Tao of Wellness

PATIENT INFORMATION:

Name: _____
Last Name First Name

Age: _____ Date of Birth: _____/_____/_____ Driver's License Number: _____ ☐ Male ☐ Female

Home Address: _____ Apt/Ste#:_____

City: _____ State: _____ Zip: _____

Contact Number: ( ) _____-_____☐HOME ☐ CELL ☐ WORK/Alt. Number: ( ) _____-_____ ☐HOME ☐CELL ☐WORK

Employer: _____ Occupation: _____

Work Address: _____City _____ State: ____ Zip: _____

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

E-mail address :_____

What is the main reason for your visit today? _____

Name of Spouse or Partner:_____

Please answer the following questions by checking Yes or No

	Yes	No		Yes	No
-Do you have a tendency to faint?	☐	☐	-(Females) Are you pregnant?	☐	☐
-Do you have a pacemaker?	☐	☐	-Do you have any allergies? Please list here: _____		
-Do you bleed easily and for a considerable length of time?	☐	☐	_____		
-Have you ever had hepatitis?	☐	☐	-What medications and/or supplements are you currently taking? _____		
-Are you HIV positive?	☐	☐	_____		

-If you have had had any surgeries list them here: _____

EMERGENCY CONTACT INFORMATION:

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

REFERRED BY:

☐ Individual** ☐ Healthcare Professional** ☐ Tao of Wellness Website ☐ Social Media

☐ Other: _____**If referred by an individual or healthcare professional, please complete below:

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

Referral's Address: _____

INSURANCE INFORMATION:

(If you require a claim form to submit to your insurance, please complete the section below)

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

Insured's ID Number: _____ Insured's Date of Birth:_____/_____/_____

Relation to Insured: _____

I have read and agree to the terms above. All of the information is true to the best of my knowledge. Please sign & print your name below.

X_____ Date: _____
Signature of Patient or Parent/Legal Guardian (if under 18 years of age)

X_____ Relation: _____
Printed Name of Patient or Parent/Legal Guardian (if under 18 years of age)

Symptom Checklist

Patient Name: _____

The following is a list of symptoms you may or may not have experienced, mark them as you see fit:

No Mark= Never or Rarely Experienced

1 = Occasionally Experienced

2 = Frequently Experienced

3 = Constantly Experienced

Cardiovascular		**Respiratory**		**Male Only**	
Shortness of Breath		Cough		Prostate Inflammation	
High Blood Pressure		Coughing Blood		Prostate Enlargement	
Low Blood Pressure		Sore Throat		Elevated PSA	
Irregular Heart Beat		Nasal Congestions		Testicular Pain	
Palpitation		Nose Bleed		Erectile Discomfort/Weakness	
Dizziness		Asthma or Wheezing			
Chest Pain/Pressure		Pneumonia		**Female Only**	
Leg Cramps		Hay Fever		Premenstrual Pain	
		Bronchitis		Menstrual Pain	
Gastrointestinal				Breast Pain/Condition	
Indigestion		**Genitourinary**		Irregular Menstruation	
Heartburn/Acid Reflux		Frequent Urination		Hot Flashes/Night Sweats	
Gall Stones		Painful Urination			
Constipation		Night Urination		**Miscellaneous**	
Diarrhea		Hesitated Urination		Jaundice	
Blood in Stool		Urinary Incontinence		Hepatitis	
Excessive Appetite		Blood in the Urine		Memory Loss	
Decreased Appetite		Venereal Disease		Hearing Loss	
Excessive Thirst		Genital Area Pains		Tinnitus	
Nausea		Decreased Libido		Headaches	
Vomiting				Insomnia	
Belching/Burping		**Musculoskeletal**		Fever	
Colitis/Diverticulitis		Back Pain		Chills	
Hernias		Neck/Shoulder Pains		Kidney Stones	
Difficulty Swallowing		Muscle Pain/Cramps		Intolerance to Weather Changes	
Skin		Painful Joints		Eye Discomfort/Pain	
Ulcerations		Numbness/Tingling in Hands/Feet		Fatigue	
Rash/Hives		Broken Bones		Depression/Anxiety	
Edema		Arthritis		Hemorrhoids	

Office Policy

Last Name: _____ First Name: _____

Please read through our office policy below, and acknowledge that you will adhere to the following Tao of Wellness policies:

1. Payment is expected at the time services are rendered. Accepted forms of payment are cash, checks, Visa, Mastercard & Discover card. There is a service charge of $20.00 for every returned check from the bank.

2. We do not bill insurance companies or accept assignments. We are not responsible for collecting from your insurance company, negotiating a settlement, or disputing a claim.

3. If you need to cancel or reschedule your appointment(s), please inform us **at least 24 hours prior** to your appointment time to avoid a cancellation fee. If you miss your appointment(s) or cancel within the 24 hours prior to your appointment(s), you will be charged for the missed appointment(s).

4. If you arrive late to your appointment(s), we will do our best to accommodate you. We cannot guarantee that you will be seen by your scheduled practitioner. Additionally, your treatment time may be shortened due to time constraints. If you have booked multiple services and the practitioner is unable to complete all services, you will still be charged for all scheduled services.

5. Herbal supplements are not returnable, nor refundable.

6. The Tao of Wellness is required by law to follow HIPAA guidelines, to maintain the privacy and confidentiality of your protected Health Information. The policy is available for you to read in our waiting room or you can request a written copy from our staff.

Please Initial here X_____ to acknowledge that you have been advised of our HIPAA guidelines and offered the policy for review or provided a written copy, upon request.

I have read and agree to the above terms and conditions.

X_____ Date: _____
Signature of Patient/Parent/ Legal Guardian (if under 18 years of age)

X_____ Relation: _____
Printed Name of Patient/Parent/ Legal Guardian (if under 18 years of age)

X_____ Date: _____
Office Signature

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

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

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

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

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

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

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

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

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: Dr. Ni and Tao of Wellness Associates

(Date)

PATIENT SIGNATURE: **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE