Jesse Hoover, DOM *Yushu Cheng, DOM*
1892 Plaza Del Sur Dr, Santa Fe, NM 87505 505-988-8017

Please fill in this questionnaire carefully. It will help us provide you with an excellent evaluation and effective treatment. The information you provide is confidential. It may be shared with other practitioners in this office only to benfit your treatment.

Health History Questionnaire

Date ________/ ________/________

Name	*Adress (Street, City, State, Zipcode)*	
Home phone	*Work phone*	*Email address*
Date of Birth *Age*	*Occupation*	*Would you like to receive an email newsletter?* *Yes* *No*
Payment Method (circle answers): *Health Insurance* *If using insurance, what is the name of the company?* ________________	*Worker's Comp* *Self-Pay (cash)*	*Personal Injury/Auto* *Other*________
Family Physician *Phone*		
Emergency contact	*Emergency contact phone*	*Relationship*
Referred by	*Have you ever been treated with acupuncture before?*	

What is the main problem (s) you would like help with? ____________________

____

____

When did the problem begin? (Date)________________ **Is it getting better or worse?** ________

Do you know what caused the problem? ____________________

____

Have you been given a diagnosis for this problem? If so, what is it?____________________

____

What kinds of treatment have you tried? ____________________

____

Current/Past Medical History (Please check if you currently have, or have had in the past. Include date)

AIDs/HIV	Diabetes	Multiple Sclerosis	Thyroid Disorder
Alcoholism	Emphysema	Mumps	Tuberculosis
Allergies	Epilepsy	Pacemaker	Typhoid Fever
Appendicitis	Goiter	Pleurisy	Ulcers
Arteriosclerosis	Gout	Pneumonia	Venereal Disease
Arthritis	Heart Disease	Polio	Whooping Cough
Asthma	Herpes	Rheumatic Fever	Tonsillectomy
Birth Trauma	Hepatitis	Scarlet Fever	Other (Specify)
Cancer	High Blood Pressure	Seizures	________
Chicken Pox	Measles	Stroke	________
	Migraines		

Surgeries (Type and date)____________________

____

____

Other significant injury (auto accidents, falls, etc. Please include approximate date.)

____

Please list any allergies

____

____

Family Medical History Allergies Alcoholism Arteriosclerosis Asthma
Cancer (type) ____________ Depression Diabetes Heart Disease
High Blood Pressure Seizures Stroke Other ____________

Please list current medications and suppliments. (Include vitamins, herbs, etc.)

Name	Dose	Frequency	Name	Dose	Frequency

Do you experience occupational stress? (chemical exposure, overexertion, stressful environment, etc.)

____

Do you exercise? (What type and how often) ____________

Please describe your typical meal for:

Breakfast:____________ Snacks____________
Lunch____________ Snacks____________
Dinner____________ Snacks____________

Do you smoke cigarettes? (Yes/no)________ If yes, how many per day (week)________
Do you drink alcohol? (Yes/no)________ If yes, how much per day (week)________
How much coffee, tea or cola do you drink per day? ____________
Please describe any drug use:____________

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD RECENTLY

General

- Chills
- Fever
- Sweat easily
- Night sweats
- Weakness in a particular area of body
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (for hot or cold drinks)
- Fatigue or Low energy
- Sudden energy drop
- Time of day?____________
- Edema Where?____________
- Poor sleep
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Sleepy after eating
- Weight gain
- Weight loss

Head, Eyes, Ears, Nose, Throat

- Dizziness
- Migraines
- Headaches
- Location:____________
- Facial Pain
- Location:____________
- Glasses
- Poor Vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tears
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Hearing aid *(continued…)*
- Earaches
- Discharge from ears
- Nose bleeds
- Sinus problems
- Excessive phlegm
- Grinding teeth
- Jaws Clicks
- Concussions
- Recurrent sore throats
- Hoarseness
- Enlarged thyroid
- Swollen glands
- Sores on lips or tongue
- Gum problems
- Teeth problems
- *Other head or EENT problems:*

____
____
____

Skin and Hair

- Rashes
- Itching
- Change in hair or skin *(continued …)*

Ulcerations
Eczema
Psoriasis
Hives
Acne
Recent moles
Hair loss
Dandruff
Fungal infections
*Other hair or skin problem:*__________

Cardiovascular

High blood pressure
Low blood pressure
Chest discomfort/pain
Heart palpitations (feeling a heart beat)
Cold hands or feet
Swelling of hands
Swelling of feet
Blood clots
Fainting
Difficulty in breathing
*Other heart/vessel problems:*__________

Respiratory

Cough
Asthma/wheezing
Pain with a deep breath
Difficulty in breathing when lying down
Production of phlegm
Color of phlegm?__________
Coughing blood
Pneumonia
Bronchitis
*Other lung problems*__________

Gastrointestinal

Vomiting
Nausea
Acid regurgitation
Bad breath
Hiccup
Bloating
Diarrhea
Constipation
Chronic laxative use
Blood in stools
Black stools
Mucous in stools
Abdominal pain or cramps *(continued...)*
Gas
Rectal Pain
Burning anus Itchy anus
Hemorrhoids
Anal fissures
*Other GI problems:*__________

Genito-Urinary

Pain on urination
Urgency to urinate
Frequent urination
Blood in urine
Decrease in flow
Unable to hold urine
Dribbling
Kidney stones
Impotency
Change of sexual drive
Genital itching
Sores on genitals
Waking to urinate at night?
How often?__________
*Other Genital/urinary system problems*__________

Pregnancy and Gynecology

Number of pregnancies__________
Age at first menses__________
Days between menses__________
Duration of menses (days)__________
Date of first day of last menses:__________

Heavy periods
Light periods
Painful periods
Irregular periods
Changes in body/mood before menstruation
Clots
Menopause
Age_____ Year_____
Vaginal discharge
Postcoital bleeding
Vaginal sores
Date of last Pap __________
Breast lumps
Nipple discharge

*Do you practice birth control?*__________

*What type and how long?*__________

Musculoskeletal

No Pain
Neck Pain
Shoulder pain
Back pain
Elbow pain
Hand/wrist pain
Hip pain
Knee pain
Foot/ankle pain
Muscle pain
Muscle weakness
Other__________

Neuropsychological

Seizures
Areas of numbness
Tics
Sleep disorder
Concussion
Bad temper
Irritability
Depression
Frustration
Sadness
Anxiety
Easily susceptible to stress
Vertigo
Loss of balance
Poor memory
Substance abuse
*Other neurological or psychological Problems:*__________

****ANY HEALTH ISSUES NOT MENTIONED ON THIS FORM:*

PATIENT NAME:

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 state 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

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

Financial Policy

Facility Located at 1892 A Plaza del Sur

I fully understand that I am directly and completely responsible to my treating physician(s) for all medical bills submitted for goods and services provided to me, and this agreement is made solely for the additional protection of my treating physician(s). However, it is also understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated to me, my treating physician or its agents will refrain from attempts and efforts to collect the amounts owed directly from me. I also understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe to treating physician.

1. You are to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges to the physician by me.

2. I authorize and assign the direct payment any and all treating physican(s) or any sum I now or hereafter owe you by my attorney out of the proceeds of ay settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you in whole or in part upon the charges made for your services. If there is a requirement that the check be made directly to myself, I authorize that the physician(s) name be included on such check.

3. I give assignment and lien against any claims against a third party whose negligence my have caused my injury, up to the amount of the bill for treatment. This includes but is not limited to so called Tort or third party auto insurance claims.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit

5. Limited Power of Attorney: I hereby grant to the treating Physician/facility power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment form any insurance company for payment of treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess or the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

6. I further agree to and do hereby irrevocably waive any right I have or may have, whether arising pursuant to the decision in Martinez vs. St. Joseph Health Care System, 117 N.M. 357 (1994) or otherwise require treating physician to reduce the payment on the bills by a proportionate share of the attorney fees, costs and other expenses of pursuing collection of my claims arising from this accident, I understand that the law may allow me to pay less than the full amount of my billing to treating physician, but I give up this right in return for the aforesaid consideration provided by treating physician/facility.

7. I wave the Statute of Limitations regarding my physician's right to recover.

Signed: ______________________________ Date: ________________________

Witness: ______________________________ Date: ________________________

A photocopy of this instrument shall serve as original.

Jesse Hoover, DOM *Yushu Cheng, DOM*
1892 Plaza Del Sur Dr, Santa Fe, NM 87505 505-988-8017

Please fill in this questionnaire carefully. It will help us provide you with an excellent evaluation and effective treatment. The information you provide is confidential. It may be shared with other practitioners in this office only to benfit your treatment.

Health History Questionnaire

Date ______/ ______/______

Name	*Adress (Street, City, State, Zipcode)*	
Home phone	*Work phone*	*Email address*
Date of Birth *Age*	*Occupation*	*Would you like to receive an email newsletter?* *Yes* *No*
Payment Method (circle answers): *Health Insurance* *Worker's Comp* *Self-Pay (cash)* *Personal Injury/Auto* *Other*______ *If using insurance, what is the name of the company?* ______		
Family Physician *Phone*		
Emergency contact	*Emergency contact phone*	*Relationship*
Referred by	*Have you ever been treated with acupuncture before?*	

What is the main problem (s) you would like help with? ______

When did the problem begin? (Date)______ Is it getting better or worse? ______

Do you know what caused the problem? ______

Have you been given a diagnosis for this problem? If so, what is it?______

What kinds of treatment have you tried? ______

Current/Past Medical History (Please check if you currently have, or have had in the past. Include date)

AIDs/HIV	Diabetes	Multiple Sclerosis	Thyroid Disorder
Alcoholism	Emphysema	Mumps	Tuberculosis
Allergies	Epilepsy	Pacemaker	Typhoid Fever
Appendicitis	Goiter	Pleurisy	Ulcers
Arteriosclerosis	Gout	Pneumonia	Venereal Disease
Arthritis	Heart Disease	Polio	Whooping Cough
Asthma	Herpes	Rheumatic Fever	Tonsillectomy
Birth Trauma	Hepatitis	Scarlet Fever	Other (Specify)
Cancer	High Blood Pressure	Seizures	______
Chicken Pox	Measles	Stroke	______
	Migraines		

Surgeries (Type and date)______

Other significant injury (auto accidents, falls, etc. Please include approximate date.)

______

Please list any allergies

____

____

Family Medical History Allergies Alcoholism Arteriosclerosis Asthma
Cancer (type) ____________ Depression Diabetes Heart Disease
High Blood Pressure Seizures Stroke Other ____________

Please list current medications and suppliments. (Include vitamins, herbs, etc.)

Name	Dose	Frequency	Name	Dose	Frequency

Do you experience occupational stress? (chemical exposure, overexertion, stressful environment, etc.)

____

Do you exercise? (What type and how often) ____________

Please describe your typical meal for:

Breakfast:____________ Snacks____________
Lunch____________ Snacks____________
Dinner____________ Snacks____________

Do you smoke cigarettes? (Yes/no)________ If yes, how many per day (week)________
Do you drink alcohol? (Yes/no)________ If yes, how much per day (week)________
How much coffee, tea or cola do you drink per day? ____________
Please describe any drug use:____________

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD RECENTLY

General

- Chills
- Fever
- Sweat easily
- Night sweats
- Weakness in a particular area of body
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (for hot or cold drinks)
- Fatigue or Low energy
- Sudden energy drop
- Time of day?____________
- Edema Where?____________
- Poor sleep
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Sleepy after eating
- Weight gain
- Weight loss

Head, Eyes, Ears, Nose, Throat

- Dizziness
- Migraines
- Headaches

Location:____________

- Facial Pain

Location:____________

- Glasses
- Poor Vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tears
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Hearing aid *(continued…)*
- Earaches
- Discharge from ears
- Nose bleeds
- Sinus problems
- Excessive phlegm
- Grinding teeth
- Jaws Clicks
- Concussions
- Recurrent sore throats
- Hoarseness
- Enlarged thyroid
- Swollen glands
- Sores on lips or tongue
- Gum problems
- Teeth problems

Other head or EENT problems:

____

____

____

Skin and Hair

- Rashes
- Itching
- Change in hair or skin *(continued …)*

Ulcerations
Eczema
Psoriasis
Hives
Acne
Recent moles
Hair loss
Dandruff
Fungal infections
*Other hair or skin problem:*______________

____

Cardiovascular

High blood pressure
Low blood pressure
Chest discomfort/pain
Heart palpitations (feeling a heart beat)
Cold hands or feet
Swelling of hands
Swelling of feet
Blood clots
Fainting
Difficulty in breathing
*Other heart/vessel problems:*______________________

____
____
____

Respiratory

Cough
Asthma/wheezing
Pain with a deep breath
Difficulty in breathing when lying down
Production of phlegm
Color of phlegm?______________
Coughing blood
Pneumonia
Bronchitis
*Other lung problems*______________________

____
____

Gastrointestinal

Vomiting
Nausea
Acid regurgitation
Bad breath
Hiccup
Bloating
Diarrhea
Constipation
Chronic laxative use
Blood in stools
Black stools
Mucous in stools
Abdominal pain or cramps *(continued…)*

Gas
Rectal Pain
Burning anus   Itchy anus
Hemorrhoids
Anal fissures
*Other GI problems:*______________

____
____
____

Genito-Urinary

Pain on urination
Urgency to urinate
Frequent urination
Blood in urine
Decrease in flow
Unable to hold urine
Dribbling
Kidney stones
Impotency
Change of sexual drive
Genital itching
Sores on genitals
Waking to urinate at night?
How often?______________
*Other Genital/urinary system problems*______________________

____
____

Pregnancy and Gynecology

Number of pregnancies______________
Age at first menses______________
Days between menses______________
Duration of menses (days)______________
Date of first day of last menses:

____

Heavy periods
Light periods
Painful periods
Irregular periods
Changes in body/mood before menstruation
Clots
Menopause
Age________ Year__________
Vaginal discharge
Postcoital bleeding
Vaginal sores
Date of last Pap ______________
Breast lumps
Nipple discharge

*Do you practice birth control?*______________

____

*What type and how long?*______________

____
____

Musculoskeletal

No Pain
Neck Pain
Shoulder pain
Back pain
Elbow pain
Hand/wrist pain
Hip pain
Knee pain
Foot/ankle pain
Muscle pain
Muscle weakness
Other______________________

____

Neuropsychological

Seizures
Areas of numbness
Tics
Sleep disorder
Concussion
Bad temper
Irritability
Depression
Frustration
Sadness
Anxiety
Easily susceptible to stress
Vertigo
Loss of balance
Poor memory
Substance abuse
*Other neurological or psychological Problems:*______________________

____
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*******ANY HEALTH ISSUES NOT MENTIONED ON THIS FORM:***

____
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Financial Policy

Facility Located at 1892 A Plaza del Sur

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7. I wave the Statute of Limitations regarding my physician's right to recover.

Signed: ______________________________ Date: ________________________

Witness: ______________________________ Date: ________________________

A photocopy of this instrument shall serve as original.

PATIENT NAME:

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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 state 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

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