



TAO OF WELLNESS
SANTA MONICA
2825 SANTA MONICA BLVD.
SUITE 300
SANTA MONICA, CA 90404
TEL: 917.2200
FAX: 310.917.2204
santamonica@taoofwellness.com
www.taoofwellness.com

TAO OF WELLNESS
NEWPORT BEACH
359 SAN MIGUEL DRIVE
SUITE 200
NEWPORT BEACH, CA 92660
TEL: 949.706.7770
FAX: 949.706.7211
newportbeach@taoofwellness.com
www.taoofwellness.com

TAO OF WELLNESS
PASADENA
171 S. LOS ROBLES AVENUE
SUITE A
PASADENA, CA 91101
TEL: 626.397.1000
FAX: 626.397.1010
pasadena@taoofwellness.com
www.taoofwellness.com

ACUPUNCTURE
CHINESE MEDICINE
NUTRITIONAL COUNSELING
TUI-NA / ACUPRESSURE
ANTI-AGING

Welcome to Tao of Wellness.

In an effort to better serve you, below is a list of things to prepare before your first visit:

- Please arrive 10-15 minutes before your appointment.
- We are located at 359 San Miguel Drive, Suite 200, Newport Beach, CA 92660 – between Avocado Avenue and Newport Center Drive.
- Fill out and sign all forms enclosed before your appointment.
- Bring the paperwork with you when you come in for your visit. All paperwork needs to be completed before any treatment can begin. You may discuss any questions you have with our staff or doctors.
- If the paperwork was faxed or emailed, an original arbitration agreement form and informed consent form will be provided to you to sign at the time of arrival.
- We do not bill any business managers, insurance companies, etc.
- Payments in the form of Visa, MasterCard, Discover, check, and cash are collected at the time services are rendered.
- Parking is available at the front of the building.
- Please allow approximately 1.5 hours for your first visit, and 1 hour for subsequent visits.
- Wear something comfortable and loose fitting.

We look forward to serving you.

Sincerely,

Tao of Wellness Staff

TAO OF WELLNESS

PATIENT INFORMATION:

Name: _____
Last Name First Name

Age _____ Date of Birth: ____/____/____ Driver's License #: _____ Male Female

Home Address: _____ Apt/Ste#: _____

City: _____ State: _____ Zip: _____

Home Number: () _____ - _____ Work/Cell Number: () _____ - _____

Occupation: _____ Employer: _____

Work Address: _____ City _____ State: _____ Zip: _____

Spouse's Name: _____ Phone Number: () _____ - _____

E-mail address (for communication & newsletters): _____

Chief Complaint: _____

Please answer the following questions by circling Yes or No

Do you have a tendency to faint?	Yes	No	Are you HIV positive?	Yes	No
Do you have a pacemaker?	Yes	No	(Females) Are you pregnant?	Yes	No
Do you bleed for a long time?	Yes	No	What medications are you on now?	_____	
Have you ever had hepatitis?	Yes	No	_____		

INSURANCE INFORMATION:

(For Health Insurance Form Completion Purposes)

Name of Insurance Co.: _____ Insured's Name: _____

Insured's ID #: _____ Insured's Date of Birth: ____/____/____ Relation: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone Number: () _____ - _____

Primary Physician's Name: _____ Phone Number: () _____ - _____

REFERRED BY:

Name: _____ Referral Phone Number: () _____ - _____

Referral Address: _____

Other: e.g. askdrmao.com, taoofwellness.com, Google, etc.: _____

**If you are under 18 years of age, please have your parent or legal guardian sign below.
I have read and agree to the terms above. All of the information is true to the best of my knowledge.**

X _____ Date: _____
Signature of Patient/Parent/Legal Guardian

X _____ Relation: _____
Printed Name of Patient/Parent/ Legal Guardian

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 named 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 be 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 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 the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____ (Date)
(Or Patient Representative) _____ (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** _____ (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

PATIENT MEDICAL HISTORY

The following is a list of symptoms which you may or may not have experienced:

(✓) sometimes experience

(+) frequently experience

No Mark- never experienced

CARDIOVASCULAR	RESPIRATORY	MALES ONLY
Shortness of breath	Cough	Prostate Problems
High Blood Pressure	Coughed up Blood	Pain in Testicles
Irregular Heart Beat	Sore Throat	
Heart Palpitations	Nasal Problems	FEMALES ONLY
Dizziness	Nose Bleed	
Chest Pain or Pressure	Asthma or Wheezing	Pre-Menstrual Pain
Leg Cramps	Pneumonia	Menstrual Pain
	Hay Fever	Irregular Menstrual Cycle
GASTROINTESTINAL	Bronchitis	Swelling or Pain in Breasts
Indigestion	GENITOURINARY	
Abdominal Pain or Cramps		MISCELLANEOUS
Gall Stones	Frequent Urination	
Constipation	Painful Urination	Jaundice (Yellowish Eyes)
Diarrhea	Bloody Discharge	Jaundice (Yellowish Skin)
Blood in Bowel Movement	Venereal Disease	Hepatitis
Black Bowel Movement	Pain in Genital Area	Memory Loss
Excess Appetite	Decreased Sex Drive	Hearing Loss
Decreased Appetite		Ringing in Ears
Excess Thirst	MUSCULAR-SKELETAL	Headaches
Nausea and Vomiting		Insomnia
Colitis or Diverticulitis	Back Pain	Fever
Belching or Burping	Arthritis	Chills
Heartburn	Muscle Pain or Cramps	Night Sweats
	Painful Joints	Intolerance-WeatherChange
SKIN		Kidney Stones
	OTHER	
Ulcerations		
Rash		
Edema		