REPRODUCTIVE WELLNESS
ACUPUNCTURE & INTEGRATIVE MEDICINE

New Patient
OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients will be given a tour of the Clinic and will receive a one-on-one consultation with one of the clinic practitioners. During this consultation, the patient's primary health concerns will be discussed and the practitioner will determine if the patient is eligible to continue on to the medical examination. If eligible, the patient will be asked to carefully read the included materials and fill out the personal Health History Questionnaire.

STEP TWO:
A medical examination, including: a adrenal gland test, range of motion test, pH and heavy metal analysis through urine sample, palpation, pulse diagnosis, and tongue diagnosis, will be given to determine the precise cause of the patient's condition. The clinic practitioner will advise if additional tests are needed.

STEP THREE:
The patient will be given an initial Report of Findings, at which time the cause of the condition will be discussed. This includes a thorough explanation of the practitioner's treatment recommendations and what results can be obtained.

STEP FOUR:
If accepted as a Patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the Clinic.

STEP FIVE:
An estimate of the future care that is needed will be given and, upon the patient's acceptance, care will continue until the personal maximum correction of the condition has been obtained.

STEP SIX:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain fullest health and optimum function.

ReproductiveWellness.com - AcupunctureSanDiego.com
2820 Camino Del Rio South, Suite 104, San Diego, CA 92108
6370 Lusk Blvd, Suite F103, San Diego, CA 92121
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Patient and Insurance Information

The following information is important to the maintenance of your account and/or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed, we will be happy to help you. ***All of the information provided is strictly confidential***

General Patient Information Today's Date: _____ / _____ /_____

Name: _____ D.O.B. _____ / _____ / _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

E-Mail: _____ Occupation: _____ Employer: _____

Gender: ☐ Male ☐ Female · Height: _____' _____" · Current wt: _____ lbs · Ideal wt: _____ lbs

Highest level of education: ☐ Elementary ☐ High School ☐ Assoc. ☐ Bach. ☐ Master ☐ PhD

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's SS# _____

Spouse's Occupation: _____ Spouse's Employer: _____

Name of guardian: (if under 18 years old) _____

Emergency Contact / Next of Kin:

Name: _____ Relationship: _____
Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Primary Insurance Information:
Provider Name: _____ Medical Record # _____
Address: _____ City: _____ State: _____ Zip: _____
Customer Service Phone Number: _____
Subscriber D.O.B. _____ / _____ / _____ Relationship to subscriber _____

Secondary Insurance Information:
Provider Name: _____ Medical Record # _____
Address: _____ City: _____ State: _____ Zip: _____
Customer Service Phone Number: _____
Subscriber D.O.B. _____ / _____ / _____ Relationship to subscriber _____

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Health History Questionnaire

Important: The information on this form will help your doctor give you the best and most comprehensive care possible. It is important that you complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing or underlying role in the diagnosis and treatment of your condition.

Is there anything limiting you from care? ☐ Yes ☐ No _____

How did you hear about our office? _____

Other physicians / therapists seen for the condition: _____

Medications you are currently taking:

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Prescribed by: _____ Prescribed on: _____ / _____ / _____

For treatment of: _____

Results: _____

Supplements you are currently taking (vitamins, herbs, minerals, etc.):

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Major Health Complaint(s).

Please list in order of significance to you, along with how long you've had each one:

Major Health Complaints / Symptoms	How Long?	Additional Health Complaints / Symptoms	How Long?
1.		4.	
2.		5.	
3.		6.	

Do you know what is causing this problem(s)? _____

Do these problems affect your: ☐ Work ☐ Relationships ☐ Hobbies ☐ Sports / Play ☐ General quality of life

Please explain how these conditions affect or impair your daily activities: _____
_____
_____

Describe your symptoms when they are at their worst: _____
_____
_____

Please describe your childhood health: _____
_____
_____

Have you ever been hospitalized? If so, please describe the procedures you had and when: _____
_____
_____

List any other conditions or complaints that you would like us to know about: _____
_____
_____

If you do not take steps to improve your health and /or symptoms now, do you think your condition will get worse?
☐ No ☐ Yes

If your condition continues on its current course, what do you think your symptoms will be like 5 years from now?
_____
_____

What do you think is most preventing you from being healthy? _____
_____
_____

What are 5 things that you know you could do to improve your health?
(1) _____
(2) _____
(3) _____
(4) _____
(5) _____

On a scale of 1-10, how committed are you to becoming healthy? (circle one) 1 2 3 4 5 6 7 8 9 10

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Family Health History

Name: _____ **Date:** _____ / _____ / _____

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank any boxes that do not apply. If you require more space, use the reverse side of this form.

CONDITION	Father Age:__	Mother Age:__	Spouse Age:__	Brother(s) Age:__		Sister(s) Age:__		Children Age:__		
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emotional Problems										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Sinus Trouble										
Stomach Trouble										
Other:										
Other:										

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

_____

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PATIENT POLICIES

The purpose of these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those Patients who adhere to the following policies get the best results.

1. CLOTHING (FOR ACUPUNCTURE PATIENTS ONLY)

The acupuncture points needed to treat your condition will determine what areas of your body need to be exposed. Please wear clothing that is loose fitting (ie pants that can be moved above the knee and shirt sleeves that can be rolled up) or bring an extra set of clothes. You will be notified if a gown is necessary. If you need to change clothing, you may use our restroom.

2. NO-WAIT CLINIC PROCEDURES

- Please arrive 15 minutes before your scheduled appointment. This will help to ensure that patients are treated in a timely manner and have enough time to complete any necessary paperwork before receiving treatment.
- Once necessary forms have been filled out, the front desk has received your payment, you have scheduled your next appointment, and any additional matters have been addressed, please go to the designated treatment room on your black portfolio and place it in the chart holder outside your room with the room number showing (horizontally). This will notify the practitioner that you are ready for your treatment.
- For acupuncture treatments, please take off your shoes and socks. Move clothing as appropriate (ie pull your pant legs above the knee and roll your sleeves up). Lay down on the table, face up (unless specified otherwise). The reason we ask you to lay down is so you can start relaxing, which will prepare your body physically and allow you to get a better treatment.

3. PAYMENT OF BILLS

We expect you to honor the financial agreements you make with the Clinic. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. It is not our policy to bill Patients, it is that Patients not maintain a personal balance due.

4. MISSING OR RESCHEDULING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

- If you need to reschedule an appointment, we ask that you give us at least 48 hours notice. If something comes up and you cannot make it to your same day appointment, plan to come at another time on the same day. If the same day is not possible, be sure to make up the missed appointment within 5 days.
- **IF YOU CANCEL, NO SHOW, OR RE-SCHEDULE YOUR APPOINTMENT WITHOUT AT LEAST A 48 HOUR NOTICE AND THIS HAPPENS MORE THAN ONCE, YOU WILL BE CHARGED THE FULL RATE FOR EACH APPOINTMENT MISSED THEREAFTER. THIS CHARGE WILL BE ISSUED VIA THE DEBIT OR CREDIT CARD LEFT ON FILE TO RESERVE APPOINTMENT TIMES.**

5. RE-EXAMINATIONS

During your treatment series, Re-Examinations may take place approximately once a month. The purpose of these visits will be to review your progress and make any adjustments necessary. It will also give us time to determine if any new condition needs to be treated and how you are progressing so far. The Re-Exam will take approximately 15 extra minutes.

6. DIETARY SUGGESTIONS, LINIMENTS, FOOD SUPPLEMENTS, AND HERBS

If applicable, dietary suggestions should be followed, liniments used, and food supplements and herbs taken. Any problems you may have with these recommendations should be communicated to your treating practitioner.

7. NOTIFY THE OFFICE IF YOU BECOME SICK

Infections and illnesses (such as a cold, the flu, ear infections, and allergies) are, often times, easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization; and second, it could be complicated by your current herbal formula. It is ESSENTIAL that you not only keep your scheduled appointment, but that you let your practitioner know of such infections and illnesses.

8. PHARMACEUTICAL DRUGS

Acupuncturists, Chiropractors, and Massage Therapists in the State of California are not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that you are currently medicating with prescription drugs, we will be happy to do so as long as the condition has been diagnosed by your doctor and is not an emergency condition. **If the patient decides they want to alter their pharmaceutical regimen in ANY way, the patient must consult their doctor before doing so!**

9. UPSETS

We are here to serve you. Please speak with your Practitioner or the Office Manager about ANY upsetting matter. We see your comments as allowing us to not only address your concerns, but also as a means to provide the best care possible to our community.

I have read and understood the above information and I accept these policies.

_____ _____

Patient Signature **Date**

_____

Patient Name Printed

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Agreement by the Patient / Guarantor to be Financially Responsible for Fees

I, _____, (patient or guarantor) understand that I am financially responsible for all charges regardless of insurance payment. I am aware that some, and perhaps all, of the services provided may not be covered by my insurance. I am also aware that verification of my insurance benefits is not a guarantee of payment. I understand that interest will be applied to any unpaid patient balance over 30 days past due.

Medical Release to Insurance Company & Notice of Privacy Practices

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay The Wellness Institute directly for those medical services.

Type of Care Choices

Most patients that come to The Wellness Institute have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem AS WELL as the symptoms corrected (Corrective Care). Your practitioner will weigh your needs and desires when recommending your treatment program. There will be occasions that you will be treated by different practitioners and it is vital to your continued therapeutic development to receive your scheduled treatments as prescribed by your case manager's individual treatment plan, regardless of the treating practitioner.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care	Corrective Care	I want my practitioner to select the appropriate care for my diagnosis

Notice of Privacy Practices Acknowledgement

- We keep a record of the health care services we provide you.
- You may ask to see and get a copy of that record. You may also ask to correct that record. To get more information, contact the Office Manager.
- We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices (attached) describes in more detail how your health information may be used and disclosed, and how you can access your information.

Your signature below is an acknowledgement that you have been provided with a copy of our Notice of Privacy Practices to read and keep for your records.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Name Printed	**Parent, legal guardian, representative**
_____	_____
Witness/Staff Member	**Date**

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INFORMED CONSENT

I voluntarily consent to be treated by The Wellness Institute of America. The Clinic offers several treatment modalities and the course of the treatment will be determined between the practitioner and myself. I hereby request and consent to the performance of Oriental Medicine treatments, Chiropractic adjustments, and/or massage therapy, including various modes of physiotherapy (or the patient named below, for whom I am legally responsible) by licensed practitioners associated with The Wellness Institute of America.

The treatments consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and meridians
2. Use of electrical, mechanical, or magnetic devises to stimulate acupuncture points
3. Moxibustion
4. Acupressure
5. Cupping
6. Dermal friction technique
7. Infra-red
8. Sonopuncture
9. Laserpuncture
10. Dietary advice based on traditional Chinese medical theory
11. Point injection therapy
12. Chiropractic manipulation of the spine and/or extremities
13. Manual therapy/myofascial release
14. Neuromuscular re-education
15. Electrical muscle stimulation
16. Hot/Cold therapy
17. Therapeutic exercise/activities
18. Medical massage

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following:

1. Some pain at the needle insertion area
2. Minor bruising at the needle insertion area
3. Infection
4. Needle sickness
5. Broken needle
6. Patients with severe bleeding disorders or pace makers should inform the practitioner prior to any treatment. If you are pregnant or have a history of seizures, you should also inform the practitioner.
7. Mild aches in muscles surrounding chiropractic treatment area
8. Inflammation/swelling of soft tissue surrounding chiropractic treatment area
9. Stiff/sore joint motion surrounding chiropractic treatment area

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time. I hereby authorize The Wellness Institute of America to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim. With notification, I also authorize The Wellness Institute of America to obtain my medical records from other physicians or medical centers.

Patient Signature **Date**

Patient Name Printed

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

AWC and Reproductive Wellness respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information for us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan
  - Accounting, legal, risk management, and insurance services
  - Audit functions, including fraud and abuse detection and compliance programs

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have the right to:

- Receive, read, and ask questions about this notice

- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice")
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

- Have us review a denial of access to your health information- except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included in any release of your records.
- When you request, we will give you a list of disclosures of your health information. This list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Office Manager/HIPAA Officer at 360-394-4357

Our Responsibilities
We are required to:

- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this notice. You may receive the most recent copy of this notice by calling and asking for it or to pick one up.

To Ask for Help or Complain
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:
Office Manager/HIPAA Officer at 360-394-4357

If you believe your privacy rights have been violated, you may discuss your concerns with a staff member. You may also deliver a written complaint to Office Manager/HIPAA Officer at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information
Notification of Family and Others:

- Unless you object, we may release health information about you to a friend of family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in the hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- [Hospitals] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
    - Your name and location
    - General condition

  - Religion (only to clergy)
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers-** if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Worker's Compensation Laws-** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public
  - To public health or legal authorities
    - To protect public health and safety
    - To prevent or control disease, injury, or disability
    - To report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Condition That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.