SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH ACUPUNCTURE NEW PATIENT INTAKE FORM

Patient Confidential Information

Name_____
(First Middle Last)

Address _____
(Street Apt. #)

_____
City, State, Zip

Email _____

Home Phone _____ Cell Phone _____

Age_____ Date of Birth _____/_____/____ Sex: M F

Please circle if your complaint is related to:
Auto Accident / Work or Workman's Comp / Other Personal Injury / N/A

Who may we thank for referring you?_____

Emergency contact: _____Phone Number:_____
(Name and Relation):_____

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Insurance Patients

Are you the primary on your insurance plan? ☐ Yes ☐ No

If No, Name of Primary: _____ Date of Birth _____/_____/_____

Social Security Number(*Required for all insurance patients!) : _____

Primary Care Physician: _____ Phone: _____

24 Hour Cancellation Policy

Please make any cancellations with a minimum of 24 hours notice. If you do not provide at least 24 hours notice, or you miss the appointment your account will be charged a $25 missed appointment fee. Thank you for your understanding.

Signature _____ Date _____/_____/_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

PATIENT INTAKE

DETAILS OF CHIEF COMPLAINT: Please answer all questions that apply to your condition.
List illnesses and/or symptoms in order of importance to you / How long you've had it / Intensity
(1-3-mild 4-6 moderate 7-8 intense 9-10 severe)
1. _____ / _____ / _____
2. _____ / _____ / _____
3. _____ / _____ / _____

Have you received any previous treatment/s for your condition? ☐ Yes ☐ No

If yes, please describe: _____
_____
Are you seeking treatment for pain? ☐ Yes ☐ No
If yes, describe the location of the pain _____
Character of Pain (sharp, dull, nervy/electric): _____
Frequency of Pain: _____
Increase of Pain during: _____
Decrease of Pain during: _____
Does your pain restrict or stop your daily activities? ☐ Yes ☐ No
If yes, please explain _____

MEDICAL HISTORY
Do you currently or have you in the past been diagnosed with an infectious or sexually transmitted disease?
Circle All That Applies
HIV Genital Herpes Hepatitis (A B C) Other: (Please describe below) Not Applicable

List any accidents, surgeries, and hospitalizations, including dates: _____
_____
List any surgical implants: _____
List any medications you are currently taking and why (if more than 3, please list on the back of the page)
_____
_____
_____
List any vitamins, herbs, supplements you are currently taking Reason for taking
(if there are more than 3, please pick list on the back of the page)
_____
_____
_____
List Allergies_____

SOCIAL HISTORY
Do you exercise regularly? Yes No If yes, list types and frequency: _____
_____
Your usual diet consists of: _____
_____
Have you ever received acupuncture therapy before? ☐ Yes ☐ No
If yes, when and for what condition? _____

FOR WOMEN ONLY
Are you pregnant? ☐ Yes ☐ No Are you using birth control pills/shot/patch? ☐ Yes ☐ No
# of Birthed Children _____ Length of Menstrual Cycle _____ days Blood Clots ☐ Yes ☐ No
Period Length _____ days Flow Light Heavy Is your period painful? ☐ Yes ☐ No
Do you experience PMS? ☐ Yes ☐ No If yes, please describe symptoms below:

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of acupuncture on me (or the patient named below for whom I am legally responsible) by the licensed acupuncturist. I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Oriental Massage), Oriental herbal medicine, and nutritional counseling. I will immediately notify the licensed acupuncturist of any unanticipated or unpleasant effects associated with the consumption of herbal pills or formulas.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 licensed acupuncturist uses only sterile single use disposable needles. Burns and/or scarring are a potential risk of cupping and moxibustion. I understand that while this document describes the more common risks of treatment, other side effects 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 Oriental Medicine, although some may be toxic in large doses. I understand some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, rashes and tingling of the tongue. I will notify the licensed acupuncturist if I become or suspect I have become pregnant.

I do not expect the licensed acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist to exercise careful judgment during the course of treatment, which the licensed acupuncturist believes, based on the facts then known is in my best interest. I understand results are not guaranteed. I understand the licensed acupuncturist 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 massage therapy is often performed as an adjunct treatment to acupuncture, and may be performed by either the licensed acupuncturist or a certified massage therapist. I understand that massage is basically for the purpose of stress management, relief of muscle tension, and to promote wellness. I also understand that massage therapists do not diagnose mental or physical illnesses nor do they prescribe medication for treatment of disease. Massage works on soft tissue and the therapist may integrate gentle range of motion exercises to the joints but will not administer spinal manipulations.

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 any future condition(s) for which I seek treatment.

Patient's Signature_____ Date _____

Or Patient Representative Signature _____ Date _____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

NOTICE OF PRIVACY POLICIES

Our clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law. We gather personal information and health information in several ways;

- Information we receive from you.
- Information we receive from healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters, and appointment reminders by calls, cards, letters, or emails.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Patient Rights
1. Upon written request you have the right to access, review, or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. Upon written request you have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
4. Upon written request you have the right to request that we amend your Protected Health Information.
5. You have the right to receive all notices in writing.

I _____ (print name) have read, reviewed, understand and agree to the statement of Privacy Policy for healthcare services in this clinic.

Patient's Signature _____ Date_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

TERMS AND CONDITIONS OF SERVICE

Admission and Medical Services Agreement

The patient, or patient's representative consents to the treatment of the patient by the licensed acupuncturist using any modalities within the acupuncturist's scope of practice, if this is deemed necessary by the licensed acupuncturist for the care of the patient.

Release of Information and Medical Records

The patient or patient's representative hereby agrees that, in accordance with HIPPA, any release of patient's medical information/records outside of Simple Health: to the patient directly, to another health care practitioner, or to another individual from the licensed acupuncturist and/or Simple Health will not occur unless with the express written consent and signed release of the patient.

Financial Agreement

1. The patient or patient's representative agrees to pay Simple Health for services rendered in accordance with the regular rates and terms. When this agreement is executed by the patient or the patient's representative, all shall by jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

2. Returned Checks will incur a $25 returned check fee plus the amount of the check.

3. For individuals utilizing medical insurance, the patient or patient's representative agrees and understands that verification of medical eligibility/benefits is not a guaranty of payment from insurance company to licensed acupuncturist and/or Simple Health. Patient or patient's representative agrees to pay Simple Health for services rendered by licensed acupuncturist in accordance with the regular rates and terms if the insurance company for any reason denies the billed charges for services rendered to the patient. Patient or patient's representative agrees to be liable and responsible for all non-reimbursed costs to licensed acupuncturist and/or Simple Health from the insurance company.

The patient or patient's representative hereby enter into the agreement with Simple Health. The patient or patient's representative certifies that he/she has read, understood, and accepted the "Terms and Conditions of Service.

Patient's Signature_____ Date_____

Signature of Patient Representative _____ Date_____

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

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 l 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

SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Acupuncture
3939 Atlantic Ave., STE 223
Long Beach Ca, 90807
PH: (562) 424-5505
Fax: (562) 424-1055
Email: simplehealthchiro@gmail.com

SIMPLE HEALTH PACKAGE SERVICES REFUND POLICY

Simple Health Acupuncture & Wellness values our relationship with you, and appreciates your purchase of our package services. If for any reason or circumstance, you are unable to complete your purchased visits, Simple Health is able to refund part or all of your purchases under the following policy.

No Visits Used
In the event that no visits in your package has been used, and you wish to have a refund, if it is within 30 days of purchasing the package, Simple Health will return 100% of what you paid for the original package. Packages purchased between 31-90 days ago will be refunded at a 80% rate. Packages purchased longer than 90 days ago will be refunded at 50%.

Some visits used
In the event that some but not all visits in your package has been used, and you wish to have a refund for the unused visits, your account will be charged for the full regular price per visit, which will be deducted from your refund amount. The following equation for calculation your refund is as follows: Refund Amount = Full Package Price - (Regular Price Per Session x No. Sessions used)

E.g., if you have used 1 visit from a 4 visit package (package price $220 for 4 visits, regular price $70 per visit), your refund amount will be $220 - ($70 x 1 session) =$130.

By signing my name below, I certify that I have read and understood the above terms as it pertains to the refund policy for package services purchased at Simple Health Acupuncture & Wellness LLC. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies.

Patient's Name (please print)_____

Patient's (or Guardian) Siganture_____ Date_____