Georgina Castle, MPH, LAc.
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INITIAL HEALTH STATUS
Acupuncture

Patient Name_____ Birthdate _____ Primary Language_____ Sex M☐ F ☐
(Last, First; MM/DD/YY)

Address_____City_____ State_____ Zip _____ Email _____

Employer_____ Occupation _____ Cell Phone _____ Other Phone _____

Subscriber Name_____ Subscriber ID#_____ Group #_____

Primary Health Plan _____ Patient/Member ID# _____

2nd Health Plan _____ Primary Care Physician (PCP) _____ PCP Phone # _____
(Required)

Are you under the care of a physician? ☐No ☐Yes, for what conditions? _____
Please describe your current health problem(s)_____
How and When it began_____ Is this work related? ☐Yes ☐No
What treatment have you received for the above condition(s)? ☐Surgery ☐Medications ☐Physical Therapy ☐Injections
☐Chiropractic ☐Massage ☐ Other_____
Please describe your progress: ☐Worse ☐No change ☐25% Better ☐50% Better ☐75% Better or _____

Check your current pain areas: ☐Head, ☐Neck, ☐Jaw, ☐Shoulder, ☐Arm, ☐Elbow, ☐Hand, ☐Wrist, ☐Upper Back, ☐Low Back, ☐Tailbone, ☐Hip, ☐Thigh, ☐Knee, ☐Ankle, ☐Foot, ☐Chest, ☐Abdomen, ☐Other_____
No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Unbearable Pain**
In the past week, how much has your pain interfered with your daily activities?
No Interference ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Unable to carry on any activities**

How often are your symptoms present? ☐Constantly ☐Frequently ☐Intermittently ☐Occasionally
Describe your current health condition? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Please check all of the following that apply to you and list any medications(s) you are taking:

☐Alcohol/Drug Dependence
☐Abnormal Menstruation
☐Allergies
☐Angina
☐Arthritis/Rheumatoid Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disorder
☐Breast Lumps
☐Cancer/Tumor
☐Convulsion/Seizures
☐Diabetes
☐Diarrhea/Constipation
☐Excessive Thirst
☐Fainting or Dizziness
☐Fatigue
☐Fever
☐Frequent Urination
☐Headache
☐Heart Attack
☐Heartburn or indigestion
☐Hypertension
☐Hospitalizations/Surgical Procedures
_____
☐Kidney Disease
☐Liver Problems
☐Osteoporosis
☐Pacemaker
☐Palpitation/Arrhythmia
☐Peptic Ulcer
☐Pregnant, # Weeks _____
☐Prostate Problems
☐Weight Gain/Loss
☐Sinusitis
☐Stroke
☐Tobacco Use – Type _____
☐Frequency_____/Day
☐Thyroid Disease
Other _____
_____
☐Medications_____
_____
_____
_____

If the family member has had any of the following, please mark the appropriate box and explain the relationship:
☐Cancer_____
☐Heart Disease_____
☐Hypertension_____
☐Lupus_____
☐Other_____
☐Last Menses DATE _____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ Date_____

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 Georgina Castle, MPH, L.Ac. if this is deemed necessary for the care of the patients. All the terms and conditions hereof also apply to such admissions.

Medical Consent:

I have read and fully understand that the patient accepts the full responsibility to follow up the medical advice given by Georgina Castle, MPH, L.Ac. the patient or the patient's representative consents to the treatment procedures and it's results and repercussions thereof and accepts arbitration if deemed necessary.

Release of Information:

Georgina Castle, MPH, L.Ac. is authorized to furnish from the patients records 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. The patient or his/her medical records from previous medical history rendered by other physicians or medical centers.

Financial Agreement:

The patient or patient's representative shall pay Georgina Castle, MPH, L.Ac. services rendered in accordance with the regular rates and terms by Georgina Castle, MPH, L.Ac. 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 collections expenses incurred shall be payable in addition to the other amounts due.

24-Hour Cancellation and Missed Appointment Policy:

Please let use know if you need to cancel or reschedule an appointment. Failure to provide 24-hour notice or failure to show will result in your account being charged for the visitation at our standard fee of $75. Your insurance carrier is not responsible for this fee.

Georgina Castle, MPH, L.Ac. and patient or 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."

X_____ X_____

Signature of Patient Date Signature of Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures from Georgina Castle, MPH. L.Ac.

X_____ X _____

Signature of Patient Date Signature of Representative Date

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 California 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.

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, 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 or preceptorship 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.

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 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

AAC-CA

PATIENT NAME:

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 named 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 be 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. Bums 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.

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE