LIFELINE
Acupuncture & Herbs Clinic

HongJoon Lee, L.Ac., M.S.

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Phone: 530-756-1445 Fax: 530-756-1450

☐ 4701 Whitney Ave, Carmichael, CA 95608
Phone: 916-589-7020 Fax: 530-756-1450

PATIENT REGISTRATION FORM

Date _____

Patient Name _____ Phone Number _____
☐ *Check box* if you want reminder (Call / Text)

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex (M / F) Marital Status (M / S / D / W)

Occupation _____ Social Security # _____

Employer _____ Work Phone _____ Drivers License # _____ State _____

Employer Address _____ City _____ State _____ Zip _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name _____ Date of Birth _____

Relationship to Patient (please check): ( ) Self, ( ) Spouse, ( ) Parent, or Other ( ) _____

Address _____ Phone Number _____
(Street) (City/State/Zip)

Occupation _____

Employer Name _____ Work Phone _____ Drivers License # _____ State _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Address _____
(Street) (City/State/Zip)

Home Phone _____ Work Phone _____ Relationship _____

Insurance Information (Please have I.D.)

Insurance Company Name _____ I.D. Number _____

Address _____ Group Number _____
(Street or P.O. Box) (City/State/Zip)

Policy Holder Name _____ Effective Date _____

Policy Holder's Social Security # _____ Sex (M / F)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Lifeline Acupuncture & Herbs Clinic. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

Medical History Form

Name _____ DOB _____ Date_____

MEDICAL HISTORY

What medical conditions do you have? Select all that apply, or write in if not listed:

Diabetes _____ High Blood Pressure _____ Thyroid Disorder _____ Heart Disease _____ High Cholesterol _____
Arthritis _____ Cancer _____ Kidney Disease _____ Glaucoma _____ Asthma _____ Allergies _____
Migraine Headache _____ Anemia _____ Obesity _____ Acid Reflux _____

Other: _____

Female Only Age of first menstrual cycle _____

Are you pregnant? _____ (Y/N) Is it possible that you are pregnant? _____ (Y/N)

Date of last period _____ Do you have a history of irregular menstrual cycles? _____ (Y/N)

Number pregnancies ____ Number births ____ Number Premature births ____ Number Miscarriages ____

Are you currently on birth control? _____ (Y/N) *If* yes, What type / name? _____

MEDICATION: Please list all medications you care now taking

Medication _____ Prescribed by _____

Medication _____ Prescribed by _____

Medication _____ Prescribed by _____

Surgeries (operations) Please list all you had in the past 10 years

_____ Year _____

_____ Year _____

_____ Year _____

ALLERGIES (Allergic reactions to medication, foods: Please list the TYPE OF REACTION)

Medication / Foods Allergy	Reaction
_____	_____
_____	_____
_____	_____

General

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Night sweats ☐ Cold abdomen
☐ Fever ☐ Cravings ☐ Poor coordination ☐ Sweat easily
☐ Chills ☐ Localized weakness ☐ Peculiar tastes/smells ☐ Change in appetite
☐ Sudden energy drop at _____time ☐ Bleed or bruise easily ☐ Strong thirst (Cold/Hot)

Skin and Hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Purpura ☐ Boil ☐ Change in hair, skin texture
☐ Tumors, Masses or Lumps (where) _____
☐ Other hair or skin problems _____

Head and Neck

☐ Dizziness ☐ Concussions ☐ Poor vision ☐ Glasses/Contacts
☐ Eye strain ☐ Eye pain ☐ Blurry vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Nose bleeds ☐ Sinus problems
☐ Ringing in ears ☐ Poor hearing ☐ Dry mouth ☐ Copious saliva
☐ Earaches ☐ Dry throat ☐ Grinding teeth ☐ Facial pain
☐ Tooth problems ☐ Jaw clicks ☐ Recurrent sore throats _____/months
☐ Sore on lips or tongue ☐ Headaches/Migraines (where/when) _____
☐ Other head or neck problems _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pains ☐ Irregular heart beat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing
☐ Other C/V problems _____

Respiratory

☐ Asthma ☐ Bronchitis ☐ C.O.P.D ☐ Pneumonia
☐ Cough ☐ Coughing blood ☐ Tight chest (how often) _____
☐ Production of phlegm: Amt./Freq.: _____ Color: _____ Consistency: _____
☐ Other lung problems _____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Bowel movement:
☐ Gas ☐ Belching ☐ Black stool _____ Frequency
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids _____ Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____ Odor
☐ Pain or cramps ☐ Laxative use. Frequency of use: _____ _____ Texture/form
☐ Other G.I. problems _____

Musculoskeletal (Draw picture next page)

☐ Neck pain ☐ Muscle pains ☐ Back pain ☐ Joint pain
☐ Other joint or bone problems _____

Neuropsychological

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/Attempted suicide
☐ Other neurological problems _____

SOCIAL

How much do you smoke? _____Pack/Day How long? _____

How much alcohol (including beer) do you drink in a week? _____

Have you used or currently use recreational drugs? _____ (Y/N) *If* yes how long_____

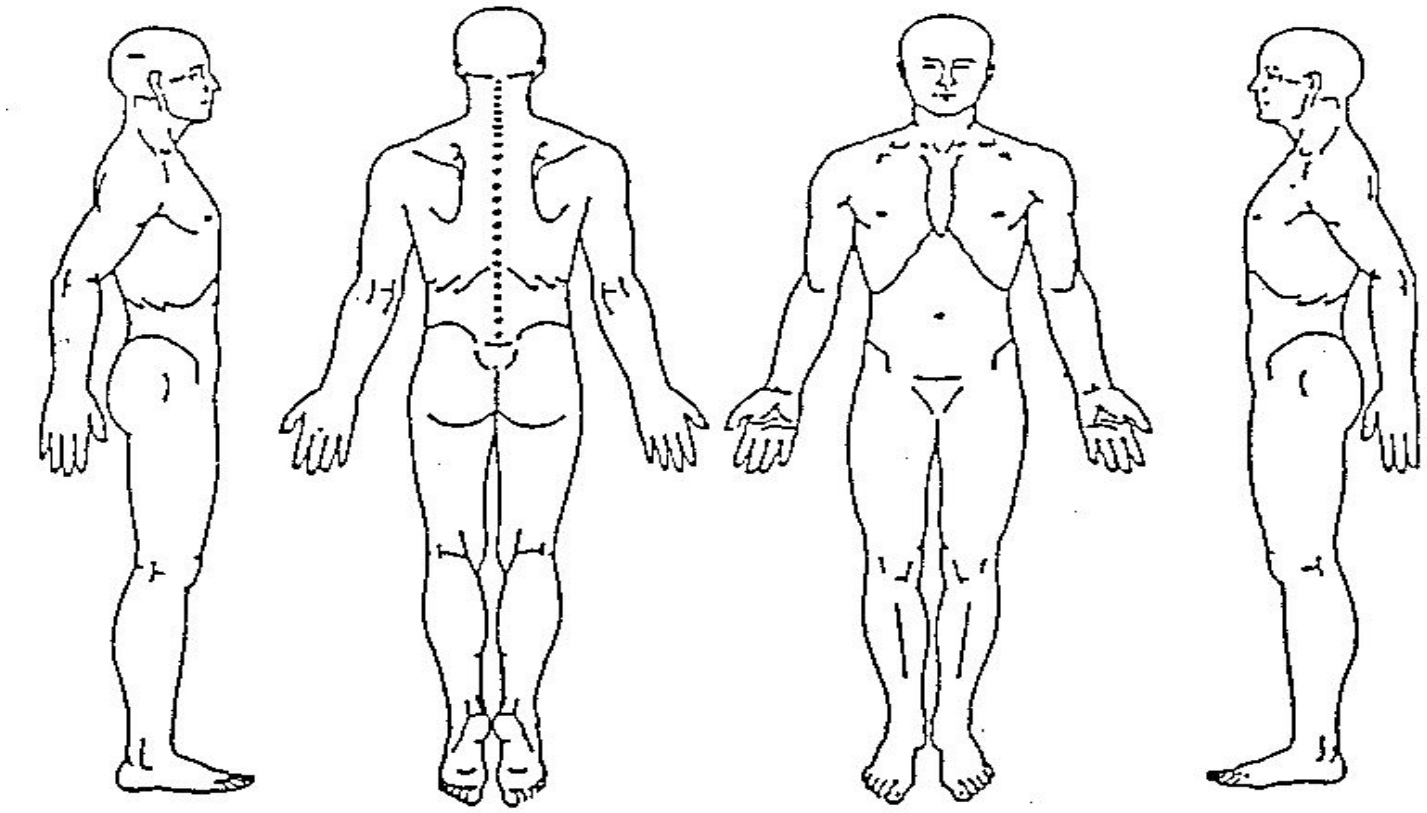
What is your major complaint(s) and symptom(s):

_____

_____

Please indicate any painful or distressed areas by circling the area

A = Ache P = Pins & Needles B = Burning S = Stabbing N = Numbness O = Others



General location and type of pain _____

When did you first notice the symptom(s)? _____

Have you given a diagnosis for this problem? *If* so, what? _____

Has this condition been treated before? _____ (Y/N) When _____ By Whom _____

Any Family history of this condition _____

Were you referred by another physician? _____ (Y/N) *If* yes, Dr.'s Name _____

If no, how did you hear about us? _____

Signature _____ **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 state and federal law, and not by 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 binds all parties as to all claims, including claims arising out of 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 office whether signatories 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 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 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 judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with the 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 PRACTICE 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 _____ Date _____
(Or Patient Representative) (Indicate relationship if signing for patient)

Office Signature _____ Date _____

ALSO SIGN THE INFORMED CONSENT

Lifeline Acupuncture & herbs Clinic
Consent for Acupuncture/Oriental Medicine Treatment

I hereby request and consent to the performance of Acupuncture and other Oriental Medicine procedures, including examination tests, on me (or on the patient named below, for whom I am legally responsible) which are recommended by the Acupuncturist named below and/or other licensed Acupuncturist who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as a backup for the Acupuncturist/Doctor of Oriental Medicine named below, Including those working at the clinic or office below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-na (oriental massage), massage, Oriental Herbal medicine, 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 recommended herbs and nutritional supplements are traditionally considered safe, but some may be toxin in large dosages. 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. The herbs may be an unpleasant smell or taste, and I will immediately notify a member of the clinical staff of any unpleasant effects associated with the consumption of the herbs.

I understand the Acupuncture/Oriental Medicine is generally a safe method of treatment, but as with any health care procedure, there are certain complications which may arise during an Acupuncture/Oriental Medicine treatment, including, but limited to, bruises, numbness, nausea, headaches, diarrhea, or tingling near the needling sites that may last a few days, and dizziness or bruising from cupping, potential burns and scars related to moxibustion. I do not expect the Doctor of Oriental Medicine/Acupuncturist/Clinical staff to be able to anticipate all possible risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known. 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 risk and benefits of Acupuncture/Oriental Medicine and other procedures, and have had an opportunity to ask questions. I hereby give my consent to that treatment. 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.

Hong Joon Lee, L.Ac., M.S.

Print Name of Patient _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____
(*If* minor, please provide the name of parent or guardian)

Translated by _____ Date _____

Office Signature _____ Date _____

ALSO SIGN THE ARBITRATION AGREEMENT

Lifeline Acupuncture & Herbs Clinic

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Lifeline acupuncture & Herbs Clinic.

Legal Responsibilities of Lifeline acupuncture & Herbs Clinic: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, text, postcards, or letters. We may also write a thank you card to whoever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.25 per page for the first 30 pages and $0.20 for every page after that plus $15.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

	Davis Office	Carmichael Office
Contact Person's Name:	Hong Joon Lee, L.Ac., M.S	Hong Joon Lee, L.Ac., M.S
Telephone:	530-756-1445	916-589-7020
Address:	1109 Kennedy Pl Suite 5	4701 Whitney Ave.
City, State, Zip:	Davis, CA 95616	Carmichael, CA 95608

I have read and understood the HIPAA privacy policies of Lifeline Acupuncture & Herbs Clinic

Print Name of Patient _____

Patient Signature _____ Date _____

Print Name of Parent/Guardian _____

Parent/Guardian Signature _____ Date _____

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FINANCIAL AGREEMENT

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 30 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 30 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our office to discuss payment arrangements. Referral to a collection agency, or naming Lifeline Acupuncture & Herbs Clinic in a bankruptcy filing, you will be charged a processing fee and any applicable legal fees. NSF checks will result in a $25 processing fee.

Cancellations and No-Shows

We require 24-hours notice in the event of a cancellation and you may be subject to a $35 charge for appointments cancelled less than 24 hours before time of appointment. You will be subject to a $35 charge for an appointment that is scheduled and not kept without any notification (No-Show). This charge will not be covered by your insurance, but is required to be paid by you personally. For Workers' Compensation and Personal Injury patients, documentation of miss appointments is forwarded to your case manager and primary physician. This could jeopardize your claim

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

I, the undersigned, agree to all terms in the ***Insurance, Patient Responsibility for Payment, Non-Payment and Cancellations and No-Show Policy.***

Print Name of Patient _____

Patient Signature _____ Date _____

Print Name of Parent/Guardian _____

Parent/Guardian Signature _____ Date _____