REGISTRATION

(PLEASE PRINT)

ADVANCED ACUPUNCTURE, Inc.

622 W. Duarte Road, Suite 204
Arcadia, CA 91007
(626) 462-9821
Fax: (626) 462-9823

1260 15th St., Suite 601
Santa Monica, CA 90404
(310) 458-2848
Fax: (310) 458-2899

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

Advanced Acupuncture, Inc
Health Questionnaire

Health Questionnaire

Name: _____ Date of Birth: _____ Visit Date: _____
Address: _____ Phone (H)_____ (O) _____

Chief Complaint(s) List your complaint (s) and state for how long:

Complaint(s) Duration

_____
_____
_____
_____

History of Present Illness: (to be filled by physician)

_____
_____
_____

History of past illness: circle the childhood disease you have had:

(1) Measles (2) Mumps (3) Rubella (4) Chickenpox (5) Tuberculosis
(6) Other_____
Have you had any serious medical illness? _____
*If yes, list them*_____
Have you had any injuries or accidents? _____
If yes, list them_____
Are you taking any medication (include over the counter)? _____
Do you have any allergies? _____

Family History:
Father: Age _____ Health_____
Mother: Age _____ Health_____
Spouse: Age _____ Health_____
Children: Age _____ Health _____

Social History:
Do you drink alcohol beverages? _____ If yes, how much? _____ How long? _____
Do you smoke? _____ How many? _____ How long? _____ Quit when? _____
What is your Occupation? _____
Have you ever filed workman's Comp? _____

General:
How tall are you? _____ What is your usual weight? _____
Any recent weight changes? _____ How many pounds? _____
Do you have a fever? _____ Do you feel weak or fatigue?_____

Vital Signs:
BP: _____ Temp: _____ Resp: _____ Pulse: _____
Tongue: Color: _____ Coating: _____
Pulse: Left: _____ Right: _____

Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

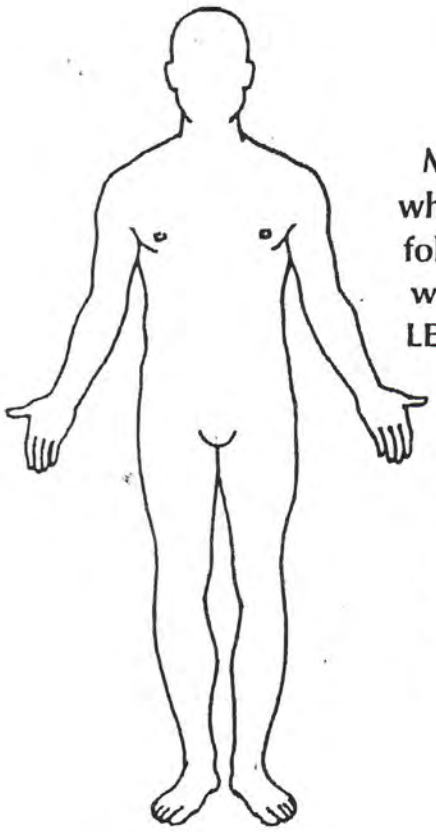
NAME _____

DATE _____

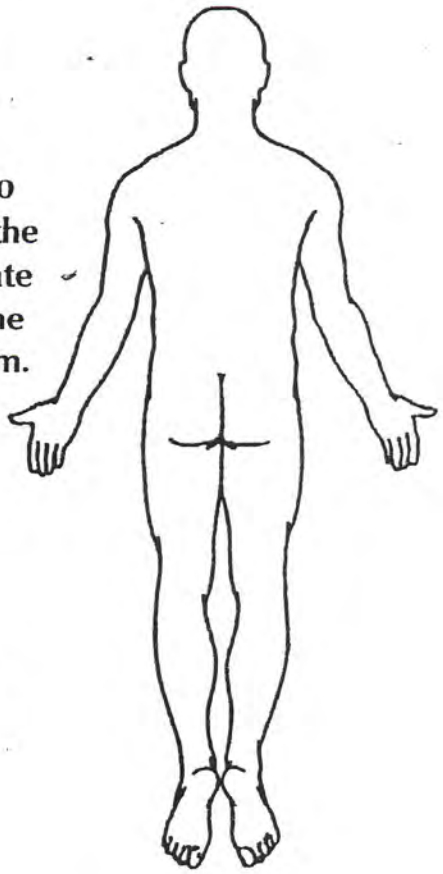
FRONT

Show Where It Hurts

BACK



Mark these drawings according to where you hurt. If you feel any of the following symptoms, please indicate where you feel them by placing the LETTER shown here on the diagram.

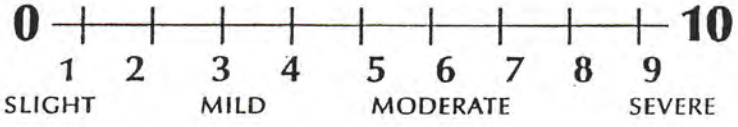


ACHING..... **A**
BURNING..... **B**
NUMBNESS..... **N**
STABBING..... **S**
TINGLING..... **T**

FRONT

BACK

PLEASE CIRCLE YOUR LEVEL OF PAIN



Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address _____

You were heading ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Other vehicle was headed ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ Improving? ☐ Getting worse? ☐ Same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM

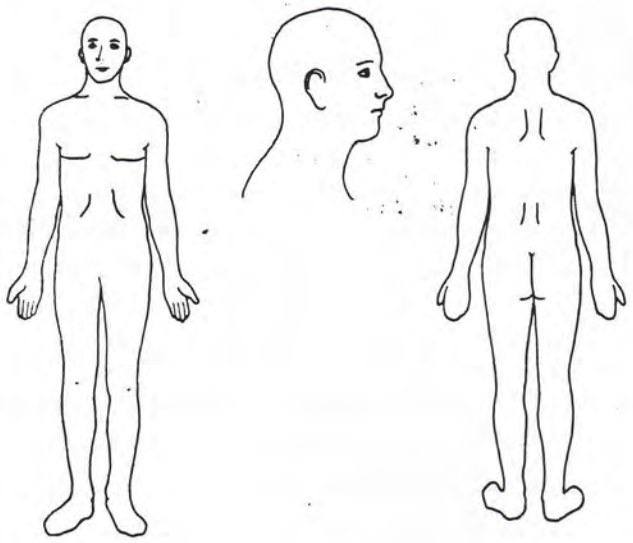
____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR-RESPIRATORY

____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Ear discharge
____ Hearing loss
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing thru nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

_____
Patient's Signature

..... DO NOT WRITE BELOW THIS LINE .....

Patient accepted? Yes____ No____ Doctor's signature_____

ACCIDENTAL INJURY FORM

Please complete the following questions:

Date of accident?_____Hour?_____am/p.m.
Location?_____
How did accident occur? Auto Collision? On-the-job injury? Other_____
Describe the circumstances_____
If an auto accident were you __driver __passenger __pedestrian.
If an auto collision were struck from __behind __front __right __left
Did your car strike the other(s) involved?_____
Did the other car strike yours?_____
As a result of the accident were traffic citations issued?_____
If yes, to whom were they issued?_____
If work related injury, did you report injury to supervisor?_____
Did he/she recommend care at our office?_____
List the extent of injuries
_____
Did you require post-accident hospitalization?_____
Check symptoms you have noticed since the accident:

__Headache	__Dizziness	__Depression
__Stomach upset	__Light bothered eyes	__Fatigue
__Neck pain	__Head seems too heavy	__Loss of Memory
__Stiff Neck	__Pins and needles in arms	__Loss of Smell
__Fainting	__Numbness in fingers	__Loss of Taste
__Face Flushed	__Pins and needles in legs	__Tension
__Nervousness	__Numbness in toes	__Chest pain
__Irritability	__Sleeping problems	__Back pain
__Cold Sweats	__Shortness of breath	__Diarrhea
__Constipation	__Loss of balance	__Fever
__Ears Ring	__Cold hands	__Cold feet

Symptoms other than above
Have you lost any days of work?_____Dates_____Insurance
companies involved:_____Other parties insurance:
Have you been contacted by an insurance representative?_____Do you have
an attorney?_____Name of attorney?
Address_____Phone_____

Date_____

Date_____

CASE HISTORY

Name:_____Age_____Birth date_____
_Address:_____
Street City State Zip Code
Phone(home):_____Social Security_____
Employer:_____
Address:_____
Phone(work):_____Work Hours_____Occupation_____
Marital Status_____Name of Spouse_____
Nearest relative_____
Full Name Address Phone
Name of person responsible for payment_____
Address if different from above_____
Name of person who referred you to this office_____

Insurance Information

Insurance Co._____
Policy #_____Group_____
Address of Insurance Co._____Phone_____
Type of Insurance: (Group, Individual, Private, Automobile, Workmen's Compensation)
Name of person who is the primary insured_____
Address if different from above_____
Social Security # of the insured_____
Has deductible been met?_____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ADVANCED ACUPUNCTURE

_____
Patient's signature

Is condition due to an auto accident?_____Date of accident_____
Is condition work related?_____Date of injury_____
Do you have an attorney for this case?_____Name_____
Address of Attorney_____Phone_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED WHILE BEING TREATED AT THIS FACILITY

_____ _____
DATE SIGNATURE

ADVANCED ACUPUNCTURE, Inc.
622 W. Duarte Rd., Suite 204 — Arcadia, CA 91007
Telephone: (626) 462-9821 Fax: (626) 462-9823

1260 15th Street, Suite 601 — Santa Monica, CA 90404
Telephone: (310) 458-2848 Fax: (310) 458-2899

RECORDS RELEASE AUTHORITY

I, _____, hereby request that _____

(Patient's name or guardian) (Doctor'name)

provide in writing To: **ADVANCED ACUPUNCTURE,INC.**
622 W. DUARTE ROAD. SUITE 204
ARCADIA, CA 91007
(626) 462-9821

a report of diagnosis, treatment, prognosis and recommendations as well as other data pertinent to her treatment of me during the period from ___all___ to ___PRESENT___.

_____ _____
Date Patient's Signature

_____
Witness

Advanced Acupuncture, Inc
622 W. Duarte Road Suite 204
Arcadia, CA 91007

INFORMED CONSENT AND DISCLOSURE

Informed consent:

_____
Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by my insurance contracted provider name above and/or other contracted provider who may treat me. I understand that the contracted provider will explain all known risk and complications, and I wish to rely on the contracted provider to exercise judgment during the course of the procedure, which the contracted provider determines is my best interest. I may request another person of my choice to be present in the treatment room during treatment

The Contracted provider has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the contracted provider's use of this treatment (if indicated).

1. **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolved with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore, or tingling sensation at the acupuncture site.
2. **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, ect., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
3. **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent contact, but the possibility of skin contact and mild burns exist. We do not allow direct moxibustion where burning material contacts the skin
4. **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from suction and slight burning or blistering due to the heat involved in the technique.
5. **Gua Sha** involves scraping over a small are by using a smooth-edge instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
6. **Tapping, Plum blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
7. **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt
8. **Treatment Using Control Points REN 1/DU 1**. In very rare cases, the contracted provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the contracted provider will notify me and will provide alternative treatment if I am uncomfortable with treatment using these points. I understand all attempt will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my provider. I consent to the treatment that involved the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that his refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my contracted provider or acupuncture clinical services manager may need to contact my medical physician when the provider or acupuncture clinical services manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain./nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and sure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to Advanced Acupuncture Inc., to contact my medical physician if/when necessary.

Treatment of pediatric patients <3 years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to Advanced Acupuncture, Inc to contact my child's medical doctor if/when necessary

_____ _____
Patient Name (please print) Patient ID number

_____ _____
Primary Care Physician (or specialist) Name Patient Signature

_____ _____
Primary Care Physician (or specialist) Telephone Date

Advanced Acupuncture, Inc
622 W. Duarte Road Suite 204
Arcadia, CA 91007

1260 15th St Suite 204
Santa Monica, CA 90404

INSURANCE BILLING AND FINANCIAL POLICY IN OUR OFFICE

In an effort to keep our prices down and be as efficient as possible, out office has a policy of NOT accepting LIENS, and Third Party Insurance. However we will be more than happy to provide you with an estimate billing of your charges so that you can get reimbursed.

Personal Injury or Medpay

After verification (pre-authorization), we will bill your medical coverage on your auto insurance for you. If at any time your insurance does not pay 100% of your services, you agree that you will be responsible for those charges at that time. During your treatment for a personal injury it is very important you keep all of your appointments. If at any time you are not seen by the doctor for a period of two or more months our office must consider your case a self release.

Health Insurance:

After verification and/or receiving an authorization from your insurance company. We will bill your medical insurance as long as acupuncture is cover and as long as your diagnosis is cover. On the day of your visit you are responsible for any co-payments, co-insurances, and deductibles that you may have. During your treatment is very important that you keep all of your appointments. If at any time you are not seen by the doctor for a period of two or more months our office must consider your case a self release.

Medicare

We do not bill Medicare health insurance, because Acupuncture is not a covered benefit. You understand that you are 100% financially responsible for your account at the time of the services are rendered.

Missed Appointments

In order for us to better accommodate our patients; we request a 24 hour cancellation notice for all appointments. If you miss appointments, there will be a $25 fee for non-sufficient notice.

Payment will be due and payable at the time the services are rendered, or at which time the insurance company denies any portion of my bill

By signing below, I am acknowledging that I have read and understand the above information regarding the financial policies and insurance policies of this offices and I take full responsibility for any balance that is due at the time of services. I also agree to keep my appointments as recommended by the doctor.

Patient signature: _____ Date: _____

MESSAGE TO MY PATIENTS ABOUT ARBITRATION

Attached is an Arbitration Agreement which I urge you to sign. We will agree that any disputes arising out of the services you receive are to be resolved by binding arbitration rather than court suit.

Binding arbitration has benefits for both doctors and patients. Both former United States Supreme Court Chief Justice Warren Burger and Chief Justice Malcolm Lucas of the California Supreme Court favor arbitration as alternative method of dispute resolution. The California supreme Court has noted that arbitration is speedier and less expensive than are jury trials for resolving disputes between doctors and patients. Both parties are spared some of the rigors of trail and the publicity which may accompany judicial proceedings. In addition, because virtually no appeals are allowed from an award in arbitration, the prevailing party can expect either fast payment or fast dismissal of the case, without lengthy appeals.

Please sign the agreement after first reading it carefully.

Dr. Cathryn Hu, Ph.D., O.M.D., L.Ac.

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.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss 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 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.

(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

AAC-CA

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

Advanced Acupuncture, Inc
622 W. Duarte Road Suite 204
Arcadia, CA 91007

1260 15th St Suite 204
Santa Monica, CA 90404

DIRECTIONS TO OUR OFFICES

Arcadia Medical Plaza
622 W. Duarte Road Suite 204
Arcadia, CA 91007

From Los Angeles Area:

Go on the I-10 E. Take exit 26B for CA-19/Rosemead Blvd. Continue on the ramp and merge onto CA-19 N. Rosemead Blvd. Turn Right onto Duarte Road. Destination will be on the right.

From San Bernardino County

Take the CA-210 W. Take exit 34 toward Myrtle Ave/ Monrovia, Merge onto E. Central Ave, Turn left onto S. Myrtle Ave. Turn right onto W. Duarte Rd. Destination will be on the left

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Santa Monica Medical Plaza
1260 15th Street Suite 601
Santa Monica, CA 90404

From Los Angeles Area:

Take the US-101N toward I-110 N. Then Take exit 3 for I-110 S/Harbor FWY toward San Pedro. Merge onto CA-110 S/Harbor FWY. Take exit 21 to merge onto I-10 W. Take exit 1C for Cloverfield Blvd. Turn Right onto Cloverfield Blvd. Turn Left onto Santa Monica Blvd. Turn Right onto 15th St. Destination will be on the left.

From San Fernando Valley Area

Take I-405 S. Take exit 55C for Wilshire Boulevard W. Merge onto Wilshire Blvd. Turn left onto 15th St. Destination will be on the right.

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AGREEMENT TO NOTICE OF PRIVACY PRACTICES

This notice is effective as of April 15th, 2012

I have read the Privacy Notice and Understand my rights contained in the notice.

BY way of my signature, I provide Advanced Acupuncture, Inc with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as describes in the Privacy Notice

_____
Patient's Name(print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

ADVANCED ACUPUNCTURE,INC.

622 W. Duarte Rd., Suite 204
Arcadia, CA 91007
(626) 462-9821

1260 15Th St., Suite 601
Santa Monica, CA 90404
(310)458-2848

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice and Why Is It Important?

By law, ADVANCED ACUPUNCTURE,INC., (AAI) includes employed or contracted acupuncturist. practitioners , medical assistant and other clinical personnel, is required to protect the privacy of your identifiable medical and other health information (protected health information).

AAI also is required by law to give you this notice to tell you how AAI. may use and give out ("disclosure") your protected health information held by AAI and its health care practitioners. AAI must follow the terms of this notice when using or disclosing your protected health information. AAI is required to obtain your permission before using or disclosing your protected health information, except as described below. This notice is effective as of April 14, 2003.

How AAI May Use Your Protected Health Information

AAI. generally is required to obtain your written authorization ("permission") before using your protected health information. This section explains those situations where, under federal law, AAI may use or disclose your protected health information without your permission.

AAI. does not need to obtain your written permission to use your protected health information for the following purposes:

- **Treatment:** We use and disclosure your protected health information to provide health care services to you. This includes uses and disclosures to:
  - treat your illness or injury, or
  - contact you to provide appointment reminders, or
  - give you information about treatment alternatives or other health related benefits and services that may interest you.
- **Payment:** We may use and disclose your protected health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
  - submit and obtain payment form your health insurer, HMO, or company that pays the cost of some or all of your health care (payor), or
  - verify that your payor will pay for your health care.

- **Health Care Operations:** We may use and disclosure your protected health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care that we provide you. This also include uses and disclosures to:

    - evaluate the quality and competence of our health care providers, medical assistant and other health care workers,
    - identify health-related services and products that may beneficial to your health and then contact you about the services and products.

We may also disclose your protected health information to third parties to assist us in these activities, but only if they agree in writing to maintain the confidentiality of your health information. We may also disclose your protected health information to your other health care providers, to enable them to conduct their own quality reviews, compliance activities and other health care operations. If you are treated by us at a hospital, the hospital may provide you with a joint notice that will give you more information about privacy practices at that location.

In addition, AAI may use and disclose your protected information under the following circumstances:

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your protected information to relative, caregivers or personal representatives who are with you or appear on your behalf. We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your AAI health care provider.

- **Public Health Activities:** We may disclose your protected health information for the following public health activities:
    - To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
    - To report information to the U.S. Food and Drug Administration (FDA) about products and services under its jurisdiction; or
    - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease;
- **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your protected health information as required by law to a social services or other government agency authorized by law to receive such reports.
- **Health Oversight Activities:** We may disclose our protected health information to a health oversight agency that is charged with responsibility for ensuring compliance with the rules of government health programs

such as Medicare and Medicaid (for example, for fraud and abuse investigations).

- **Specialized Government Functions:** We may use and disclose your protected health information to units of the government with special functions, such as the U.S. military, under certain circumstances required by law.
- **Law Enforcement Officials, Judicial and Administrative Proceedings:** We may disclose protected health information to police or other law enforcement officials. We also may disclose protected health information in judicial or administrative proceedings, such as in response to a subpoena.
- **Coroners or Medical Examiners:** We may disclose protected information to a coroner or a medical examiner as required by law.
- **Health or Safety:** We may disclose protected health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Marketing Activities:** We may provide you with marketing materials in a face-to-face encounter, without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining your authorization. We will ask your permission before we use your health information for any other marketing activities.
- **Workers' Compensation:** We may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs or as required under laws relating to workplace injury or illness.
- **As Required by Law:** We may disclose protected health information when required to do so by any other law not already referred to in the preceding categories.

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE, WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHENYOU GIVE US YOUR WRITTEN AUTHORIZATION.

Your Rights Regarding Your Health Information

Rights to Request Access to Your Health Information: You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please obtain a record request form from your health care provider. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under California law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please submit a written amendment request to AAI. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for AAI and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to the AAI office where is indicated on your authorization.

Right to An Accounting of Disclosures of Your Health Information: Upon written request, you may obtain an accounting of certain disclosures of health information made by us (other than for treatment, payment or health care operations and for any disclosure made pursuant to your authorization.) The period of your request cannot exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you reasonable fee.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive protected health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: You may request that we restrict the use of your protected health information. All requests for such restrictions must be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction and it is AAI's general policy not to agree to such restrictions.

Right to Change Terms of this Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we hold, including any information created or received prior to issuing the new notice. If we change this notice, we will post the revised notice in our practice areas.

Further Information; Complaints

If you would like additional information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made bout access to protected health information, you may contact our office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, they will provide you with the current address for the Director. We will not retaliate against you if you file a complaint with us or the Director.