David Lee Acupuncture
166 N. Moorpark Road #201
Thousand Oaks, CA 91360
P: 805.497.6200 F: 805.497.6233

Date_____

PATIENT CONFIDENTIAL INFORMATION (PLEASE PRINT)

Patient_____ □Male □Female □Other SSN:_____
First Name Last Name Initial

Home Phone (_____)_____Cell Phone (_____)_____E-mail_____
□ Appointment Reminder Text

Street Address_____ City_____ State_____ Zip_____

Birthdate_____ Age____ Height_____ Weight_____ □Single □Married □Separated □Divorced □Widowed

Occupation_____ Business Phone (_____)_____

Who may we thank for referring you? _____

What is your illness/injury? _____

Have you seen any other doctor about this condition? □Yes □No If yes, when? _____

Who is your primary physician? Name_____ Phone (____)_____

Is your condition related to employment (current or previous)? □Yes □No

Employer's Name_____

Is your condition related to auto accident? □Yes □No If yes, when? _____

Other accident? □Yes □No Please describe: _____

FOR FEMALES: Are you pregnant? □Yes □No If yes, for how long? _____

FOR MINORS: parent's name and date of birth _____

In case of emergency, call:

Phone(_____)_____

Name_____

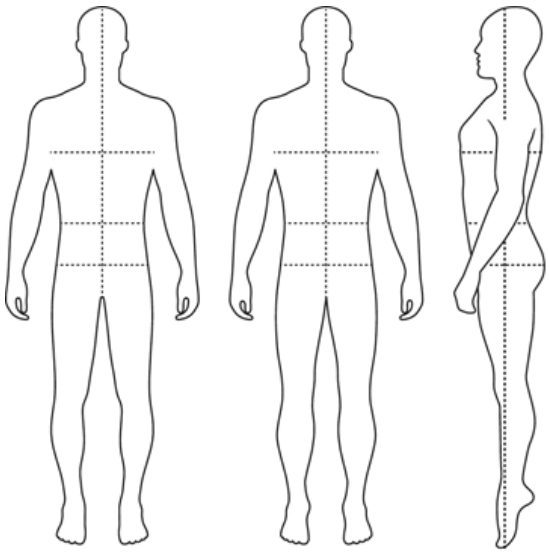
Relationship to patient _____

FINANCIAL ARRANGEMENTS
How do you plan to handle your account?
□Cash □Check □Visa/Master □AmEx

INSURANCE INFORMATION
Do you have medical insurance? □Yes □No

If yes, please have the office make a copy of your insurance card.

Please mark the locations of pain or discomfort.



For Office Use Only: □ Print □ E-Mail

FINANCIAL POLICY & PATIENT RESPONSIBILITY

We request payment on the date of service. We are able to accept payment in the form of cash, check, American Express, Visa, Discover, and MasterCard.

Charge Rates

- New Patient Consultation (applies to non-insured patients only): $30
- Acupuncture Treatment (applies to non-insured patients only): $90
- 10-Day Herbal Formula (non-refundable): $60-$90
- Dietary Consultation including *Tetrasoma Diet* Book: $40.
- Acupressure Consultation: $60 in combination with another service; $150 by itself.

Insurance

Patients should contact their insurance company prior to treatment to determine their acupuncture benefits. Be sure you are clear about your responsibilities such as deductibles and co-pays/co-insurance. As a courtesy to patients, our office will confirm acupuncture benefits and submit claims to the insurance carrier. Due to the varying calculations involved, please ***do not assume final payment*** until the explanation of benefits (EOB) and insurance payment is received. Please note that you, the patient, have ultimate financial responsibility for your care. If your acupuncture insurance benefits seem vague, ***you may be required to make full payment until the explanation of benefits is received***. If there is an issue with an insurance payment it is your responsibility to contact the insurance to rectify the issue. Herbal formulas, dietary consultations, and acupressure consultations are not covered by any insurance plan. By signing below you are authorizing David Lee Acupuncture to release all information necessary to process any insurance or collection claims.

Cancellation Policy

Because our time and space is limited, David Lee Acupuncture's cancellation policy requires patients to give a 24-hour notice of cancellation prior to their appointment. This allows other patients the opportunity to schedule for that time. ***The cancellation fee for missed appointments or appointments cancelled without a 24-hour notice is $40*.** Patients will not be able to see the doctor for another appointment until the cancellation fee is paid. Exceptions may be made for emergencies on a case-by-case basis. We ask that you please value our time and understand the reason for our cancellation policy. Thank you for your cooperation.

I understand and agree to the fees outlined above and may receive a copy of this Financial Policy & Patient Responsibility form upon request.

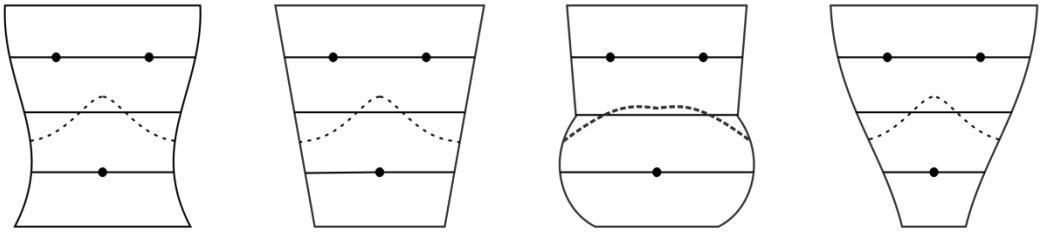
Name _____ Signature _____ Date_____

Parent/Guardian if patient is a minor

Patient Torso Measurement Agreement

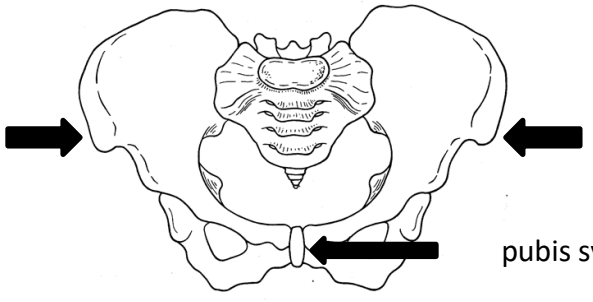
Dr. David Lee's acupuncture style is based on Four Constitutional Medicine, therefore knowing your torso shape facilitates identifying your body type and leads to proper treatment of your ailments. He determines your body type diagnosis by measuring five lines as illustrated below with a caliper (a measuring ruler). For females, the second line across the chest is not measured for protection of privacy.

Exaggerated example of torso shapes:



Lesser Yin | Lesser Yang | Greater Yin | Greater Yang

Three points of palpation:



anterior superior iliac spine (ASIS)

pubis symphysis

The sides and front of the pelvic bone are also palpated. Below the pubis symphysis is not palpated.

I approve of Dr. David Lee measuring my torso and palpating my pelvic bone for the purpose of establishing an Asian medical diagnosis for the treatment of my illnesses.

Patient Name	Patient Signature	Date

PATIENT CONFIDENTIAL INFORMATION **Patient name**_____

Please complete the following as accurately as possible whether <u>in the recent past or present</u>.

❒ epstein barr virus (EBV) ❒ cold sores ❒ genital herpes ❒ heart disease ❒ rheumatic fever ❒ high blood pressure ❒ stroke ❒ kidney disease ❒ urinary bladder problems/infections ❒ diabetes ❒ cancer ❒ pneumonia ❒ emphysema ❒ tuberculosis ❒ asthma ❒ peptic ulcer ❒ anemia or other blood disorder ❒ bleeding disorder ❒ fibromyalgia ❒ osteoarthritis ❒ rheumatoid arthritis ❒ mental disorder ❒ gout ❒ hepatitis ❒ liver cirrhosis ❒ gall stones ❒ jaundice ❒ hernia	❒ thyroid disorder ❒ disorder of genitals ❒ gynecological disorder ❒ congenital abnormalities ❒ skin diseases ❒ elevated cholesterol ❒ cardiac pacemaker ❒ surgical implants ❒ change in bowel or bladder habits ❒ sores that will not heal ❒ unusual bleeding or discharge ❒ indigestion ❒ sjögren's disease ❒ crohn's disease ❒ irritable bowel disease ❒ lupus erythmatosis ❒ difficulty swallowing ❒ obvious change in a wart or mole ❒ alzheimer's ❒ parkinson's ❒ epilepsy or convulsions ❒ history of smoking #_____ day ❒ history of smokeless tobacco use ❒ history of drinking alcohol ❒ history of recreational drug use ❒ history of sexually transmitted disease ❒ HIV

Check the appropriate box below if you have taken a psychological behavior assessment test.

DiSC Social Style:

□Dominant □Influence □Steady □Conscientious

Myers-Briggs Type Indicator:

□INFP □INFJ □INTP □INTJ □ISFP □ISFJ □ISTP □ISTJ

□ENFP □ENFJ □ENTP □ENTJ □ESFP □ESFJ □ESTP □ESTJ

Please complete the following as you feel they are significant to you.

PATIENT CONFIDENTIAL INFORMATION **Patient name**_____

❒muscle pain ❒shoulder pain ❒elbow pain
❒knee pain ❒low back pain ❒neck pain
❒other joint or muscular pain: _____
❒migraine headache ❒tension headache ❒cluster headache

❒cold/flu/bronchitis/pneumonia ❒hay fever/allergies ❒asthma
❒nose bleeds frequently ❒wheezing ❒bad breath
❒tongue sores ❒lack of thirst/forget to drink ❒easy thirst/dry mouth/dry throat

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❒poor or no appetite ❒high hunger ❒nausea
❒bloating/indigestion/acid reflux ❒abdominal pain/cramp/ulcer
❒hemorrhoids ❒hard dry stools ❒chronic loose stools/diarrhea
❒bowel movement every _____ days

❒vertigo, dizziness ❒ringing in ears ❒palpitations/irregular heartbeat
❒color blind ❒dry eyes ❒hair loss
❒eczema/acne/skin eruptions ❒skin tags on neck ❒fatty nodules under skin
❒brittle nails ❒edema/ water retention
❒difficult gaining weight ❒difficult losing weight

❒I get chills easily ❒cold hands and feet ❒wear socks to sleep often
❒cannot take cold shower ❒my body is constantly hot
·My body accepts more: ❒ the Winter season ❒ the Summer season

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❒insomnia ❒sleeping too much ❒night sweats
❒anxiety/depression/worry ❒ADD/ADHD (attention deficit disorder/attention deficit hyperactive disorder)

❒incontinence of urine ❒frequent urination ❒cloudy / bubbling urine
❒painful burning urination ❒bladder-kidney stones ❒ urinate_____ x night

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·How often do you urinate during the day? ❒every hour ❒every 2 hours ❒every 3 hours ❒every 4 hours

·When passing the bowel, does it most of the time feel complete ❒ or often feel unrelieved? ❒

·When passing the bowel, do you sit for a pro-longed period ❒ or is it excreted in a few seconds? ❒

·How many hours do you need to sleep through the night? _____ hours

·Do you enjoy meats❒ or do you find them to be heavy and hardly digestible? ❒

·Do you enjoy fried foods❒ or do you find them to be heavy and hardly digestible? ❒

·Have you been on the Atkins Diet? and did well❒ got sick from it ❒ never tried it ❒

·Do you get seasick or motion sickness easily? ❒yes ❒no

·Do you see yourself accomplishing tasks at the last moment❒ or in step-by-step increments? ❒

·Are you highly sensitive to initially perceived criticisms❒ or do you let them pass easily? ❒

·When I act or move, I sweat: ❒a lot ❒little ❒almost never.

·I usually sweat on my: ❒head ❒face ❒neck ❒back ❒upper body
❒arm pit ❒lower body ❒whole body ❒palm and sole

PATIENT CONFIDENTIAL INFORMATION **Patient name**_____

·I have fear of or discomfort with: ❒heights ❒closed places ❒open places ❒insects/reptiles

·Childhood/infantile illnesses: ❒wetting bed other _____

Check any of the following that gives you negative reaction:
❒caffeine ❒milk/dairy ❒wheat/gluten ❒shellfish ❒dander/dust/pollen ❒egg
❒melon ❒mango ❒perfumes ❒penicillin ❒nickel in jewelry
❒other_____

Are you taking herbs? _____

MEN

❒potency issue ❒prostatitis ❒fertility difficulties

WOMEN

Age when periods began_____ Last pap smear date_____
Duration of flow /days _____ Is your cycle regular? ❒yes ❒no
Date of the last period _____ Do you believe you are pregnant? ❒yes ❒ no

Difficulties during period: ❒excessive flow ❒less flow ❒cramps ❒clots ❒breast distension
❒emotional changes

❒fertility difficulties ❒habitual miscarriage ❒ breast cysts ❒low libido ❒menopausal symptoms
❒vaginal yeast (candida) infections
Menstrual cramps: ❒every or almost every period ❒infrequent
Birth control history, method, & duration of use_____

____pregnancies ____births ____abortions ____miscarriages _____C-sections

HISTORY & HEALTH GOALS

What is your major history of illnesses?

_____

_____

_____

Surgeries & dates _____

_____

What is your health goal through the treatment at this clinic?

❒pain management ❒treatment of the illness ❒preventative lifestyle

From the above, which condition bothers you the most? _____

_____

_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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. 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 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, 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 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. 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 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**

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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

Bring this signed form with you for your initial office visit!