Welcome to OMBE!

Welcome to OMBE and the office of Jessica L. Molleur, Lic.Ac., DNBAO. As a licensed acupuncturist, my goal is to help you achieve your health and well-being goals. The following health questionnaire will take you several minutes to complete. You may need to gather previous records, health insurance information, or other records to answer all the questions on this form. Please complete the questionnaire as carefully and completely as you can. All the information you provide is confidential and we will review your health history together during the initial acupuncture session. I understand that filling out these forms can be challenging. Please call my office if you have any questions as you fill this form out in advance. If there is anything you wish to bring to my attention that is not addressed on this form, please note it in the additional comments section at the end of the form.

I look forward to meeting with you at our first appointment.

Regards,

Jessica L. Molleur, Lic.Ac., DNBAO

ACUPUNCTURE HEALTH HISTORY

CLIENT INFORMATION

1. Name:_____
First Middle Last

2. Address: _____
Street Apt City State Zip

3. Phone: _____ 4.Email address:_____

5. Date of Birth: _____ 6. Age:_____ 7. Gender: _____

8. Marital Status:_____ 9. Partner's Name: _____

EMPLOYMENT INFORMATION

☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

10. Occupation: _____ 11. Employer: _____

12. Employer's Address:_____
Street Address City State Zip Phone

HEALTH CARE INFORMATION

13. Primary Care Physician:_____
Name Specialty Phone

14. Physician Address: _____
Street Apt City State Zip

15. Have you received acupuncture previously? YES NO

16. If yes, please list the names of any acupuncturist that you have received treatment from recently.

_____
Name Street Ste State Zip Phone

17. Who may we thank for referring you? _____

18. (MINORS ONLY) List guardian names, addresses and contact information.

_____
Name Street State Zip Phone

19. In case of an emergency, please call: _____

Name Relationship

_____

Street Apt City State Zip Phon

CHIEF COMPLAINT

20. If your office visit is for a specific health condition, please describe your concern in as much detail as possible.

21. Have you received a diagnosis for this condition? _____ 22. By whom were you diagnosed? _____

23. Please list any additional physicians, healthcare practitioners, or treatments you have received for this condition.

Physician Name Office Address City State Zip Office Phone

Treatment Received Dates of Care

Physician Name Office Address City State Zip Office Phone

Treatment Received Dates of Care

24. Please list any other important health concerns or conditions.

_____

_____

CURRENT MEDICATIONS

25. Please list all physician prescribed medication, over-the-counter medication, nutritional supplements, herbal, or homeopathic remedies that you have taken within the last three months. Please feel free to attach a separate page if necessary.

NAME	DATE BEGAN	DOSAGE	REASON FOR TAKING
1.			
2.			
3.			
4.			
5.			

SURGERIES & HOSPITALIZATIONS

26. Please indicate the reason and date of any surgeries or hospitalizations.

_____

_____

OTHER SIGNIFICANT TRAUMA

27. (Automobile accidents, falls, head injuries, etc…)

_____

_____

ALLERGIES

28. Please list all known allergies.

ALLERGEN	TYPICAL REACTION	ALLERGEN	TYPICAL REACTION
Animal hair/dander		Food	
Chemicals		Mold	
Drugs/medications		Pollens	
Dust		Other	

HEALTH SCREENING HISTORY

29. Please complete the following chart or bring copies of any relevant or recent lab work to your first appointment.

EXAM/TEST	DATE	RESULTS	EXAM/TEST	DATE	RESULTS
Blood Panel			Glucose Screening		
Blood Pressure			Mammogram		
Cholesterol			Pap Smear		
Colonoscopy			Prostate Exam/PSA		
Complete Physical Exam			Sexually Transmitted Disease Screening		
Current Height			Thyroid Panel		
Current Weight			Urinalysis		
Other:			Other:		

PAST MEDICAL HISTORY

30. Please complete the following chart for yourself and each family member by placing an X in the appropriate box. Use the blank columns for additional family members.

Health History	SELF	MOTHER	FATHER	SISTER	BROTHER		
Age							
Allergies							
Asthma							
Cancer							
Chemical Dependency							
Chronic Fatigue Syndrome							
Diabetes							
Fibromyalgia							
Gastrointestinal Disorder							
Heart Disease							
High Blood Pressure							

Health History	SELF	MOTHER	FATHER	SISTER	BROTHER		
Mental Illness							
Multiple Sclerosis							
Osteoporosis							
Seizures							
Stroke							
Thyroid Disorder							
Other:							

REVIEW OF SYSTEMS

Please indicate all symptoms that you feel are significant or that you have experienced in the last six months.

MUSCULOSKELETAL

- ☐ Ankle Pain
- ☐ Back Pain
- ☐ Difficulty Sitting
- ☐ Difficulty Walking
- ☐ Foot Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Loss of Sensation
- ☐ Muscle Spasm
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Numbness/Tingling
- ☐ Shoulder Pain
- ☐ Swelling

31. What is your chief musculoskeletal complaint & when did this condition begin?_____

32. How frequent and for how long do you experience pain? _____

33. What is the intensity of the pain from a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

34. What is the quality of your pain? Place an X in any box that applies.

- ☐ Achy
- ☐ Burning
- ☐ Dull
- ☐ Electric
- ☐ Loss of Sensation
- ☐ Numb
- ☐ Pins & Needles
- ☐ Sharp
- ☐ Stabbing

35. Does your pain radiate or travel to any other area of your body? _____

36. Have you seen any other physician about this condition? YES NO If yes, when? _____

37. Physician's Name: _____
Street Address Phone

38. Have you had recent X-rays, MRIs, CT scans, or other special tests performed? YES NO

_____

NEUROLOGICAL

- ☐ Change in Gait
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Loss of Sensation
- ☐ Numbness
- ☐ Seizures
- ☐ Slow or slurred speech
- ☐ Tremors
- ☐ Vertigo

39. Have you experienced any other neurological problem? (circle one) YES NO

_____

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Contacts/Glasses
- ☐ Difficulty Chewing
- ☐ Ear Ringing
- ☐ Facial Pain
- ☐ Glaucoma
- ☐ Grinding Teeth
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Jaw Clicks
- ☐ Post Nasal Drip

40. Have you experienced any other head, eyes, ears, nose or throat problems? (circle one) YES NO

_____

RESPIRATORY

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Difficulty Swallowing
- ☐ Frequent Colds & Flus
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Wheezing

41. Have you experienced any other respiratory problems? (circle one) YES NO

_____

DERMATOLOGY

- ☐ Dry Skin
- ☐ Eczema
- ☐ Pimples
- ☐ Psoriasis
- ☐ Rash
- ☐ Ulcerations

42. Have you experienced any other skin problems? (Circle one) YES NO

_____

CARDIOVASCULAR

- ☐ Bruise Easily
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Cold Hands & Feet
- ☐ Dizziness
- ☐ High Blood Pressure
- ☐ Murmur
- ☐ Pacemaker
- ☐ Palpitations

43. Have you experienced any other heart or circulation problems? (Circle one) YES NO

_____

GASTROINTESTINAL

- ☐ Abdominal Cramping
- ☐ Abdominal Pain
- ☐ Acid Reflux
- ☐ Blood in the Stool
- ☐ Constipation
- ☐ Decreased Appetite
- ☐ Diarrhea
- ☐ Eating Disorders
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Mucus in Stools
- ☐ Nausea
- ☐ Ulcers
- ☐ Vomiting

44. Have you experienced any other digestive problems? (circle one) YES NO

_____

GENITOURINARY

- ☐ Blood in the urine
- ☐ Burning Urination
- ☐ Cloudy Urine
- ☐ Decreased urination
- ☐ Frequent Urination
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Painful Urination
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Urination at Night

45. Have you experienced any other genitourinary problems? (circle one) YES NO

_____

WOMEN'S HEALTH

- ☐ Absence of a period
- ☐ Bleeding between periods
- ☐ Decreased sex drive
- ☐ Heavy bleeding
- ☐ Hot flashes/nightsweats
- ☐ Infertility
- ☐ Irregular menstrual cycle
- ☐ Light bleeding
- ☐ Menstrual clots
- ☐ Menstrual pain
- ☐ Swelling or pain of breasts
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Vaginal pain

46. Have you experienced any other gynecological problems? (circle one) YES NO

_____

_____

_____

47. Please complete the following:

_____Age Menstruation Began
_____First Day of Last Cycle
_____Number of days cycle lasts
_____Number of days between cycles
_____Age of Menopause

Describe your average monthly cycle:_____

_____

_____

48. Please list the number of:

Births_____
Children_____
C-sections_____
Ectopic Pregnancies_____
Elective Abortions_____
Miscarriages_____
Pregnancies_____
Premature Births_____
VBACs_____

49. Are you currently pregnant? (circle one) YES NO

50. Are you currently trying to conceive? (circle one) YES NO

51. Are you currently nursing? (circle one) YES NO

52. Do you currently have a partner? (circle one) YES NO

53. Are you sexually active? (circle one) YES NO

54. What are your current methods of contraception? _____

55. Please list the contact information for your current OB/GYN and/or Endocrinologist:

OB/GYN:_____
Name Facility

_____
Address Phone

ENDOCRINOLOGIST:_____
Name Facility

_____
Address Phone

MEN'S HEALTH

- ☐ Decreased sex drive
- ☐ Decreased/difficult urination
- ☐ Low sperm count
- ☐ Low sperm motility/
- ☐ Low sperm morphology
- ☐ Genital pain
- ☐ Impotence
- ☐ Infertility
- ☐ Prostate Enlargement

56. Have you experienced any other genitourinary problems? (circle one) YES NO

_____

MENTAL HEALTH

- ☐ Anger
- ☐ Anxiety
- ☐ Crying
- ☐ Depression
- ☐ Fear
- ☐ Grief
- ☐ Irritability
- ☐ Lethargy
- ☐ Memory Loss
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Concentration
- ☐ Restlessness
- ☐ Stress
- ☐ Suicidal Thoughts

57. On a scale from 1-10, please rate your stress level: 1 2 3 4 5 6 7 8 9 10

58. What are major stress factors in your life? _____

59. Please rate your emotional health: (circle one) excellent good fair poor unstable/crisis

60. Are you currently in psychotherapy, counseling or involved in a support group? YES NO

NUTRITION

61. Please describe your typical diet in the chart below. Include beverages such as water, soda, tea, coffee, or alcohol.

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

62. What percentage of your meals do you prepare at home?_____

63. What percentage of your meals are made from organic foods?_____

64. How many glasses of the following do you drink each day?

_____Coffee _____Juice _____Soda _____Tea _____Water _____Other

65. Please complete the below chart:.

Alcohol	Yes	No	_____amount per day/week	_____age began _____age quit
Crack/cocaine	Yes	No	_____use per day/week	_____age began _____age quit
Heroin	Yes	No	_____use per day/week	_____age began _____age quit
Marijuana	Yes	No	_____use per day/week	_____age began _____age quit
Tobacco (cigarettes)	Yes	No	_____cigarettes per day/week	_____age began _____age quit
Other Recreational Drugs	Yes	No	_____use per day/week	_____age began _____age quit

66. Have you ever been treated for substance abuse? YES NO

EXERCISE

67. What type of exercise do you do? _____

68. How frequent and for how long?_____

69. Are you training for any specific event or have specific exercise goals? _____

SLEEP

70. How many hours per night do you sleep?_____

71. Do you feel rested when you wake up? YES NO

72. Do you have insomnia? YES NO

73. Do you have any other difficulties sleeping? _____

ENERGY

74. How would describe your energy: (circle one) excellent good average tired exhausted

75. Have you experienced any significant change in your energy level? YES NO

GOALS

76. What are your current health goals? _____

77. What potential obstacles do you have in the achieving these goals? _____

ADDITIONAL COMMENTS

Please address any additional concerns or conditions. Feel free to include anything else about yourself that you would like me to know that you were unable to explain in the above form. You may also include any concerns or questions that you have specifically about acupuncture.

_____
_____
_____
_____
_____
_____
_____
_____

I have read the above information and certify it to be true and hereby authorize Jessica L. Molleur, Lic.Ac., DNBAO to do whatever is necessary for the care and management of this complaint.

Signature of client or legal guardian: _____ Date: _____

Client Agreement and Policies

Welcome to OMBE and the office of Jessica L. Molleur, Lic.Ac., DNBAO. To familiarize you with the financial and billing policies of our office, I would like to explain how your medical bills will be handled.

Declaration: You are the primary person responsible for your bill. Charges for the treatment are due at the time of service, unless other payment arrangements are made.

Payment Methods: OMBE accepts cash, checks, MasterCard, Visa, and American Express as methods of payment for services. A credit card is required to reserve your appointment. A receipt will be furnished for you upon request. If you wish to submit claims to your insurance company, a detailed description of your visit will be made available to you upon written request.

Returned Checks: If your check is returned by the bank due to insufficient funds, there will be an additional $25.00 charge added to your account which you are responsible to pay.

Cancellation Policy: Thank you in advance for observing OMBE's 24-hour cancellation policy. If you need to reschedule or cancel your appointment, please call OMBE (617.447.2222) 24-HRS in advance of your scheduled session. If you are unable to provide 24-HRS notice for the scheduled appointment, you will be responsible for the full charge of the session.

I have had the opportunity to read and discuss all of the above information, and I fully understand all of its meaning and its terms. I am aware of and accept these polices noted above.

Client Signature: _____ Date: _____

Office Signature: _____ Date: _____

OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

How OMBE May Use or Disclose Your Health Information

Treatment: We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Health Care Operations: We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

Appointment Reminders: We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Notification and Communication with Family: We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

Marketing: We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

Required by Law: When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Health & Safety: We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with

respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

Right to Inspect and Copy: You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

More About OMBE's Privacy Policy

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

OMBE Privacy Policies Acknowledgement

I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

_____

Signature of Patient or Authorizes Representative Date

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, 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 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

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 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

.

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 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 have 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.

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.

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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE