EMPEROR'S COLLEGE
ACUPUNCTURE CLINIC

1807 Wilshire Boulevard Suite B
Santa Monica, CA 90403
p 310.453.8383 f 310.829.3838

PATIENT CONFIDENTIAL INFORMATION

Name_____
First Middle Last

Address_____
Street City State Zip

Primary phone_____ Secondary phone_____

Email address _____

Age_____ Date of Birth _____/_____/_____ Sex M F * Marital Status S M D W
MM DD YY

Emergency contact: _____
Name Relation Phone #

_____
Street City State Zip

*Place of Birth_____ *Social Security Number _____-_____-_____

*Occupation or profession_____ *Employer _____

**This information is helpful, but optional. All other information is mandatory.*

TREATMENT OF MINORS

During the treatment of patients under 18 years of age, the patient's legal guardian must be present in the clinic during the entire session for each treatment. Please speak to the front desk for details.

INSURANCE AND WORKER'S COMP

We will only prepare insurance billing information for patients paying our standard fee. Billing information is prepared after every fifth visit. Emperor's College Acupuncture Clinic does not treat workers compensation injuries.

EMPEROR'S COLLEGE ACUPUNCTURE 24-HOUR CANCELLATION POLICY

In order to maintain the integrity of our low-cost community treatment clinic, Emperor's College Acupuncture Clinic must request that all cancellations be made with a minimum of 24-hour notice. Appointments and cancellations must be made with the front desk only. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee. Last minute cancellations and failures to show affect our ability to serve both our community and our interns.

OBSERVERS

Given that Emperor's College Acupuncture Clinic is a teaching clinic, all patients must assume that observers will be present during the course of their appointment. Emperor's College Acupuncture Clinic charges a reduced fee because we are a teaching clinic. Patients who refuse to allow observers can be denied service.

SEXUAL HARASSMENT

Be advised that interns and student observers attending Emperor's College Clinic do so in pursuit of an education only. All comments or questions from patients regarding an intern's or student observer's appearance, dating habits or personal life are not permitted. Any complaint regarding a violation of this policy will result in that patient being barred from this facility. We have high expectations of professionalism from our interns and student observers and expect the same of our patients. We will vigorously protect the intern's and student observer's right to pursue their education in an environment completely free from all harassment.

EMPEROR'S COLLEGE ACUPUNCTURE CLINIC TERMS AND CONDITIONS OF SERVICE

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Emperor's College Acupuncture Clinic if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

MEDICAL CONSENT

I have read and fully understand that Emperor's College Acupuncture Clinic is a teaching clinic. I understand that interns and Oriental Medical students, as observers and post-graduate fellows under the supervision of attending Practitioners of Oriental Medicine (Licensed Acupuncturists), are participating in my treatment procedures as part of the medical education program of the institution. Under this condition, the patient or the patient's representative consents to any Oriental Medical treatments or procedures that are given by the Interns under the general and special instructions of the attending practitioner or any other Practitioner of Emperor's College Acupuncture Clinic assisting in the care of the patient. The patient accepts the full responsibility to follow up the medical advice given at Emperor's College Acupuncture Clinic.

The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

RELEASE OF INFORMATION

Emperor's College Acupuncture Clinic will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

SUPERVISORS SUBJECT TO CHANGE

As a teaching clinic with numerous supervisors and the circumstances involving the availability of any supervisor at any one time sometimes changing, the supervisor originally scheduled for being present on a particular shift may not be available—this change in scheduling may even occur at the last minute. As such, although every effort will be made to keep the schedule as consistent and predictable as possible, Emperor's College Acupuncture Clinic does not guarantee that a particular supervisor will be available at the time of a treatment. We reserve the right to replace a supervisor at any point in time with another qualified supervisor who fulfills our high standards for experience and knowledge. In the event that a supervisor is replaced on a particular shift, patients will not be given an exception to allow a last minute cancellation of their appointment without consequence and will not be given a refund.

FINANCIAL AGREEMENT

The patient or patient's representative shall pay Emperor's College Acupuncture Clinic for services rendered in accordance with the regular rates and terms of the Emperor's College Acupuncture Clinic. When this agreement is executed by the patient or the patient's representative or a financial guarantor, all shall be 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.

The Emperor's College Acupuncture Clinic and the patient's representative hereby enter into this agreement. The patient or the patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service"

Patient Signature _____ *Date*_____

*Patient Representative*_____ *Date*_____

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 the patient named below for whom I am legally responsible) by the acupuncturist or acupuncture interns and/or other licensed acupuncturists or acupuncture interns who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist or acupuncture intern named below, included those working at Emperor's College Acupuncture 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 (Oriental Massage), Oriental herbal medicine and nutritional counseling. I understand that the preparation of these herbs will take time and may require waiting beyond the scheduled treatment time and that the teas need to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or bitter 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 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 clinic sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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 of Emperor's College Acupuncture Clinic 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.

Patient Signature _____ *Date*_____

*Patient Representative*_____ *Date*_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Emperor's College Acupuncture Clinic, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Emperor's College Acupuncture Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures. (This allows your information to be used for clinic and teaching purposes only! We will not release this information unless we receive a subpoena or "authorization to release" signed by you.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Emperor's College Acupuncture Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Emperor's College Acupuncture Clinic Privacy Officer at 1807-B Wilshire Blvd., Santa Monica, Ca 90403.

Emperor's College Acupuncture Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Emperor's College Acupuncture Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

Emperor's College Acupuncture Clinic may e-mail to me appointment reminder cards and patient statements. I have the right to request that Emperor's College Acupuncture Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Emperor's College Acupuncture Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Emperor's College Acupuncture Clinic may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient Name *Date*

_____

Print Name of Patient or Legal Guardian

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible.

Patient Name: _____ Date: _____

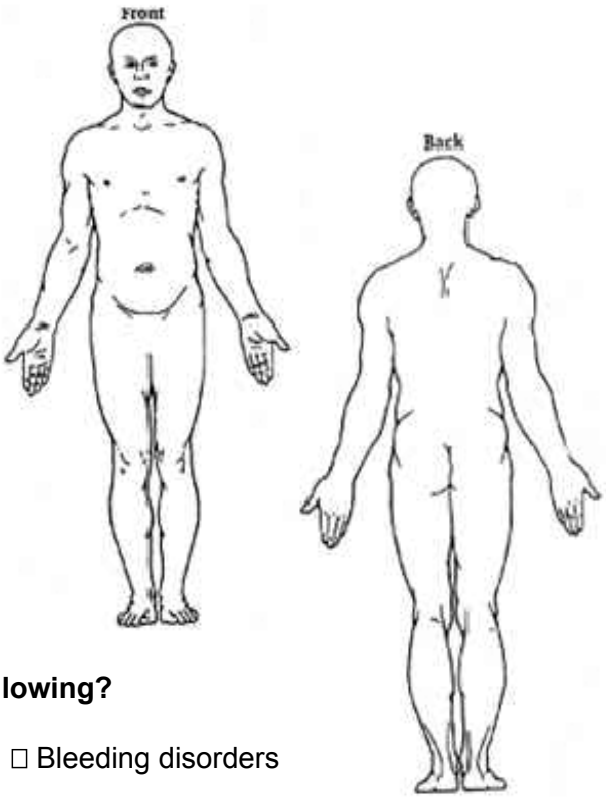
PRESENT CONDITION:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Mark below with an X where you feel pain or discomfort.



MEDICAL HISTORY:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?

Which, if any, of your blood relatives have had any of the following?

☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Tuberculosis ☐ Bleeding disorders
☐ Diabetes ☐ High blood pressure

PLEASE LIST YOUR PRIMARY PHYSICIAN'S NAME AND CONTACT INFORMATION:

Name: _____ Phone: _____
Address: _____
Specialty, if any:
_____

MENSTRUAL HISTORY:

Age of your first period: _____
Vaginal discharge: _____
Length of cycle, day 1 to day 1: _____
Length of flow (days): _____
Date of your last period: _____
Do you believe you are pregnant? Yes____ No____
Number of pregnancies: _____
Number of live births: _____

RECREATIONAL SUBSTANCE USAGE:

History of smoking? _____
how many years? _____
how many per day? _____
History of smokeless tobacco use? _____
History of drinking alcohol? _____
how many drinks/week? _____
History of recreational drug use? _____
How many cups of coffee/day? _____
How many sodas/day? _____

MEDICAL HISTORY QUESTIONNAIRE

CHECK ALL CURRENT AND PAST CONDITIONS.
(please write the word PAST next to those conditions which you have had only in the past and are no longer present)

HEAD AND NECK:
____ Dizziness
____ Fainting
____ Neck Stiffness
____ Enlarged lymph glands
____ Headaches
_____ Other

EARS:
____ Infection
____ Ringing
____ Decreased hearing
_____ Other

EYES:
____ Blurred vision
____ Visual changes
____ Poor night vision
____ Spots/Floaters
____ Eye inflammation/Styes
_____ Other

NOSE, THROAT & MOUTH:
____ Bleeding
____ Sinus infection
____ Hay fever or allergies
____ Sore throat
____ Hoarseness
____ Changes in taste
____ Difficulty swallowing
____ Changes in smell
____ Oral ulcers/Canker sores
_____ Other

SKIN:
____ Hives
____ Rashes
____ Eczema
____ Psoriasis
____ Seborrhea
____ Night sweating
____ Excess sweating
____ Dryness
____ Bruises easily
____ Changes in moles or lumps
_____ Other

NEUROLOGICAL:
____ Numbness or tingling of limbs
____ Seizures
____ Tremors
____ Pain
____ Paralysis
____ Epilepsy or Convulsions
_____ Other

INFECTION HISTORY:
____ HIV/AIDS, or HIV risks: Self or partner
____ TB: Self or household
____ Hepatitis, or Hepatitis risk: Self or partner.
____ History of sexually transmitted diseases: Self or partner.
____ Gonorrhea
____ Chlamydia
____ Syphilis
____ Genital warts
____ Herpes (oral)
____ Herpes (genital)
____ MRSA, Staph, CRE, or other Drug-Resistant Infections

RESPIRATORY:
____ Chronic cough
____ Coughing up blood
____ Coughing phlegm frequently
____ Difficulty breathing
____ Wheezing/Asthma
____ Frequent Colds
____ Emphysema
____ Pneumonia repeatedly
_____Other

CARDIOVASCULAR:
____ Palpitations
____ Chest pain or tightness
____ Rapid heart beat
____ Irregular heart beat
____ Heart Disease
____ Poor circulation
____ Swelling of ankles
____ Phlebitis
____ Cold hands/feet
____ Cardiac Pacemaker
____ High blood pressure
____ Stroke
_____ Other

GASTROINTESTINAL:
____ Indigestion
____ Nausea
____ Stomach pain
____ Irritable bowel disease
____ Colitis
____ Crohn's Disease
____ Pancreatitis
____ Celiac Disease
____ Recent change in bowel habits
____ Diarrhea (___ /day)
____ Constipation (___ /week)
____ Dry, hard stools
____ Soft, difficult, sticky stools
____ Irregularly or poorly-formed stools
____ Poor appetite
____ Excessive hunger
____ Blood in stool or black stools
____ Hemorrhoids
____ --with pain or blood
____ Gall bladder disorder
____ Vomiting blood
____ Peptic Ulcer
____ Recent change in weight
____ Food cravings
_____ Other

MUSCLES AND JOINTS:
____ Joint disorder
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Spinal curvature
____ Backache
____ Back pain
____ Fibromyalgia
_____ Other

MALE:
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Impotence
____ Premature ejaculation
____ Prostate problems
____ Infertility (e.g., abnormal sperm)
_____ Other

FEMALE:
____ Frequent vaginal infections
____ Infertility
____ Pain/itching of genitalia
____ Genital lesions/discharge
____ Pelvic inflammatory disease
____ Abnormal Pap smear
____ Irregular periods
____ Emotional changes with menses
____ Clots with menses
____ Painful menstrual periods/cramps
____ Premenstrual Syndrome
____ Abnormal bleeding
____ Menopausal symptoms (hot flashes, etc.)
____ Breast lumps/cysts
____ Breast swelling and/or pain
_____ Other

URINARY:
____ Frequent urinary tract/bladder infections
____ Weak urinary stream
____ Recent change in bladder habits
____ Kidney Disease
____ Frequent day urination (___ X)
____ Frequent night urination (___ X)
_____ Other

GENERAL:
____ Fatigue
____ Thirst
____ Aversion to cold
____ Insomnia
____ Frequent dreams/nightmares
____ Depression
____ Agitation
____ Irritability
____ Anxiety
____ History of psychiatric treatment
____ Poor memory
____ Difficulty concentrating
____ Sores that don't heal
____ Congenital abnormalities
____ Surgical implants
____ Unusual bleeding or discharge
____ Jaundice
____ Hernia
____ Epstein Barr virus (EBV)
____ Rheumatic Fever
____ Diabetes mellitus
____ Thyroid Disorder
____ Cancer
____ Anemia or other blood disorder
____ Lupus erythematosis
_____ Other

TO BE COMPLETED BY PATIENT: **Name**: _____ **Date**: _____

LIST OF WESTERN MEDICATIONS YOU CURRENTLY USE

Please list the **Medication, Dosage** and **Frequency** of the medications you currently use. (ex., Lisinopril, 5 mg 3X/day; or Dimetapp, 1 teaspoon 2X/day):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____

Patient name: _____ ***Date***: _____