

PATIENT CONFIDENTIAL INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Home phone _____ Cell phone _____

Work 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 ____-____-____

*How did you hear about us? _____

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

INTERN CLINIC TERMS AND CONDITIONS OF SERVICE

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 does not treat worker's compensation injuries.

ECTOM 24-HOUR CANCELLATION POLICY

In order to maintain the integrity of our low-cost community treatment clinic, Emperor's College 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 Clinic is a teaching clinic, all patients must assume that an observer will be present during the course of their appointments. Emperor's College charges a reduced fee because we are a teaching clinic. Patients who refuse to allow an observer 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.

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Emperor's College Teaching 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 Intern 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 Teaching 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 Teaching 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 Teaching 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 Community 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.

PATIENT RESPONSIBILITIES

As a patient of Emperor's College Acupuncture Clinic, it is important that you are not intoxicated or under the influence of any type of medication or drug, medically-prescribed or recreational, at the time of your treatment. This policy exists for the safety of our patients, as the effect of acupuncture on the nervous system of an individual in such a state is unpredictable and potentially dangerous. If it is determined by the supervisor, intern, or clinic staff that you are in such a state, you will be denied treatment and will be asked to leave. If this happens repeatedly, we reserve the right to bar any such patient from scheduling appointments in the future.

We train our faculty, students and staff to behave professionally and respectfully in regard to all patients and expect them to exhibit this behavior at all times. Similarly, we expect our patients to behave with respect and consideration to our faculty, students and staff. If a patient exhibits repeated episodes of inappropriate, disrespectful, belligerent or strongly rude behavior to any faculty, students or staff, we reserve the right to bar said patient from returning to the clinic for future treatments. We also request that any instances of inappropriate or

unprofessional behavior on behalf of the faculty, students or staff be reported immediately to the Dean of Clinical Education, his assistant, or the Clinic Manager.

As this is a teaching clinic, students have a required protocol on every visit that can include asking numerous questions about all aspects of a patient's functions and body systems; also, several basic vital signs must be measured every visit for both instructive purposes and medical safety of patients : blood pressure, temperature, heart rate and weight (and height on certain visits). You can be denied service and asked to leave if you refuse to cooperate with this process. Also, if you are found to have signs or symptoms of any problem that is so severe that an urgent western medical intervention is considered necessary by our supervisor, you will be denied treatment and strongly urged to go to a hospital emergency room.

FINANCIAL AGREEMENT

At the time that services are rendered, the patient or patient's representative shall pay the Emperor's College of Teaching Clinic for services rendered in accordance with the regular rates and terms of the Emperor's College Teaching 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. All sales on herbs are final: there are NO refunds or returns on any herbal products.

The Emperor's College Teaching 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 _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ECTOM Clinic, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ECTOM 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. ECTOM 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 ECTOM Clinic Privacy Officer at 1807-B Wilshire Blvd., Santa Monica, Ca 90403.

ECTOM 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.

ECTOM 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.

ECTOM Clinic may e-mail to me appointment reminder cards and patient statements. I have the right to request that ECTOM 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 ECTOM 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, ECTOM 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 Illness:

What is your chief complaint?

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

When did this condition begin?

What treatment have you received already?

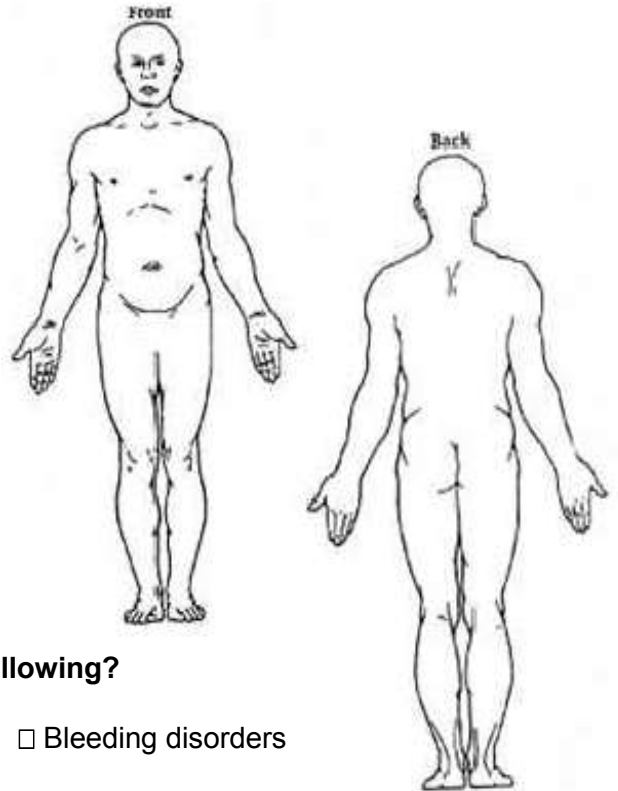
Medical History:

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: _____

Occupation or profession _____ Employer _____

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—SYMPTOM CHECKLIST

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(please write the word "Past" next to those conditions which you have ONLY had in the past and which 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 up 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 (___ stools/day)
- Constipation (___ stools/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 erythematosus
- _____ Other

PATIENTS PLEASE FILL IN: Name: _____ Date: _____