San Diego Healing Arts Cancellation Policy

Thank you for choosing San Diego Healing Arts at La Costa Chiropractic. Please contact us at least 24 hours to cancel or reschedule your appointment. We enforce a strict cancellation policy and you will be charged $55 for your scheduled appointment time if cancellation or rescheduling is less than 24 hours.

I _____ (please print name), have read the above policy and acknowledge that I will be charged the $55 and am responsible for payment of my scheduled appointment if I cancel or reschedule with less than 24 hours' notice.

Signed (patient signature): _____

Date: _____

Appointment Date:

General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____

Have you had Acupuncture or Oriental medicine before? Yes No

Are your presently under a doctor's care? Yes No Who and for what? _____

Are there any other therapies which you are involved in? Who and for what? _____

Insurance Information

Insurance Company _____ Contact # _____

ID # _____ Co-pay $ _____ Visit # _____ Referral Yes No Covered % _____

Date called _____ Contact Name _____ Deductable amount _____

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____

What are your health goals? _____

List any past or future surgeries._____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in:_____

Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Medical History

Do you have any allergies? Yes No If so, to what?_____

Do you take medication? Yes No If so what types and how often_____

Do you take supplements? Yes No If so what types and how often_____

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When?_____ Do you have a low point during the day? Yes No When?_____

What are your indulgences?_____

What are your hobbies/pleasures? _____

Web of Wellness

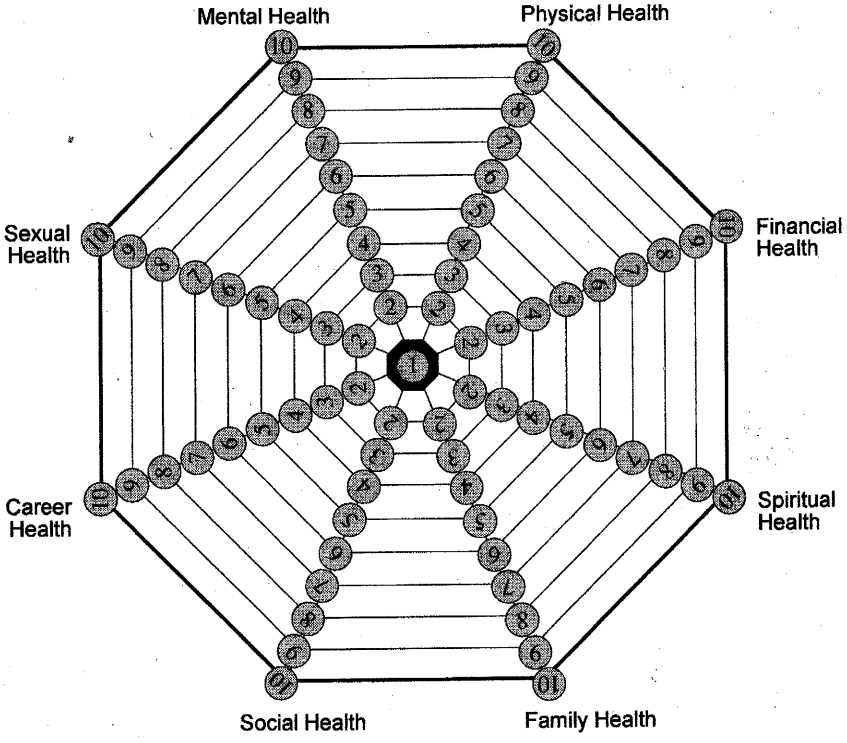
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

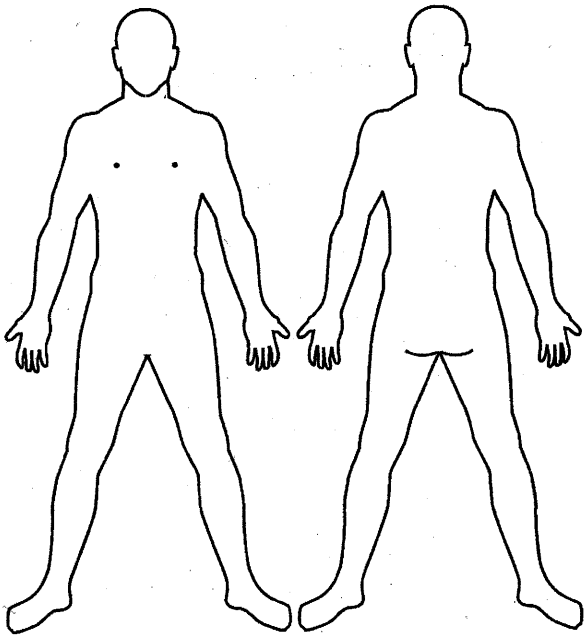
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



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 and federal law, and not by a lawsuit or resort to court process except as California and federal law provide 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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 equal 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE: **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

UPDATED Insurance Policy Information

Being healthcare providers for almost 40 years, we understand how confusing insurance coverage can be. Our office will obtain **general** benefit information from your insurance (only from information on the insurance website when possible) to get an idea of what your benefits **may be.** That being said, it may not include all of the details of your policy. When insurance companies quote benefits, they state: *"Verification of benefits is not a guarantee of payment. Benefits will be determined at the time claims are processed."*

Therefore, please understand that we do not guarantee any benefits from your insurance company.

It is understood and agreed that I shall pay the full amount of the charges should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company fails to pay my claim or processes my claim differently than expected.

Please sign your name below, indicating that you have read, understand, and agree to all of the above.

_____

Patient Name (Please print)

_____ _____

Patient Signature or Legal Guardian Date Signed

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture and Oriental Medicine
For questions, please call ASH at 800.972.4226

Patient Name_____ Birthdate_____ Primary Language_____ Sex M / F
Last First

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ PCP Phone #_____
(Required) (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? Y / N

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_____

Circle 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 medication(s) you are taking:

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ 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 a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

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**_____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

MEMBER BILLING ACKNOWLEDGMENT

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____ (Name of Patient/Member/Subscriber), a member being treated by RICARDO PETERSON (Practitioner Name),

do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____ (Name of Health Plan).

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
	cupping add on	$ 25.00
	cupping only	$ 45.00
		$
		$
		$

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Practitioner may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Practitioner may not bill the member for the difference between what the ASH Contracted Practitioner bills and what the ASH Contracted Practitioner agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Practitioner agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the member. This agreement may only be used to allow the member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my practitioner, RICARDO PETERSON (Practitioner Name), to pay for these services myself.

Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date