SLK Acupuncture
Acupuncture·Herbal Medicine·Cupping·Moxibustion

NEW PATIENT FORM

PATIENT INFORMATION

Date:_____ SS#:_____ Date of Birth: ___
First Name:_____ Middle Name:_____ Last Name: ___
Sex: ___M_F Height:_____ Weight: _____
Marital Status:_Yes ___No Spouse Name:_____ # of Children: _____
Address: _____
City:_____ State:_____ Zip: _____
Home #_____ Work #_____ Cell # _____
Email:_____ Preferred method of contact: _____
_____ Emergency Contact:_____ Relationship:_____
Emergency Phone #:

REFERRAL INFORMATION

Referring Physician:_____Referring Patient:_____Referred by: _____

INSURANCE INFORMATION

Payment:___Personal___3rd Party___Self Resp. for Payment:_____Resp. Phone #: _____
Health Insurance Co._____Policy #:_____Group #: _____
Secondary Insurance Co._____Policy #:_____Group #: ___
Are you the Primary Subscriber to the above Policy?____Yes No
If you answered "No", Name of the Primary Subscriber:_____DOB: _____
If you are involved in an auto-accident:
Claim #:_____Claim Contact:_____Claim Phone #: _____
Attorney:_____Attorney Phone #: _____

COMPLAINT INFORMATION

Injury Occurred:___Automobile___Work___3rd Party Other Injury Date: ___
Chief Complaint: _____
_____ Frequency: Always Hourly Daily Occasionally
Interfere w/ Activities? Yes No Affects Sleep? Yes No Affects Appetite? Yes No
Affects Work? Yes No Missed Work? Yes No Unable to Work from: _____
Condition is Aggravated by: _____
Condition is Improved by: _____
Have you received any Treatments for this Condition before? Yes No
If "Yes", explain:_____Practitioner/Doctor: _____
Has your Condition improved/worsened/same? _____

HEALTH HISTORY

Last Physical Exam:_____ Primary Physician:_____ Phys Phone #: ____
Health Conditions: _____
_____ Previous Acupuncture/Chinese
Medicine Care: Yes No Explain: _____ Chance Pregnant: Yes No
Planning Pregnancy: Yes No
Medications: _____
Supplements: _____
Past Surgery: _____
Past accidents/trauma: _____
Family Health History: _____

PATIENT SOCIAL

Alcohol: Daily Weekly Occasion Never
Tobacco: Daily Weekly Occasion Never
Aspirin: Daily Weekly Occasion Never
Fast Food: Daily Weekly Occasion Never
Laxatives: Daily Weekly Occasion Never
Caffeine: __Daily Weekly Occasion Never
Soda: __Daily Weekly Occasion Never
OTC Meds: __Daily Weekly Occasion Never
Exercise: __Daily Weekly Occasion Never
Diet Products: Daily Weekly Occasion Never

HEALTH CHECKLIST (□)

MUSCULO-SKELETAL SYSTEM
___ Low Back Pain
___ Mid Back Pain
___ Shoulder Pain
___ Pain between Shoulders
___ Neck Pain
___ Arm, problems
___ Leg Problems
___ Swollen Joints
___ Painful Joints
___ Stiff Joints
___ Sore Muscles
___ Weak Muscles
___ Walking Problems
___ Spasms
___ Fractures

GASTRO-INTESTINAL SYSTEM
___ Poor Appetite
___ Excessive Hunger
___ Excessive Thirst
___ Sour Regurgitation
___ Bloating
___ Fullness
___ Nausea
___ Abdominal Pain
___ Diarrhea
___ Constipation
___ Black Stool
___ Bloody Stool
___ Hemorrhoids
___ Weight Gain
___ Weight Loss

CARDIO-VASCULAR SYSTEM
___ Chest Pain
___ Difficulty Breathing
___ Persistent Cough
___ Coughing Phlegm
___ Palpitations
___ Blood Pressure Problems
___ Heart Problems
___ Lung Problems

NERVOUS SYSTEM
___ Loss of feeling
___ Dizziness
___ Fainting
___ Headaches
___ Muscles twitching
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression
___ Insomnia

EYE, EAR, NOSE, THROAT
___ Eye Strain
___ Eye Inflammation
___ Vision Problems
___ Ear Pain
___ Ear Discharge
___ Hearing Loss
___ Nose Pain
___ Nose Bleeding
___ Nose Discharge
___ Nasal Congestion
___ Sore Gums
___ Dental Problems
___ Sore Mouth
___ Sore Throat
___ Hoarseness
___ Difficult Speech
___ Sinus
___ Allergy
___ Jaw Pain

GENITO-URINARY SYSTEM
___ Bladder trouble
___ Excessive Urination
___ Scanty Urination
___ Painful Urination
___ Discolored Urine

FEMALE SYSTEM
___ Vaginal Discharge
___ Vaginal Bleeding
___ Vaginal Pain
___ Breast Pain
___ PMS

PATIENT NAME:

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. 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. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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 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)**

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:

PATIENT SIGNATURE X **(Date)**

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

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390 N. Sepulveda Blvd., Suite 1140
El Segundo, CA 90245
P. 951.297.9445

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that we will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, _____ (print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: **X** _____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DO NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Acupuncture benefits, your insurance claim will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 60 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 7 days.**

Assignment of Rights and Conveyance of Lien Interest
I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with the California Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to SARAH LEE KIM ACUPUNCTURE, INC., and payment to be sent to: 390 N. Sepulveda Blvd., Suite 1140, El Segundo, CA 90245

This demand specifically conforms to the California Insurance Code, providing for attorney fees, penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

PATIENT SIGNATURE X **(Date)**

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

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CREDIT CARD INFORMATION FORM

We require new patients to keep their card on file in order to hold future appointments and close any and all open invoices.

In regard to our cancellation policy, we will charge the card on file if the appointment is cancelled without 24-hour notice or in the event of a no-show to a scheduled appointment. Late cancellation fee and no-show fees are the full amount of the cost of the scheduled appointment.

I hereby authorize Sarah Lee Kim Acupuncture, Inc. to charge my card on file for payment of all charges, including but not limited to: Overdue/open invoices, all appointment fees, late cancellation/missed appointment fees, herbal purchases, insurance reimbursements made directly to the patient, etc.

CARD TYPE: VISA MASTERCARD DISCOVER AMEX

CARD NUMBER: _____-_____-_____-_____

EXP. DATE: _____ /_____

SEC. CODE: _____

BILLING ZIP CODE: _____

CARD HOLDER'S NAME: _____

PHONE NUMBER: _____

EMAIL: _____

I would like a receipt to the transaction via (circle one): TEXT EMAIL

I hereby authorize Sarah Lee Kim Acupuncture, Inc. to take my verbal authorization as my signature for all future credit/debit card charges.

SIGNATURE: _____ **DATE:** _____