REGISTRATION

(PLEASE PRINT)

ADVANCED ACUPUNCTURE, Inc.

622 W. Duarte Road, Suite 204
Arcadia, CA 91007
(626) 462-9821
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1260 15th St., Suite 601
Santa Monica, CA 90404
(310) 458-2848
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Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

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

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 _____ and assign directly to
Name of Insurance Company(ies)
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
622 W. Duarte Road Suite 204
Arcadia, CA 91007

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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:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Tuberculosis
☐ 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

Form PHQ-202

Rev 7/16/05

Patient Name _____ *Date* _____

1. Describe your symptoms _____

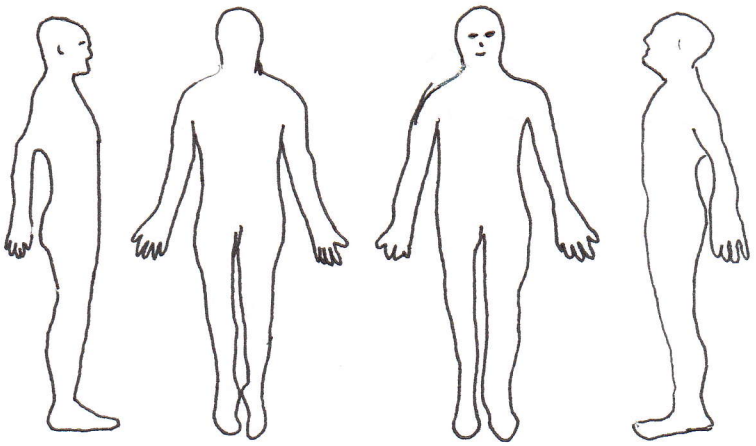
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ○ Sharp
- ○ Shooting
- ○ Dull ache
- ○ Burning
- ○ Numb
- ○ Tingling

4. How are your symptoms changing?

- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Unbearable

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

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

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

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

8. Who have you seen for your symptoms?

○ No One ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

a. What treatment did you receive and when? _____

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

○ Xrays *date:* _____ ○ CT Scan *date:* _____
○ MRI *date:* _____ ○ Other *date:* _____

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

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

○ This Office ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

10. What is your occupation?

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

_____

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

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature _____ *Date* _____

Workmen's Compensation Questionnaire

Please answer all questions completely

INSURANCE CARRIER _____

1. EMPLOYER _____
2. Address (No., Street & City) _____ Phone _____
3. Type of Business (mfg, construction, retail, etc.) _____ _____

4. EMPLOYEE _____ Social Security No. _____
5. Address (No., Street & City) _____ Phone _____
6. Occupation _____ Age _____ Sex _____
7. Date injured _____ Hour _____M. Date last worked _____
8. Injured at (No., Street & City) _____ County _____
9. Date of your first examination _____ Hour _____M. Who engaged your services? _____
10. Name other doctors who treated employee for this injury _____

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? _____
    Employee's statement of cause of injury or illness:

Have you retained an attorney ☐Yes ☐No Litigation? ☐Yes ☐No ☐Maybe
If so, name and address _____

Give time and date present injury occurred _____ ☐AM ☐PM _____19_____
Where did you feel pain immediately after the accident? _____
Did you return to work? ☐Yes ☐No If so, date returned to work _____

Did you consult any other doctor? ☐Yes ☐No
If so, give doctor's name _____ ☐D.C. ☐M.D. ☐D.O. ☐D.D.S.
Doctor's diagnosis _____
What treatments did you receive? _____

Have you ever injured this area before? ☐Yes ☐No If so, when? _____

If injured before, did you lose time from work? ☐Yes ☐No
If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? ☐Yes ☐No If so, explain _____

In your work, do you have to favor any part of your body? ☐Yes ☐No If so, explain _____

Do you have a history of absenteeism caused from accidents on the job? ☐Yes ☐No
Have you ever had a Workman's Compensation claim before? ☐Yes ☐No
Before the injury, were you capable of working on an equal basis with others your age? ☐Yes ☐No
Are your work activities retricted as a result of this accident? ☐Yes ☐No

Since this injury, are your symptoms ☐improving? ☐getting worse? ☐the same?

Advanced Acupuncture, Inc

Initial Examination

Physical medicine and rehabilitation
Report transcription form
Private

Date: _____

Patient Name: _____
Last First MI

SS # _____

PHYSICAL MEDICINE and REHABILITAION
CONSULTATION

The patient is a ___ year old man/woman who was seen in Physical Medicine/ Rehabilitation for evaluation of his / her:

- ☐ ARM
- ☐ CHEST
- ☐ ELBOW
- ☐ FOOT
- ☐ HEAD
- ☐ HIP
- ☐ KNEE
- ☐ LEG
- ☐ UPPER BACK
- ☐ LOW BACK
- ☐ NECK
- ☐ SHOULDER
- ☐ OTHER: _____PAIN.

HISTORY OF ILLNESS

Describe illness of injury:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Treatments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

\

PRESENT COMPLAINTS

☐ Slight	☐- Slight to Moderate	☐Severe
☐-Moderate	☐-Moderate to Severe	

☐-Occasional	☐-Intermittent	☐-Frequently	☐-Constant

Currently, what are the patient's complains, pain, physical restrictions, etc., those related to his work injury.

___ ☐Headaches☐frontal☐occipital☐temporal]
___ ☐Neck pain [radiating to___☐___ right ___☐____left arm]
___ ☐ Upper back pain
___ ☐ Low back pain [radiating to ☐ right ☐ left leg]
___ ☐ Anxiety
___ ☐ Depression
___ ☐ Other: _____

Describe the physical limitations or restrictions that the patient presently has as a result of his injury.

At this time the patient is unable to:

- ☐ Bend from waist ☐ to knees☐ to floor
- ☐ Bend at knees [squatting]
- ☐ Carry [list items:_____]
- ☐ Lift _____lbs.
- ☐ Pull [list items:_____]
- ☐ Push [list items: _____]
- ☐ Reach:☐ up ☐ down ☐ across
- ☐ Repeat movements of _____hands
- ☐ Sit ___ hours per day
- ☐ Twist [specific body part: _____]
- ☐ Prolonged positioning of the head
- ☐ Walk
- ☐ Drive
- ☐ Grasp
- ☐ Overhead☐reach☐grasp☐push☐pull☐lift]
- ☐ Other [specific duty] _____

PAST MEDICAL HISTORY

PRIOR ILLNESSES

- ☐ Non- contributory
- ☐ It is notable that [insert significant history]

PRIOR INJURIES

- ☐ Non-contributory
- ☐ It is notable that [insert significant history]

ALLERGIES

- ☐ None
- ☐ The patient reports being allergic to [specify types]
- ☐ Plants_____
- ☐ Animals _____
- ☐ Foods_____
- ☐ Medications _____

SURGERIES

- ☐ None
- ☐ They patient has had the following surgeries: [list procedures and dates]

_____

_____

_____

MEDICATIONS

- ☐ None
- ☐ Tylenol #3 ____Dosage___ Frequency for:_____
- ☐ Motrin ____Dosage___ Frequency for:_____
- ☐ Soma ____Dosage___ Frequency for:_____
- ☐ Xanax ____Dosage___ Frequency for:_____
- ☐ Other_____[specify]

____Dosage___ Frequency for: _____

- ☐ Other _____[specify]

____Dosage___ Frequency for: _____

- ☐ Other_____[specify]

____Dosage___ Frequency for: _____

PERSONAL HISTORY

The patient's primary language is:

- ☐ English
- ☐ Spanish
- ☐ Other _____ [specify]
- ☐ The patient communicated with the aid of an interpreter

The patient was born in _____ [state or country]
And came to the United States in _____ [year]

The patient is

- ☐ Single
- ☐ Married
- ☐ Divorce
- ☐ Widowed

The patient has

- ☐ No children
- ☐ Children _____[state number]

The patient

- ☐ Does not smoke
- ☐ Smokes _____ cigarettes per day [state number]

The patient

- ☐ Does not drink
- ☐ Consumes _____drinks per week [state number]

The patient has participated in the following sport and recreational activities:

_____

_____

_____

Occupation: _____

Family History:

REVIEW OF SYSTEMS

Neurological

- ☐ The patient denied having headaches, seizures, or body weakness
- ☐ Other: [describe]

Respiratory

- ☐ In the respiratory system, there was no shortness of breath, productive cough or hemoptysis.
- ☐ Other: [describe]

Cardiovascular

- ☐ The cardiovascular system was normal, without chest pain, abnormal rhythms, dyspnea or paroxysmal nocturnal dyspnea.
- ☐ Other: [describe]

Gastrointestinal

- ☐ Review to the gastrointestinal system was negative for nausea, vomiting, diarrhea or epigastric pain.
- ☐ Other [describe]

Genitourinary

- ☐ The patient denied urinary frequency, urgency, dysuria, or hematuria.
- ☐ Other: [describe]

Musculoskeletal

- ☐ There was no joint pain, myalgia or extremity weakness
- ☐ Other: [describe]

Hematological

- ☐ The patient denied bleeding tendencies
- ☐ Other [describe]

Review of Systems:

- ☐ Review of systems was essentially non-contributory with regard to this patient's industrial injury.
- ☐ Review of systems was notable in that –describe

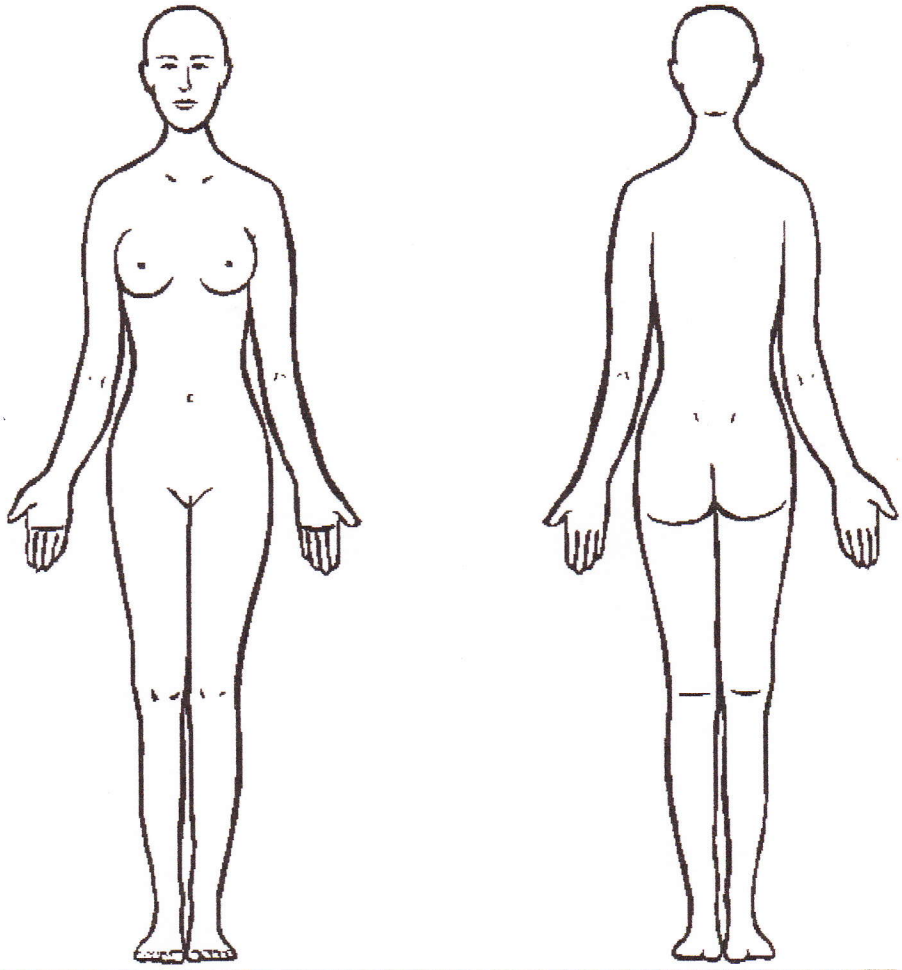
Other: This patient has

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Weight loss
- ☐ Intractable pain
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Weight gain

Advanced Acupuncture, Inc

Whole Body Symptom Description

Patient name: _____ Date: _____



Key:

Ache	Numbness	Burning	Stabbing
^ ^ ^ ^	= = = =	x x x x	/ / / /

Please indicate on the line blow the number between 0 and 100 that baest describe syour pain.
A zero (0) would mean "no pain" and a one-hundred (100) would mean the "worst pain possible"

Please write only one number: _____

Advanced Acupuncture, Inc

Visual Analog Scales for Chronic Pain

Please mark an "X" along the line to show how your pain has affected your level of function.

1. At what level do you perceive your pain?

   No Pain ——|——|——|——| Worst Possible

2. At what level do you experience pain at night?

   No Pain ——|——|——|——| Worst Possible

3. Has the pain affected your level of activity?

   No Problem ——|——|——|——| Total Change

4. How well does medication relieve your pain?

   Complete relief ——|——|——|——| Worst Possible

5. How stiff is your back/ neck?

   No Stiffness ——|——|——|——| Totally Stiff

6. Does your pain interfere with sitting?

   No Problem ——|——|——|——| Cannot Sit

7. Is it painful for you to walk?

   No Pain ——|——|——|——| Cannot Walk

8. Does your pain keep you from standing/ sitting still?

   No Problem ——|——|——|——| Cannot Do It

9. Does your pain interfere with your normal household chores?

   No Problem ——|——|——|——| Cannot Do Them

10. Does your pain affect your driving time in a car?

    No Problem ——|——|——|——| Cannot Do It

11. Do you get relief from your pain by lying down?

    Complete Relief ——|——|——|——| No Relief at All

12. How much have you had to change your job responsibilities?

    No Change ——|——|——|——| So Much I Can't Work

13. How much control do you feel you have over the pain?

    No Control ——|——|——|——| No Control

14. How much control have you lost over other areas of your life due to the pain?

    No Control Lost ——|——|——|——| Total Loss Control

Numerical scores can be obtained by measuring the placement of the mark along the line scores may be compared with repeat administration of the scale.

Advanced Acupuncture, Inc

Pain and Relief Diary

Time	Pain Location or type (A, B)	Pain rating	Pain medicine	Relief 1-2 hours later	What else helped?
7:00 A.M. ☐					
8:00 ☐					
9:00 ☐					
10:00 ☐					
11:00 ☐					
12:00 noon ☐					
1:00 P.M ☐					
2:00 ☐					
3:00 ☐					
4:00 ☐					
5:00 ☐					
6:00 ☐					
7:00 ☐					
8:00 ☐					
9:00 ☐					
10:00 ☐					
11:00 ☐					
12:00 mdnt ☐					
1:00 AM ☐					
2:00 ☐					
3:00 ☐					
4:00 ☐					
5:00 ☐					
6:00 ☐					

Pain is an individual puzzle; the more pieces (of information) you have that fit together, the better. This form was developed to help you find and communicate information often required to develop and effective pain treatment plan with your doctor.

OSWESTRY PAIN QUESTIONNAIRE

Patient Name: _____

Patient Number: _____

Date of Test: _____

Please Read: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in every day life. Please answer every section, and mark in each section **only the one** box that applies to you.

Section 1- Pain Intensity

- ☐ I can tolerate the pain I have without having to use painkillers
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6- Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8- Sex Life

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal and causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9- Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I can manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30'
- ☐ Pain prevents me from traveling except to the doctor or the hospital.

(-) Pain Scale (+)

0	1	2	3	4	5	6	7	8	9	10

Advanced Acupuncture, Inc
Neck Disability Index Questionnaire

Name: _____ Date: _____ Score: _____

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected, our ability to manage your everyday activities. Please answer each section, by circling one choice that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain intensity ☐ I have no pain at the moment ☐ The pain is very mild at the moment. ☐ The pain is moderate at the moment. ☐ The pain is fairly severe at the moment. ☐ The pain is very severe at the moment. ☐ The pain is worst imaginable at the moment.	Section 6 – Concentration ☐ I can concentrate fully when I want to with no difficulty. ☐ I can concentrate fully when I want to with slight difficulty. ☐ I have a fair degree of difficulty in concentrating when I want to. ☐ I have a great deal of difficulty in concentrating when I want to. ☐ I cannot concentrate at all.
Section 2- personal care (washing, dressing, ect) ☐ I can look after myself normally without causing extra pain. ☐ I can look after myself normally but it is very painful. ☐ It is painful to look after myself and I am slow and careful. ☐ I need some help but manage most of my personal care. ☐ I need help every day in most aspects of self care. ☐ I do not get dresses, wash my difficulty and stay in bed.	Section 7 – Work ☐ I can do as much work as I want to ☐ I can only do my usual work, but no more. ☐ I can do most of my usual work, but no more. ☐ I cannot do my usual work ☐ I can hardly do any work at all. ☐ I cannot do any work at all.
Section 3 – Lifting ☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights, but it causes extra pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ☐ I can only lift very light weights, at most. ☐ I cannot lift or carry anything at all	Section8 – Driving ☐ I can drive my car without any neck pain ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck. ☐ I cannot drive my car as long as I want because of moderate pain in my neck ☐ I can hardly drive at all because of severe pain in my neck. ☐ I cannot drive my car at all.
Section 4 – Reading ☐ I can read as much as I want to with no pain in my neck. ☐ I can read as much as I want to with slight pain in my neck. ☐ I can read as much as I want to with moderate pain in my neck. ☐ I cannot read as much as I want because of severe pain in my neck ☐ I cannot read at all.	Section 9 – Sleeping ☐ I have no trouble sleeping ☐ My sleep is slightly disturbed (less than 1 hr sleepless) ☐ My sleep is mildly disturbed (1-2 hours sleepless). ☐ My sleep is moderately disturb (2-3hrs sleepless) ☐ My sleep is greatly disturbed (3-5 hrs sleepless) ☐ My sleep is completely disturbed (5-7 hours)
Section 5 - Headaches ☐ I have no headaches at all. ☐ I have slight headaches which come infrequently. ☐ I have moderate headaches which come infrequently. ☐ I have moderate headaches which come frequently ☐ I have headaches almost all the time.	Section 10 – Recreations ☐ I am able to engage in all of my recreational activities with no neck pain ☐ Ii am able to engage in all of my recreational activities with some pain I my neck. ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck. ☐ I am able to engage in a few of my recreational activities because of pain in my neck. ☐ I can hardly do any recreational activities because of pain in my neck. ☐ I cannot do any recreational activities at al

Comments:

_____

_____

_____

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name:_____ File #_____ Date:_____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain lam unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ❑ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain on walking but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

SECT ION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by less than 1/4.
- ❑ Because of pain my normal night's sleep is reduced by less than 1/2.
- ❑ Because of pain my normal night's sleep is reduced by less than 3/4.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home. -
- ❑ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING

- ❑ I get no pain whilst traveling.
- ❑ I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain whilst traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain whilst traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better,
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain-is gradually worsening.
- ❑ My pain is rapidly worsening.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Advanced Acupuncture, Inc
The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today do you or would you have any difficulty at all with:

	Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing heavy activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Waling 2 blocks	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum level of Detectable Change (90% confidence): 9 points Score: ___/80

Advanced Acupuncture, Inc

Low Back Pain and Disability Questionnaire

Name: _____ Date:_____

Age: _____ Score:_____

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most the time because of my back pain.
- ☐ I walk more slowly than usual because of my back
- ☐ Because of my back, I use a handrail to get upstairs
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold onto something to get out of an easy chair
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I stand up only for short periods of time because of my back
- ☐ Because of my back, I try not to bend or kneel down
- ☐ I find it difficult to get out of a chair because of my back
- ☐ My back or leg is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back
- ☐ I have trouble putting on my socks (or Stockings) because of pain in my back.
- ☐ I sleep less well because of my back
- ☐ I avoid heavy jobs around the house because of my back

- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.

WORKERS COMPENSATION PATIENTS

POLICY

Welcome to our office. We aim to give you the highest care possible both clinically and in regard to the business aspect of our practice.

Excessive missed appointments are detrimental to your care. If you miss 5 visits without advanced notice, the doctor will have a discussion with you regarding your committment to your care..

FINANCIAL POLICY

Workers Compensation Insurance covers all examination, treatment, and x-ray cost once treatment has been authorized. Your employer and the Workers Compensation Insurance have the right to grant authorization for treatment or not. If authorization is refused, the patient may undergo treatment using coverage provided by a major medical/group health plan or as a private paying patient.

Patients involved in a Workers Compensation case must bring signed authorization for treatment to our office. If signed authorization is not brought to our office within two weeks from the date of your first visit, the balance will be transferred to your health insurance or to a cash account. Our skilled office will do everything to assist you with your Workers Compensation Insurance.

If your insurance carrier refuses to pay, due to a lawsuit pending, you will be notified and the bill can be submitted to your group health insurance or paid by you and your attorney by signing a Workers Compensation green lien. All patients are required to sign two green liens.

The patient must notify this office of the attorney's name, address, and phone number that has been chosen to represent his/her case, or be responsible for the bill.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

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

1260 15th St Suite 204
Santa Monica, CA 90404

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

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

****

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.

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

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

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 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: _____

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.