Soma Therapeutics
Radiant Health & Wellness

925.272.9109
www.soma-therapy.com

New Patient Health History Form

Contact Information

Name (Last, First, M.I.)	Date

Home Address
City, State, Zip

Preferred Phone: ☐ Home ☐ Work ☐ Cell	Alternate Phone: ☐ Home ☐ Work ☐ Cell

Email Address	How would you prefer to receive appointment reminders? ☐ Text/SMS ☐ Email ☐ Both	Would you like to be contacted with clinic news and special offers? ☐ Yes ☐ No

Patient Info

Age	Birth Date (MM/DD/YY)	Height	Weight	

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Other _____	How would you like to be addressed?

Relationship Status: ☐ Married ☐ Partnered ☐ In a Relationship ☐ Single ☐ Other _____	Past Relationships: ☐ Divorced _____ time(s) ☐ Widowed _____ time(s)

Emergency Contact	Phone	Relationship

Employment

Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student	Occupation

Employer or School	City	Phone

Insurance

Insurance Type: ☐ Private ☐ Worker's Comp ☐ Med Pay ☐ None ☐ Other	Insurance	Phone
Policy Holder's Name / Relationship if other than self	Policy Number / ID Number	Group Number
Billing Street Address	City, State	Zip

Secondary Insurance Type (if applicable): ☐ Private ☐ Worker's Comp ☐ Med Pay ☐ None ☐ Other	Insurance	Phone
Policy Holder's Name / Relationship if other than self	Policy Number / ID Number	Group Number
Billing Street Address	City, State	Zip

Assignment and Release:

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signed:_____ Date:_____

Health Provider Contact Information

Please list any physicians or other health care providers whose care you are under:

Provider's name and address	Specialty	Phone
1.		
2.		
3.		
4.		
5.		

Reason(s) for Office Visit

Health Concerns	Date of Onset	Have you been treated for this?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No
5.		☐ Yes ☐ No

Prior Treatment (Please complete if you checked "Yes" to any of the above questions)

Practitioner	Type of Treatment and Approximate Dates	Were the treatments helpful?
1.		
2.		
3.		
4.		
5.		

What makes the above condition(s) better?	What makes the above condition(s) worse?
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Have you had acu therapy before?	What are your goals for your acu therapy treatments?
☐ Yes ☐ No	_____
If yes, were you satisfied with your treatments?	_____
☐ Yes ☐ No	_____
	_____

Supplements, Vitamins, Herbs (☐ I used additional space on a separate sheet)

Name	Purpose	Dose	Doses per Day	Taken for how long?
1.				
2.				
3.				
4.				
5.				

OTC and Prescription Medication (☐ I used additional space on a separate sheet)

Name	Purpose	Dose	Doses per Day	Taken for how long?
1.				
2.				
3.				
4.				
5.				

Food, Drug, Herb, and Environmental Allergies

Do you have any food, drug, herb, or environmental allergies? ☐ No ☐ Yes (Please List):

Health & Lifestyle (Please check any of the habits below that apply to you now or in the past)

☐ Tea	____ Cups /	☐ Day ☐ Month ☐ Week ☐ Year	Age Started	If Quit, Age?		☐ Alcohol	_____ /	☐ Day ☐ Month ☐ Week ☐ Year	Age Started	If Quit, Age?
☐ Coffee	____ Cups /	☐ Day ☐ Month ☐ Week ☐ Year				☐ Meth	_____ /	☐ Day ☐ Month ☐ Week ☐ Year		
☐ Energy Drinks	_____ /	☐ Day ☐ Month ☐ Week ☐ Year				☐ Crack/Cocaine	_____ /	☐ Day ☐ Month ☐ Week ☐ Year		
☐ Soft Drinks	_____ /	☐ Day ☐ Month ☐ Week ☐ Year				☐ Non-Prescribed Prescription Drugs	_____ /	☐ Day ☐ Month ☐ Week ☐ Year		
☐ Cigarettes	_____ /	☐ Day ☐ Month ☐ Week ☐ Year				☐ Heroin	_____ /	☐ Day ☐ Month ☐ Week ☐ Year		
☐ Marijuana	_____ /	☐ Day ☐ Month ☐ Week ☐ Year				☐ Other	_____ /	☐ Day ☐ Month ☐ Week ☐ Year		

Do you exercise regularly? ☐ Yes ☐ No

If yes, How often? _____

What activities? _____

_____

_____

_____

How much sleep per night? _____ hrs.

Please describe the type of foods you eat regularly:

Breakfast: _____

_____

Morning Snack: _____

_____

Lunch: _____

_____

Do you follow a special diet? If so, which: _____

Afternoon Snack: _____

_____

Dinner: _____

_____

Evening Snack: _____

_____

Hospitalizations, Injuries, Serious Illnesses, or Operations (☐ I used additional space on a separate sheet)

Operations / Illnesses / Injury / Procedure / Problem	Year	Hospitalized?	City, State
1.			
2.		☐ Yes ☐ No	
3.		☐ Yes ☐ No	
4.		☐ Yes ☐ No	

Family History (Mark an X in the boxes that apply)

	Self	Mother	Father	Brother	Sister	Child	Spouse
Allergies							
Autistic Spectrum							
Blood Disorder / Anemia							
Cancer or Tumors							
Depression / Mental Illness							
Diabetes							
Drug / Alcohol Abuse							
Heart Disease							
Hypertension							
Kidney / Bladder Disorder							
Obesity / Weight Issues							
Premature Graying (Hair)							
Seizures							
Stomach / Intestinal Disorder							
Stroke / Cerebral Vascular Accident							
Thyroid Issues							
Other:							
If Deceased, Age at Death							

Birth History

Number of siblings: _____

Number of older siblings: _____

Number of months separating you from the next older sibling:

_____

Were you breast fed?

☐ No ☐ Yes ☐ Unsure

Were you born vaginally, without a C-Section?

☐ No ☐ Yes ☐ Unsure

Mother's pregnancies prior to your birth:

Living: _____ ☐ Unknown

Miscarriages: _____ ☐ Unknown

Ectopic: _____ ☐ Unknown

Induced Abortions: _____ ☐ Unknown

If you were not your mother's first pregnancy, approximately how many months separate you and your mother's last pregnancy of any kind prior to your birth?

_____ months ☐ Unknown

Did you experience any known birth trauma?

☐ No ☐ Yes ☐ Unsure

Was your mother's pregnancy and/or labor with you particularly difficult?

☐ No ☐ Yes ☐ Unsure

If yes, please explain: _____

_____

_____

_____

_____

Musculoskeletal Pain

Area	Quality of Pain
1.	☐ Dull ☐ Achy ☐ Burning ☐ Sharp/Stabbing ☐ Constant ☐ Intermittent
2.	☐ Dull ☐ Achy ☐ Burning ☐ Sharp/Stabbing ☐ Constant ☐ Intermittent
3.	☐ Dull ☐ Achy ☐ Burning ☐ Sharp/Stabbing ☐ Constant ☐ Intermittent
4.	☐ Dull ☐ Achy ☐ Burning ☐ Sharp/Stabbing ☐ Constant ☐ Intermittent
5.	☐ Dull ☐ Achy ☐ Burning ☐ Sharp/Stabbing ☐ Constant ☐ Intermittent

Additional Information

Review of Systems

General

Past/Current	Past/Current	Past/Current
☐ / ☐ Low Appetite	☐ / ☐ Insomnia	☐ / ☐ Chills
☐ / ☐ Excessive Appetite	☐ / ☐ Hepatitis A B C D	☐ / ☐ Fevers
☐ / ☐ Change in Appetite	☐ / ☐ Cancer	☐ / ☐ Night Sweats
☐ / ☐ Poor Coordination	☐ / ☐ Diabetes	☐ / ☐ Sweats Easily
☐ / ☐ Strong Thirst	☐ / ☐ HIV/AIDS	☐ / ☐ Weight Gain
☐ / ☐ Fatigue (Chronic)	☐ / ☐ Parasites	☐ / ☐ Weight Loss

Ears

Past/Current	Past/Current	Past/Current
☐ / ☐ Infection	☐ / ☐ Hearing Loss	☐ / ☐ Other _____
☐ / ☐ Discharge	☐ / ☐ Ringing/Tinnitus	☐ / ☐ Other _____
☐ / ☐ Aches		

Eyes

Past/Current	Past/Current	Past/Current
☐ / ☐ Inflammation	☐ / ☐ Glasses/Contacts	☐ / ☐ Glaucoma
☐ / ☐ Dry Eyes	☐ / ☐ Blurred Vision	☐ / ☐ Cataracts
☐ / ☐ Excessive Tearing	☐ / ☐ Poor Night Vision	☐ / ☐ Other
☐ / ☐ Laser Eye Surgery	☐ / ☐ Spots/Floaters	_____

Head & Neck

Past/Current	Past/Current	Past/Current
☐ / ☐ Enlarged Lymph Nodes	☐ / ☐ Headaches	☐ / ☐ Dizziness
☐ / ☐ Stiff Neck	☐ / ☐ Migraines	☐ / ☐ Vertigo
☐ / ☐ Hyperthyroid	☐ / ☐ Concussions	☐ / ☐ Fainting
☐ / ☐ Hypothyroid	☐ / ☐ Other _____	☐ / ☐ Other _____

Urinary

Past/Current	Past/Current	Past/Current
☐ / ☐ Frequent Urination	☐ / ☐ Dribbling/Leaking	☐ / ☐ UTI
☐ / ☐ Urinary Urgency	☐ / ☐ Incontinence	☐ / ☐ Kidney Stones
☐ / ☐ Inability to Urinate	☐ / ☐ Weak Stream	☐ / ☐ Blood in Urine
☐ / ☐ Painful Urination	☐ / ☐ Interrupted Stream	☐ / ☐ Other _____

Musculoskeletal

Past/Current	Past/Current	Past/Current
☐ / ☐ Arthritis	☐ / ☐ Scoliosis	☐ / ☐ Fibromyalgia
☐ / ☐ Joint Pain	☐ / ☐ Disc Problems	☐ / ☐ Osteoporosis
☐ / ☐ Muscle Spasms	☐ / ☐ Pinched Nerve	☐ / ☐ Localized Weakness

Cardiovascular

Past/Current	Past/Current	Past/Current
☐ / ☐ High Blood Pressure	☐ / ☐ Irregular Heartbeat	☐ / ☐ Varicose Veins
☐ / ☐ Low Blood Pressure	☐ / ☐ Chest Pain/Angina	☐ / ☐ Phlebitis
☐ / ☐ Cold Hands/Feet	☐ / ☐ Palpitations	☐ / ☐ Blood Clots
☐ / ☐ Hand/Foot Swelling	☐ / ☐ Pacemaker	☐ / ☐ Hemophilia
☐ / ☐ High Cholesterol	☐ / ☐ Fainting	☐ / ☐ Anemia

Gastrointestinal

Past/Current	Past/Current	Past/Current
☐ / ☐ Nausea	☐ / ☐ Heartburn	☐ / ☐ Gallbladder Issues
☐ / ☐ Vomiting	☐ / ☐ Indigestion	☐ / ☐ Blood in Stool/Black Stool
☐ / ☐ Belching	☐ / ☐ Abdominal Pain	☐ / ☐ Rectal Pain
☐ / ☐ Hiccups	☐ / ☐ Gas	☐ / ☐ Hemorrhoids
☐ / ☐ Diarrhea	☐ / ☐ Bad Breath	☐ / ☐ IBS/Crohn Disease
☐ / ☐ Constipation	☐ / ☐ Ulcers	☐ / ☐ Other _____

Nose, Throat, Mouth

Past/Current	Past/Current	Past/Current
☐ / ☐ Allergies/Hay Fever	☐ / ☐ Nose Bleeds	☐ / ☐ Grinding Teeth
☐ / ☐ Recurring Sore Throat	☐ / ☐ Sinus Infections	☐ / ☐ TMJ
☐ / ☐ Difficulty Swallowing	☐ / ☐ Sinus Congestion	☐ / ☐ Dry Mouth

Skin & Hair

Past/Current	Past/Current	Past/Current
☐ / ☐ Itching	☐ / ☐ Tumors/Lumps	☐ / ☐ Eczema
☐ / ☐ Rashes	☐ / ☐ Acne	☐ / ☐ Psoriasis
☐ / ☐ Hives	☐ / ☐ Dry Hair	☐ / ☐ Bruising
☐ / ☐ Dry Skin	☐ / ☐ Thinning Hair	☐ / ☐ Other _____

Respiratory

Past/Current	Past/Current	Past/Current
☐ / ☐ Frequent Colds	☐ / ☐ Asthma	☐ / ☐ Shortness of Breath
☐ / ☐ Phlegmy	☐ / ☐ Pneumonia	☐ / ☐ Emphysema
☐ / ☐ Cough	☐ / ☐ Bronchitis	☐ / ☐ COPD
☐ / ☐ Tight Chest	☐ / ☐ Tuberculosis	☐ / ☐ Other _____

Neurological

Past/Current	Past/Current	Past/Current
☐ / ☐ Limb Numbness/Tingling	☐ / ☐ Tremors	☐ / ☐ Seizures
☐ / ☐ Autistic Spectrum Disorder	☐ / ☐ Paralysis	☐ / ☐ Dementia
☐ / ☐ Learning Difficulties	☐ / ☐ Stroke	☐ / ☐ Pain
☐ / ☐ Other _____	☐ / ☐ Concussion	☐ / ☐ Neuritis

Psychological

Past/Current	Past/Current	Past/Current
☐ / ☐ Depression	☐ / ☐ ADD/ADHD	☐ / ☐ Mania/Bipolar
☐ / ☐ Anxiety/Stress	☐ / ☐ PTSD	☐ / ☐ Panic Attacks
☐ / ☐ Irritability	☐ / ☐ Foggy Thinking	☐ / ☐ Other _____

Men's Health

Past/Current	Past/Current	Past/Current
☐ / ☐ Genital Lesions	☐ / ☐ Nocturnal Emission	☐ / ☐ STI
☐ / ☐ Genital Pain	☐ / ☐ Nocturnal Enuresis	☐ / ☐ Prostatitis
☐ / ☐ Genital Itching	☐ / ☐ Premature Ejaculation	☐ / ☐ Lumps in Testes
☐ / ☐ Genital Discharge	☐ / ☐ Erectile Difficulty	☐ / ☐ Other
☐ / ☐ Vasectomy	☐ / ☐ Abnormal Libido (+/--)	_____

Emotions

☐ Anger ☐ Irritability ☐ Depression ☐ Suicidal Thoughts ☐ Overthinking ☐ Worry ☐ Fear ☐ Anxiety ☐ Nervousness ☐ Easily Startled ☐ Other _____

Women's Reproductive Health

Past/Current	Past/Current	Past/Current	Past/Current
☐ / ☐ Heavy Periods	☐ / ☐ PMS	☐ / ☐ Pelvic Adhesions	☐ / ☐ Menopausal Symptoms
☐ / ☐ Light Periods	☐ / ☐ HPV	☐ / ☐ Fibroids/Polyps	☐ / ☐ Hot Flashes
☐ / ☐ < 25-day cycle	☐ / ☐ Frequent Vaginal Infections	☐ / ☐ Endometriosis	☐ / ☐ Night Sweats
☐ / ☐ > 32-day cycle	☐ / ☐ Genital Pain/Itching	☐ / ☐ PCOS (Polycystic Ovaries)	☐ / ☐ Headaches / Migraines
☐ / ☐ Irregular Periods	☐ / ☐ Genital Lesions	☐ / ☐ Abnormal Pap Smear	☐ / ☐ Breast Lumps
☐ / ☐ Bleeding Between Periods	☐ / ☐ Pain During Sex	☐ / ☐ Pelvic Inflammatory Disease (PID)	☐ / ☐ Unexplained Infertility
☐ / ☐ Painful Periods/Cramps	☐ / ☐ Abnormal Libido	☐ / ☐ Sexually Transmitted Infection (STI)	☐ / ☐ Other _____

Pregnancy & Menstrual History

Are you currently pregnant?

☐ No ☐ Yes ☐ Unsure

If yes, for how long? _____

Total Pregnancies: _____

Living: _____ Ages: _____

Miscarriages: _____

Ectopic: _____ Induced Abortions: _____

Age of First Period (Menarche) _____

Are You Sexually Active? ☐ Yes ☐ No **Current Contraception:** _____

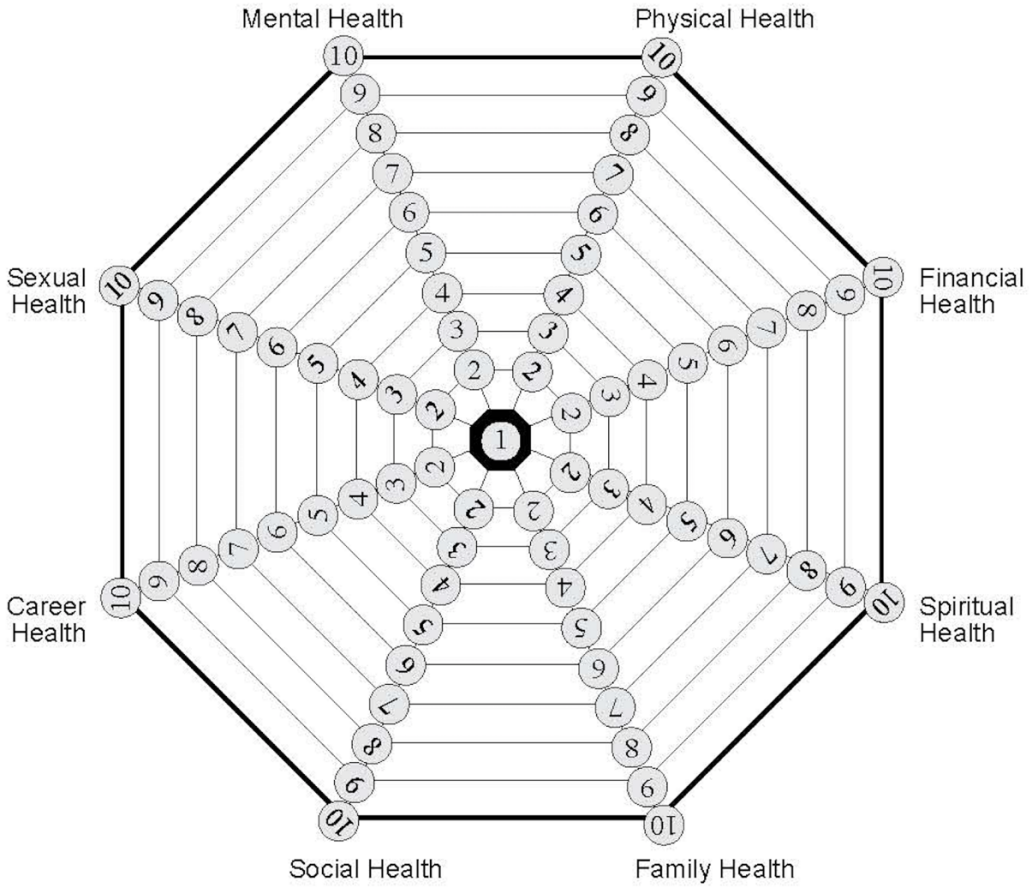
Start Date of Last Period: _____ **# of Days:** _____

Interval Since Previous: _____ **Typical Cycle Duration:** _____

Menopause: ☐ Yes ☐ No **If yes, age:** _____ **Any Bleeding Since?** ☐ Yes ☐ No

Wellness Web

Health and wellness are a balance of many factors that affect our lives in various ways.
Starting at the center of the diagram, choose your level of satisfaction in each of the areas.
For example, if you are extremely satisfied with your career, shade in the #10 circle on the Career line.
1 = Not Happy
10 = Extremely Satisfied



Types of Care

According to your signs and symptoms, please indicate (X) where your current state of health falls along this continuum.

Acute Care	*Maintenance*	*Wellness & Prevention*
Obvious symptoms and signs Get me out of pain and discomfort, fast! Most patients begin treatment to provide relief from pain, discomfort, and symptoms. Acute Care helps to ease your initial problem(s) quickly.	*Symptoms and signs disappear* Feeling good, no major problems, and let's keep it this way… Maintenance give you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.	*You feel great!* Feeling good, and life is wonderful! Prevention and Wellness helps you achieve and maintain optimal health and well-being, free of disease.

Notice of Privacy Practices

Pledge Regarding Your Medical Information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it.

Health Record and Medical Information

We create a record of the care and services you receive at Soma Therapeutics. This is required to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

Use and Disclosure of Your Medical Information:

We gather personal health information in several ways. This information comes from you, other healthcare providers, and third-party payers. We will only disclose your medical information for the purposes listed below with your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

- For treatment
- For communication with other healthcare providers who contribute to your care
- For payment
- For healthcare operations
- When required or permitted by law

We will not use your health information for marketing communications without your written authorization. We may, however, send birthday cards, holiday greetings, newsletters, clinic letters and updates, and appointment reminders by telephone, text/SMS, mail, or e-mail.

Patient Rights

Upon written request you have the right to:

- Access, review, or receive copies of your healthcare records within 10 working days for a copy fee of $15
- Receive a list of items this office disclosed about your health care information
- Request that this office place additional restrictions on disclosure of your protected health information
- Request that we amend your protected health information
- Receive all notices in writing

If you have questions, complaints, or want more information please contact us at Office@Soma-Therapy.com or 925.272.9109.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have read, reviewed, understand, and agree to the statement of the Privacy Practices for the healthcare services in this office. Soma Therapeutics provides each patient with a statement of Privacy Practices upon request.

_____ _____

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

Date

925.272.9109
www.soma-therapy.com

Consent to Use and Disclose Health Information for the Purposes of Treatment, Payment, and Healthcare Operations

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, by your authorization, or when required or permitted by law.

I, _____, give consent to Soma Therapeutics to use and disclose my individual identifiable health information of Protected Health Information for the specific purposes of:

- Providing and planning my care and treatment
- Communicating among health professionals who contribute to my care
- Applying my diagnosis to my bill
- Allowing a third-party payer to verify that services billed were provided
- Administering routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to read and discuss the *Notice of Privacy Practices* prior to signing this consent form regarding the use and disclosures of my protected health information.

I understand that I have the right to request a restriction on the use and disclosure of my protected health information for the purposes of treatment, payment, and healthcare operations of the clinic. If Soma Therapeutics agrees to a restriction I request, the restriction is binding.

I understand that I have the right to revoke this consent, in writing, at any time except to the extent that Soma Therapeutics has acted in reliance on this consent.

_____ _____

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

Date

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Financial Policies

Payment Options

All fees for service are due at the time of visit unless previous arrangements have been made. Cash or check is preferred. However, we gladly accept all major credit cards and approved FSA and HSA debit cards.

Appointment Policy (Cancellation, No Show, & Late Arrival)

If you are unable to keep your appointment and must reschedule or cancel, we require a 24-hour notice. The more notice you can provide, the better. We may not have adequate treatment time if you arrive more than 15 minutes past your appointment time, and will consider the appointment a last-minute cancellation.

***Please note, if you fail to cancel or reschedule an appointment within 24 hours, miss an appointment, or arrive more than 15 minutes past your scheduled appointment time, you will be charged the full price of your scheduled appointment*.**

As this practice continues to grow, we encourage our clients to adhere closely to scheduled appointments for the consideration of other clients, as we may have turned away clients who desired your appointment time. Your appointment time is reserved specifically for you. We understand that sometimes unexpected events occur, and your cooperation with our appointment policy is greatly appreciated.

Insurance Responsibility Policy

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill. If your insurance carrier does not remit within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to us.

Returned Checks

There is a $30 service fee for every returned check.

Special Circumstance Pricing

Special circumstance price reduction may be available for patients who show financial need or experience an unexpected hardship. If at any point you wish to be considered for a lower fee please discuss this with us before your next appointment.

Credit Card Information

When scheduling a new patient appointment, we ask that you provide a valid credit card number to reserve the appointment. All information will be kept confidential and secure.

Name (as it appears on card)	**3 Digit CVV Code on Back** **(AmEx: 4 Digit code on front)**
Credit Card Number (☐ Visa ☐ MasterCard ☐ Discover ☐ American Express)	**Expiration Date (MM/YY)**

Agreement to Financial Policies:

I, _____, understand and agree to the financial policies listed above.
I authorize my credit card on file to be charged to settle any balance or to enforce the Returned Checks or Cancellation Policy.

_____ _____

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

Date

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 California and federal law provide 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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 equal 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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 Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: Daniel Linder DAIM, LAc Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Daniel Linder DAIM, LAc

(Date)

PATIENT SIGNATURE **X**

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