LA Herbs & Acupuncture

Wellness through ancient wisdom

Patient Confidential Information   Date_______________

Patient Name____

Address____

City______________________ State_________ Zip Code__________

Primary Phone__________________ Other Phone______________

Email Address____

Age__________ Date of Birth_______/________/_________

Sex Male/Female   Marital Status S/M/D/W/Cohab

Referral Source______________________

Place of Birth______________________________

Occupation or Profession_____________________ Employer________________

Emergency Contact_______________________ Relation____________________

Phone______________________________

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Financial Agreement

Please remember that insurance is considered a method of reimbursement to our healthcare facility, but is not a substitute for the patient's responsibility. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance payments, or any other balance that is not paid by insurance. When this agreement is executed by the patient or the patient's representative or a financial guarantor, all shall be jointly and individually liable for payment. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to other amounts due.

I authorize disclosure of portions of the patient's records to the extent necessary to determine liability for payment and to obtain reimbursement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance and other health plans, to L. A. Herbs & Acupuncture, An Integrative Medical Corp.

L. A. Herbs & Acupuncture, An Integrative Medical Corp. and the patient or patient's representative hereby enter into this agreement. The patient or patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service." **I understand the 24-hour cancellation policy, and I agree to pay the standard fee if cancellation occurs within 24 hours of the date and time of my scheduled appointment.**

Signed _______________________________________ Date__________________

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Medical History All information is kept strictly confidential

Patient Name_______________________________Date________________
Chief Complaint_________________________Date of Onset____________

Briefly describe the circumstances surrounding this complaint, and other treatments you may have received as well as the results of those treatments.

List all Surgeries and their approximate dates:

Describe any traumatic injuries such as car accident, sporting accident, and their approximate dates:

Describe other traumatic experiences such as death of a loved one, divorce, and the approximate dates:

Describe any serious illness you have experienced and the approximate dates, include any serious childhood illness:

Describe any chronic illness or aches and pains which come and go:

Do you have any allergies? Yes No Please list:

List ALL prescription and non-prescription medication you are currently taking (include nutritional supplements):

Describe any history of prescription, non-prescription, or recreational drug use:

Are you, or were you a smoker? Yes/No For how long______________ How many cigarettes per day__________

List one or two emotions that are predominant in your life, and which are either frequently experienced or difficult to express:

Describe a typical days' diet, including beverages:

-Breakfast

-Lunch

-Dinner

Describe your current program of physical fitness:

Describe your employment history:

Do you have a family history of any of the following illnesses?

ASTHMA	AUTOIMMUNE DISEASE	HEART DISEASE
HIGH BLOOD PRESSURE	DIABETES	MIGRAINE
ALLERGIES	ARTHRITIS	EPILEPSY
KIDNEY DISEASE	INFERTILITY	BLEEDING DISORDERS
HEPATITIS	STROKE	MISCARRIAGE
ALCOHOLISM/ DRUG ADDICTION	CANCER	MENTAL ILLNESS

WOMEN'S HEALTH

Number of days between cycles____ If irregular, give range______________
Number of days of bleeding______ Color of menstrual blood, i.e, bright red, dark red, brown, purple

Consistency of menstrual blood, i.e. thick, watery, sticky, clotted, normal

Describe any undesirable menstrual symptoms, and whether the symptom occurs before, during or after the onset of menses

Breast Pain/Distention____
Cramps____
Headache____
Back Pain____
Bloating____
Food Cravings (list foods)____
Irritability____
Melancholy____
Other____

Are you or might you be pregnant___________ Date of last menstrual period________________ Date of last gynecological exam________ Number of pregnancies___________

Number of births____________

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to , L.A. Herbs & Acupuncture, An Integrative Medical Corp.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ,L.A. Herbs & Acupuncture, An Integrative Medical Corp. reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp may email to me appointment reminder cards and patient statements. I have the right to request that L.A. Herbs & Acupuncture, An Integrative Medical Corp. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to L.A. Herbs & Acupuncture, An Integrative Medical Corp use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, L.A. Herbs & Acupuncture, An Integrative Medical Corp may decline to provide treatment to me.

Signature of Patient or Legal Guardian____

Patient's Name ________________________________ **Date** __________________________

Print Name of Patient or Legal Guardian_______________________________________

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 the patient named below for whom I am legally responsible) by the licensed acupuncturist(s) 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, included those working at L.A. Herbs & Acupuncture, An Integrative Medical Corp., 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 (Oriental Massage), Chinese herbal medicine and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herb

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses only sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

Patient Signature ____________________________________Date______________

Patient representative_________________________________Date_______________

L.Ac____Date_______________