my individually identifiable health information and any other medical records to my healthcare provider are any entity or entities that are subject to the privacy requirements of ***HIPAA*** and CMIA.

I intend that We Love Acupuncture, Inc. be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

Pursuant to this authorization, We Love Acupuncture, Inc. may make whatever use of such information as is necessary for purposes of carrying out my healthcare treatment as determined by We Love Acupuncture, Inc.

This Authorization is effective immediately.

Patient Name (Print): _____

Signature: _____ Date: _____
(Guardian or Legal Representative)

Indicate relationship to patient: _____

WE LOVE ACUPUNCTURE, INC.

Our Clinic Protects Your Health Information and Privacy

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 authorize.

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 part 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. If you have questions about our privacy guidelines, please call us during regular business hours at (619)800-2287.

Be Well,

We Love Acupuncture, Inc.
4455 Twain Ave, Ste. H1
San Diego, CA 92120