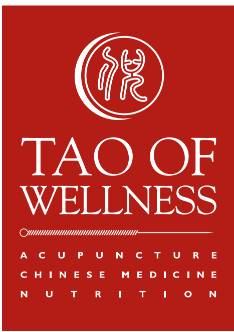

TAO OF WELLNESS
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TEL: 917.2200
FAX: 310.917.2204
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ACUPUNCTURE
CHINESE MEDICINE
NUTRITIONAL COUNSELING
TUI-NA / ACUPRESSURE
ANTI-AGING

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 171 South Los Robles Avenue, Suite A, Pasadena, CA 91101.
- 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
Do you have a pacemaker? Yes No
Do you bleed for a long time? Yes No
Have you ever had hepatitis? Yes No

Are you HIV positive? Yes No
(Females) Are you pregnant? Yes No
What medications are you on now? _______________
____

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	
Shortness of breath	
High Blood Pressure	
Irregular Heart Beat	
Heart Palpitations	
Dizziness	
Chest Pain or Pressure	
Leg Cramps	

GASTROINTESTINAL	
Indigestion	
Abdominal Pain or Cramps	
Gall Stones	
Constipation	
Diarrhea	
Blood in Bowel Movement	
Black Bowel Movement	
Excess Appetite	
Decreased Appetite	
Excess Thirst	
Nausea and Vomiting	
Colitis or Diverticulitis	
Belching or Burping	
Heartburn	

SKIN	
Ulcerations	
Rash	
Edema	

RESPIRATORY	
Cough	
Coughed up Blood	
Sore Throat	
Nasal Problems	
Nose Bleed	
Asthma or Wheezing	
Pneumonia	
Hay Fever	
Bronchitis	

GENITOURINARY	
Frequent Urination	
Painful Urination	
Bloody Discharge	
Venereal Disease	
Pain in Genital Area	
Decreased Sex Drive	

MUSCULAR-SKELETAL	
Back Pain	
Arthritis	
Muscle Pain or Cramps	
Painful Joints	

OTHER	

MALES ONLY	
Prostate Problems	
Pain in Testicles	

FEMALES ONLY	
Pre-Menstrual Pain	
Menstrual Pain	
Irregular Menstrual Cycle	
Swelling or Pain in Breasts	

MISCELLANEOUS	
Jaundice (Yellowish Eyes)	
Jaundice (Yellowish Skin)	
Hepatitis	
Memory Loss	
Hearing Loss	
Ringing in Ears	
Headaches	
Insomnia	
Fever	
Chills	
Night Sweats	
Intolerance-WeatherChange	
Kidney Stones	