Welcome

Silverlake Acupuncture, Inc.
3818 Tracy Street
Los Angeles, CA 90027

TODAY'S DATE:

PATIENT INFORMATION

Patient Name
Address Apt #
City State Zip
Gender ☐M ☐F ☐X Birth Date:
E-Mail:
Patient SSN:
Patient's Principal Spoken Language:
Occupation:
Who may we thank for referring you?

ACCIDENT INFORMATION

Type of accident: ☐Auto ☐Work ☐Home ☐Other
Date of Accident:
Attorney Name & Address:
Attorney Name & Address:
Attorney Phone: Fax:
Case/Claim #:

PATIENT'S HEALTH INSURANCE

Name of Primary Insured:
Relationship to Patient:
Insurance Co:
Subscriber #
Is Patient covered by additional insurance? ☐Yes ☐No
Additional Insurance Information:

PATIENT'S AUTO INSURANCE

Adjustor Name:
Adjustor's Direct Phone:
Insurance Co Name & Address:
Insurance Phone: Fax:
Your Policy #:
Claim #:

PATIENT'S PHONE NUMBERS

Home:
Work: Ext:
Cell:
Best time and place to reach you:

EMERGENCY INFORMATION

IN CASE OF MEDICAL EMERGENCY, CONTACT:
Name:
Relationship: Home Phone:
Work Phone: Ext.:
Cell Phone:

OTHER DRIVER'S INFORMATION

Name
Address Apt #
City State Zip
Gender ☐M ☐F ☐X Birth Date:
Policy Holder Name:

OTHER DRIVER'S AUTO INSURANCE

Adjustor Name:
Adjustor's Direct Phone:
Insurance Co Name & Address:
Insurance Phone: Fax:
Their Policy #:
Claim #:

PATIENT NAME:	TODAY'S DATE:

MEDICAL HISTORY

List any conditions you had PRIOR TO the accident which may affect your treatment or prognosis:

CONDITIONS	DATE

LIST ANY PRIOR INJURIES AND/OR SURGERIES YOU'VE HAD	DATE
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS

Have you seen any other doctors or other practitioners as a result of this accident? □No □ Yes

If Yes, please list their name, address, and phone number below if you have them.
List City and State if you don't know the address.

OTHER PRACTITIONERS TREATING INJURIES FROM THIS ACCIDENT	PHONE

Silverlake Acupuncture, Inc.
Michael L. Fox, Licensed Acupuncturist
3818 Tracy Street ☯ Los Angeles, CA 90027
Phone: 323.662.6560 Fax: 323.395.0617

PATIENT NAME _____PATIENT'S BIRTHDATE _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I consent to the use or disclosure of my identifiable health information by Michael L. Fox, L.Ac., (hereafter noted as Acupuncturist) and/or Silverlake Acupuncture, Inc., (hereafter noted as Clinic) and by his staff, for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data.
IMPORTANT NOTE: This summary does not include all of the details about our privacy policy.
For more details, please read the NOTICE OF PRIVACY PRACTICES on our web site or ask to see a copy.

I. How we may use and share health data about you: treatment, payment, and healthcare operations

II. Disclosures where we do NOT have to give you a chance to agree or object: As required by federal, state, or local law, administrative court orders or law enforcement responses to criminal activities, to coroners, medical examiners, funeral directors or organ/tissue donation facilities if you are an organ donor, or to avert a threat to an individual or to public health safety.

III. Disclosures where we DO have to give you a chance to agree or object:

a) Patient directories – We do NOT release or publish a patient directory.
b) Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I consent to the use and disclosure of health information as described above, and acknowledge that I have read or received the NOTICE OF PRIVACY PRACTICES of this acupuncture practice.

_____

Signature of patient or representative Today's Date

PATIENT NAME:	TODAY'S DATE:

What was the date of the accident? _____

Where did the accident happen? _____

_____

Describe the accident in your own words: _____

_____

_____

_____

_____

_____

_____

What was your position in the car?

☐ Driver If Driver, were your hands on the steering wheel? ☐ No ☐ Yes: ☐ Left ☐ Right ☐ Both
☐ Passenger If Passenger, where were you sitting? ☐ Front ☐ Right Rear ☐ Left Rear ☐ Center Rear

Did your vehicle strike another vehicle? ☐ No ☐ Yes
Was your vehicle struck by another vehicle? ☐ No ☐ Yes
Where was your vehicle impacted (struck)? First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right
Were you wearing a seat belt? ☐ No ☐ Yes
Did you brace for impact? ☐ No ☐ Yes: ☐ braced with hands ☐ braced with feet ☐ Both hands and feet
Which way were you facing at the time of impact? ☐ Forward / straight ahead ☐ Left ☐ Right ☐ Back
Did any part of your body strike any part of the vehicle at impact? ☐ No ☐ Yes
If yes: write which part of your body struck these vehicle parts. Leave blank if there was no impact.

☐ Steering Wheel _____ ☐ Dashboard _____
☐ Windshield _____ ☐ Roof _____
☐ Left Side Door _____ ☐ Right Side Door _____
☐ Left Side Window _____ ☐ Right Side Window _____
☐ Other _____

Did the seat back bend or break? ☐ No ☐ Yes

Immediately following the accident, how did you feel? ☐ dizzy/dazed ☐ disoriented ☐ unconscious
☐ nervous ☐ nauseated ☐ upset ☐ weak ☐ other _____

PATIENT NAME:	TODAY'S DATE:

Did you go to the hospital? ☐ No ☐ Yes If yes, were you admitted? ☐ No ☐ Yes: how long _____
If you went to the hospital, when? ☐ At time of accident ☐ next day ☐ on this date _____
How did you get to the hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation ☐ _____
Name of Hospital with City/State: _____
Name of attending doctor: _____

At the hospital, what treatment was given? ☐ none ☐ placed in a cervical collar ☐ x-ray ☐ MRI or CT Scan
☐ pain medications ☐ stitches/sutures ☐ bandaged ☐ splint/cast ☐ other _____
☐ instructed regarding concussions ☐ instructed regarding sprains and strains
☐ referred to ☐ physical therapy ☐ orthopedic surgeon ☐ private physician ☐ other: _____
☐ other: _____

Have you seen any other doctor(s) as a result of this accident? ☐ No ☐ Yes

As of today, have you lost any time from work due to your injuries? ☐ No ☐ Yes
If yes, how much time total, to date? _____
List dates of lost work: _____

Occupation:_____

Employer: _____

Employer Address _____

Employer City/State/Zip _____

Employer Phone and Contact Person: _____

Have you ever had a prior motor vehicle accident? ☐ No ☐ Yes: Dates: _____
If yes, please give description(s) of previous accidents and injuries and their date(s):

1. _____
2. _____
3. _____

Prior to this accident, was there any residual pain from any of these previous injuries? ☐ No ☐ Yes

How much better did you feel prior to your current condition? (i.e. 100%, 80%, etc) _____

Please complete the "Symptoms Form" on the next page.

Silverlake Acupuncture, Inc.
Michael L. Fox, PhD, Licensed Acupuncturist
3818 Tracy Street ☯ Los Angeles, CA 90027
Phone: 323.662.6560 Fax: 323.395.0617

NOTICE OF MEDICAL LIEN

PATIENT: _____ DATE OF ACCIDENT: _____

I do hereby authorize Michael L. Fox, PhD, LAc, (hereafter Acupuncturist) of Silverlake Acupuncture, Inc., to furnish you my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident or incident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Silverlake Acupuncture, Inc., such sums as may be due and owing it for medical service rendered to me both by reason of this accident or incident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said Acupuncturist. And I hereby further give a Lien on my case to said Acupuncturist against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Acupuncturist for all medical bills submitted by him for service rendered me and that this agreement is made solely for said Acupuncturist's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment of verdict by which I may eventually recover said fee.

I agree to promptly notify said Acupuncturist of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the Acupuncturist's office. I have been advised that if my attorney does not wish to cooperate in protecting the Acupuncturist's interest, the Acupuncturist will not await payment but may declare the entire balance due and payable.

Dated _____ Patient's Signature _____
Printed name of Patient _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said acupuncturist above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ Attorney's Signature _____
Printed Name of Attorney: _____

Please date, sign, and return one copy to acupuncturist's office, keeping one copy for your records.

Michael L. Fox, L.Ac., Ph.D.
Silverlake Acupuncture, Inc.
3818 Tracy Street
Los Angeles, CA 90027

323.662.6560 Clinic phone/appointments
323.395.0617 fax
Billing/Payments contact: Mori West
Ms. West's phone: 310. 944.6189

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to_____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident*.

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident*.

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*.

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walkiing
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____
- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for ____ weeks

Please check all that apply to your HOBBY Activities *because of the accident*.

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities *because of the accident*.

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*.

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending at the waist
- ☐ Sitting in a movie theater
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*.

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date

PATIENT NAME:	AGREEMENT TO ARBITRATE

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 or 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 o 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 the 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 provided 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 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 is (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 (or patient Representative)	X	DATE:
	(indicate relationship if signing for patient)	
OFFICE SIGNATURE	X	DATE:

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, Tiu-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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Silverlake Acupuncture, Inc.
Michael L. Fox, Licensed Acupuncturist
3818 Tracy Street ☯ Los Angeles, CA 90027
Phone: 323.662.6560 Fax: 323.395.0617

THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

I hereby authorize and direct _____ (Insurance Company) to pay to:

Michael L. Fox, L.Ac
Silverlake Acupuncture, Inc.

Such sums as may be due and owing him for acupuncture services and other health care services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said acupuncturist. I hereby further request that payment be made directly to said acupuncturist which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said acupuncturist for all medical bills submitted by him for services rendered me and that this agreement is made solely for said acupuncturist's protection and in consideration of his awaiting payment. I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning it to the acupuncturist's office listed below. I have been advised that if you do not wish to cooperate in protecting the acupuncturist's interest, the acupuncturist will not await payment, but may declare the entire balance due and payable by me.

PATIENT'S SIGNATURE: _____ DATE: _____

PATIENT'S PRINTED NAME: _____

The undersigned Insurance Company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said acupuncturist above and below named and make payment payable directly to said acupuncturist.

_____ DATE: _____ _____
Signature of Authorized agent printed name of agent

On behalf of:
Insurance Company name: _____

Address: _____
_____
_____

Please return signed form to: Silverlake Acupuncture, Inc. via fax: 323.395.0617
3818 Tracy Street, Los Angeles CA 90027 phone: 323.662.6560