

Date _____

PATIENT CONFIDENTIAL INFORMATION (PLEASE PRINT)

Patient _____ Sex: M F Social Security#: _____
First Name Last Name Initial

Home Phone(_____) _____ Cell Phone(_____) _____ E-mail _____

Street Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Height _____ Weight _____ Single Married Separated Divorced Widowed

Occupation _____ Business Phone(_____) _____

What is your illness/injury? _____

Who may we thank for referring you? _____

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

Who is your 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 _____

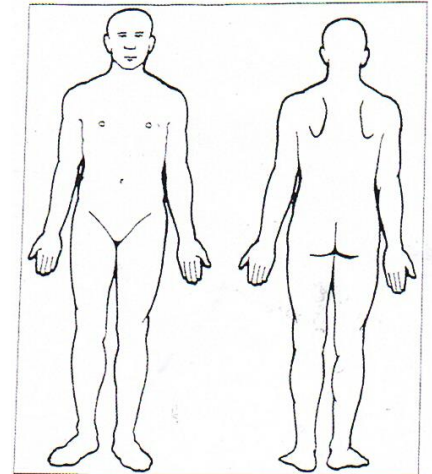
In case of emergency, call:
 Phone(_____) _____
 Name _____
 Relationship to patient _____

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

INSURANCE INFORMATION
 Do you have personal, group health
 or accident insurance? Yes No

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

Please mark the
 locations of pain or
 discomfort.



FINANCIAL POLICY & PATIENT RESPONSIBILITY

We request payment at the time service is provided. We are able to accept the payment in forms of cash, check, American Express, Visa, Discover, and MasterCard.

Charge Rates

Acupuncture per visit is \$70. Initial consultation fee is \$30.

Herbs are \$40-\$70 per bottle for a one week supply.

Dietary consultation fee is \$40.

4 BodyType Magnet Consultation is \$60 in combination with another service and \$150 by itself.

You will be given options to best treat your complaints.

Philosophy

We make the highest effort to serve the patients as quickly and economically as possible. Usual visits are twice a week for the first few weeks and once a week thereafter. Refer to the brochures that pertain to you and ask Dr. David Lee about how long and how often your treatments should be to achieve maximum recovery.

Insurance

If you are requesting to pay for your care through your insurance company, make sure you are clear with your insurance carrier about your responsibilities, such as deductible and co-pay. Due to the varying calculations involved, please *do not assume the final payment* until you receive the explanation of benefit from your insurance carrier. Please note that you, the patient, have the final financial responsibility for your care. If your acupuncture insurance benefits seem to be vague, then *you may be requested to make full payment until the explanation of benefits is received*. Chinese herbs and dietary consultations are not covered by any insurance plan. I hereby authorize David Lee Acupuncture to release all information necessary to process any insurance or collection claims.

Cancellation Policy

David Lee Acupuncture’s cancellation policy requires patients to give a 24-hour notice of cancellation prior to their appointment. As time and space is limited someone else may be able to take your spot if a 24-hour notice is given. If you are not sure you will make your scheduled appointment, please do not schedule it. We ask that you please value our time and understand the reason for our cancellation policy.

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. By signing below you are acknowledging our cancellation policy and agreeing to pay \$40 for missed appointments or appointments cancelled without a 24-hour notice. 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.

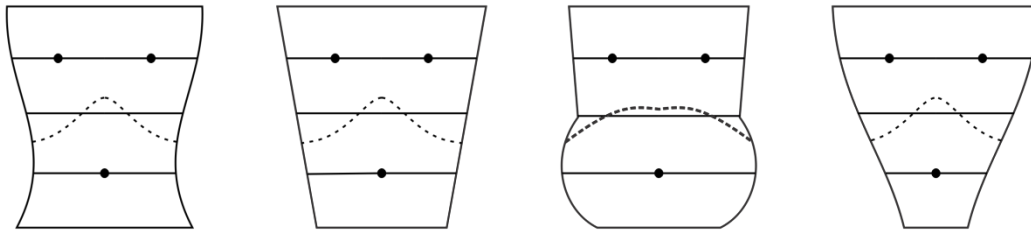
Name _____ Signature _____ Date _____

Parent/Guardian if patient is a minor

Patient Torso Measurement Agreement

Dr. David Lee’s acupuncture style is based on Four Constitutional Medicine, where knowing your torso shape facilitates identifying your body type and therefore leads to proper treatment for 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:



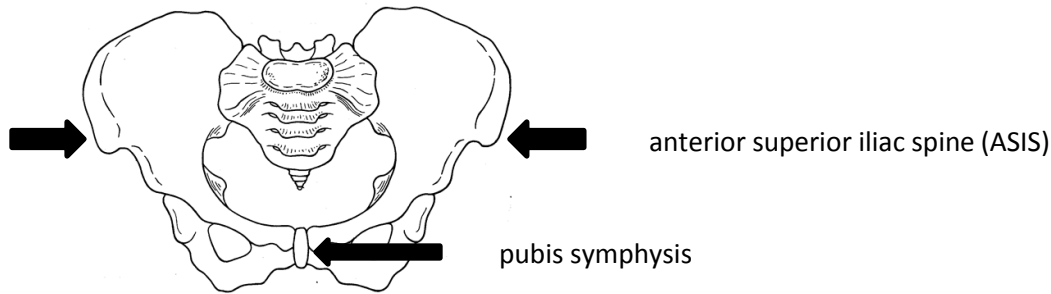
Lesser Yin

Lesser Yang

Greater Yin

Greater Yang

Three points of palpation:



The sides and front of the pelvic bone is 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 in the recent past or present.

<ul style="list-style-type: none"><input type="checkbox"/> epstein barr virus (EBV)<input type="checkbox"/> cold sores<input type="checkbox"/> genital herpes<input type="checkbox"/> heart disease<input type="checkbox"/> rheumatic fever<input type="checkbox"/> high blood pressure<input type="checkbox"/> stroke<input type="checkbox"/> kidney disease<input type="checkbox"/> urinary bladder problems or infections<input type="checkbox"/> diabetes<input type="checkbox"/> cancer<input type="checkbox"/> pneumonia<input type="checkbox"/> emphysema<input type="checkbox"/> tuberculosis<input type="checkbox"/> asthma<input type="checkbox"/> peptic ulcer<input type="checkbox"/> anemia or other blood disorder<input type="checkbox"/> bleeding disorder<input type="checkbox"/> fibromyalgia<input type="checkbox"/> osteoarthritis<input type="checkbox"/> rheumatoid arthritis<input type="checkbox"/> mental disorder<input type="checkbox"/> gout<input type="checkbox"/> hepatitis<input type="checkbox"/> liver cirrhosis<input type="checkbox"/> gall stones<input type="checkbox"/> jaundice<input type="checkbox"/> hernia	<ul style="list-style-type: none"><input type="checkbox"/> thyroid disorder<input type="checkbox"/> disorder of genitals<input type="checkbox"/> gynecological disorder<input type="checkbox"/> congenital abnormalities<input type="checkbox"/> skin diseases<input type="checkbox"/> elevated cholesterol<input type="checkbox"/> cardiac pacemaker<input type="checkbox"/> surgical implants<input type="checkbox"/> change in bowel or bladder habits<input type="checkbox"/> sores that will not heal<input type="checkbox"/> unusual bleeding or discharge<input type="checkbox"/> indigestion<input type="checkbox"/> sjögren's disease<input type="checkbox"/> crohn's disease<input type="checkbox"/> irritable bowel disease<input type="checkbox"/> lupus erythmatosis<input type="checkbox"/> difficulty swallowing<input type="checkbox"/> obvious change in a wart or mole<input type="checkbox"/> alzheimer's<input type="checkbox"/> parkinson's<input type="checkbox"/> epilepsy or convulsions<input type="checkbox"/> history of smoking #_____ day<input type="checkbox"/> history of smokeless tobacco use<input type="checkbox"/> history of drinking alcohol<input type="checkbox"/> history of recreational drug use<input type="checkbox"/> history of sexually transmitted disease<input type="checkbox"/> HIV
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PATIENT CONFIDENTIAL INFORMATION

Patient name _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> muscle pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> elbow pain |
| <input type="checkbox"/> knee pain | <input type="checkbox"/> low back pain | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> other joint or muscular pain: _____ | | |
| <input type="checkbox"/> migraine headache | <input type="checkbox"/> tension headache | <input type="checkbox"/> cluster headache |
-
- | | | |
|--|---|---|
| <input type="checkbox"/> cold/flu/bronchitis/pneumonia | <input type="checkbox"/> hay fever/allergies | <input type="checkbox"/> asthma |
| <input type="checkbox"/> nose bleeds frequently | <input type="checkbox"/> wheezing | <input type="checkbox"/> bad breath |
| <input type="checkbox"/> tongue sores | <input type="checkbox"/> lack of thirst/forget to drink | <input type="checkbox"/> easy thirst/dry mouth/dry throat |
-
- | | | |
|---|--|--|
| <input type="checkbox"/> poor or no appetite | <input type="checkbox"/> high hunger | <input type="checkbox"/> nausea |
| <input type="checkbox"/> bloating/indigestion/acid reflux | | <input type="checkbox"/> abdominal pain/cramp/ulcer |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> hard dry stools | <input type="checkbox"/> chronic loose stools/diarrhea |
| <input type="checkbox"/> bowel movement every ____ days | | |
-
- | | | |
|---|--|---|
| <input type="checkbox"/> vertigo, dizziness | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> palpitations/irregular heartbeat |
| <input type="checkbox"/> color blind | <input type="checkbox"/> dry eyes | <input type="checkbox"/> hair loss |
| <input type="checkbox"/> eczema/acne/skin eruptions | <input type="checkbox"/> skin tags on neck | <input type="checkbox"/> fatty nodules under skin |
| <input type="checkbox"/> brittle nails | <input type="checkbox"/> edema/ water retention | |
| <input type="checkbox"/> difficult gaining weight | <input type="checkbox"/> difficult losing weight | |
-
- | | | |
|--|--|--|
| <input type="checkbox"/> I get chills easily | <input type="checkbox"/> cold hands and feet | <input type="checkbox"/> wear socks to sleep often |
| <input type="checkbox"/> cannot take cold shower | <input type="checkbox"/> my body is constantly hot | |
| ·My body accepts more: | <input type="checkbox"/> the Winter season | <input type="checkbox"/> the Summer season |
-
- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> insomnia | <input type="checkbox"/> sleeping too much | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> anxiety/depression/worry | <input type="checkbox"/> ADD/ADHD (attention deficit disorder/attention deficit hyperactive disorder) | |
-
- | | | |
|--|--|--|
| <input type="checkbox"/> incontinence of urine | <input type="checkbox"/> frequent urination | <input type="checkbox"/> cloudy / bubbling urine |
| <input type="checkbox"/> painful burning urination | <input type="checkbox"/> bladder-kidney stones | <input type="checkbox"/> urinate _____ x night |

·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?

PATIENT CONFIDENTIAL INFORMATION

Patient name _____

- 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
- You have special fear of or discomfort with height 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

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!