Evolve Wellness Center, Inc.

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PATIENT CONFIDENTIAL INFORMATION

DATE _____ **REFERRED BY** _____

PATIENT NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **BUSINESS PHONE** _____

CELL PHONE _____ **EMAIL ADDRESS** _____

AGE _____ **DATE OF BIRTH** _____/_____/_____ **SEX** M F

EMPLOYER _____ **OCCUPATION** _____

SS# _____ **EMERGENCY CONTACT NAME** _____

RELATION _____ **PHONE** _____

METHOD OF PAYMENT INSURANCE CASH/C.C./CHECK GIFT CERTIFICATE

DO NOT WRITE BELOW THIS LINE!!!

INSURANCE INFORMATION (OFFICE USE ONLY)

NAME OF INSURANCE _____ INS. ID# _____

INS. GROUP# _____ INS. PHONE # _____

ELIGIBLE DATE _____/_____/_____ # VISITS PER YEAR/QUARTER _____

SHARED VISITS? Y N ANY USED? _____ % COVERED _____

CALENDAR/BENEFIT YEAR DEDUCTIBLE AMT. _____ MET? Y N COPAY _____

NOTES: _____

_____

EVOLVE WELLNESS CENTER
MEDICAL HISTORY QUESTIONNAIRE
Please complete the following as accurately as possible.

Name: _____ Date: _____

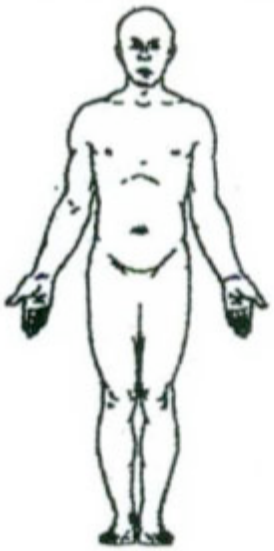
Present Illness:

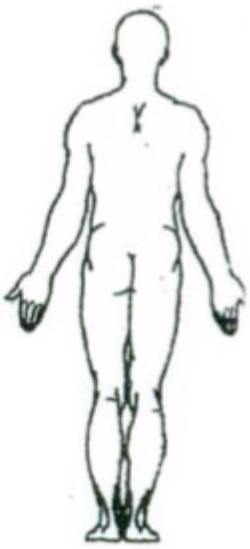
What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Mark an X where you feel pain or discomfort.





Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?

Which, if any, of your blood relatives have had any of the following?

- Stroke
- Cancer
- Heart Disease
- Tuberculosis
- Bleeding Disorders
- Diabetes
- High Blood Pressure

FEMALE PATIENTS - Menstrual History:

Age of first period: _____
Vaginal Discharge: _____
Length of cycle (days) : _____
Date of your last period: _____
Do you believe you are pregnant? Y or N

Recreational Substance Usage:

Smoking: Y or N
-How many years? _____
-How many per day? _____
Alcohol: Y or N
-How many drinks a week _____
Cups of coffee/day? _____
Sodas/day? _____

EVOLVE WELLNESS CENTER

NAME: _____ DATE: _____

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(Please write the word "PAST" next to those conditions which you have ONLY had in the past and which are no longer present.)

HEAD & NECK:
_____ Dizzyness
_____ Fainting
_____ Neck Stiffness
_____ Enlarged Lymph Glands
_____ Headaches
_____ Other

EARS:
_____ Infection
_____ Ringing
_____ Decreased Hearing
_____ Other

NOSE, THROAT, & MOUTH:
_____ Bleeding
_____ Sinus Infection
_____ Hay Fever or Allergies
_____ Sore Throat
_____ Hoarseness
_____ Changes in Taste
_____ Difficulty Swallowing
_____ Changes in Smell
_____ Oral Ulcers/Canker Sores
_____ Other

SKIN:
_____ Hives
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Seborrhea
_____ Night Sweating
_____ Excess Sweating
_____ Dryness
_____ Bruises Easitly
_____ Changes in Moles or Lumps
_____ Other

NEUROLOGICAL:
_____ Numbness or Tingling of Limbs
_____ Seizures
_____ Tremors
_____ Pain
_____ Paralysis
_____ Epilepsy or Convulsions
_____ Other

INFECTION SCREENING:
_____ HIV/AIDS or HIV Risks: Self or Partner
_____ TB: Self or Partner
_____ Hepatitis or Hepatitis Risk: Self or Partner
_____ History of Sexually Transmitted Diseases: Self or Partner
_____ Gonorrhea
_____ Chlamydia
_____ Syphilis
_____ Genital Warts
_____ Herpes: Oral or Genital (Circle 1 or Both)

RESPITORY:
_____Chronic Cough
_____ Coughing Up Blood
_____ Coughing Up Phlegm
_____ Difficulty Breathing
_____ Wheezing/Asthma
_____ Frequent Colds
_____ Emphysema
_____ Pneumonia repeatedly
_____ Other

CARDIOVASULAR:
_____ Palpitations
_____ Chest Pain or Tightness
_____ Rapid Heart Beat
_____ Irregular Heart Beat
_____ Heart Disease
_____ Poor Circulation
_____ Swelling of Ankles
_____ Phlebitis
_____ Cold Hands/Feet
_____ High Blood Pressure
_____ Stroke
_____ Other

GASTROINTESTINAL:
_____ Indigestion
_____ Nausea
_____ Stomach Pain
_____ Irritable Bowel Disease
_____ Colitis
_____ Crohn's Disease
_____ Pancreatits
_____ Celiac Disease
_____ Recent Change in Bowel Habits
_____ Diarrhea (_____ stools/day)
_____ Constipation (_____ stools/day)
_____ Dry, Hard Stools
_____ Soft, Difficult, Sticky Stools
_____ Irregularity or Poorly formed stools
_____ Poor Appetite
_____ Excessive Hunger
_____ Blood in Stool or Black Stools
_____ Hemorrhoids
_____ Gall Bladder Disorder
_____ Vomiting Blood
_____ Peptic Ulcer
_____ Recent Change in Weight
_____ Food Cravings

MUSCLE & JOINTS:
_____ Joint Disorder
_____ Sore Muscles
_____ Weak Muscles
_____ Difficulty Walking
_____ Spinal Curvature
_____ Backache
_____ Back Pain
_____ Fibromyalgia

MALE:
_____ Pain/Itching of Genitalia
_____ Genital Lesions/Discharge
_____ Impotence
_____ Premature Ejaculation
_____ Prostate Problems
_____ Infertility (e.g. abnormal sperm)
_____ Other

FEMALE:
_____ Vaginal Infection
_____ Infertility
_____ Pain/Itching of Genitalia
_____ Genital Lesions/Discharge
_____ Pelvic Inflammatory Disease
_____ Abnormal Pap Smear
_____ Irregular Periods
_____ Emotional Changes w/Menses
_____ Clots w/Menses
_____ Painful Menstrual Period
_____ Abnormal Bleeding
_____ Breast Swelling&/or pain
_____ Other

URINARY:
_____ Frequent urinary tract/ Bladder Infection
_____ Weak Urinary Stream
_____ Recent Change in Bladder Habits
_____ Kidney Disease
_____ Other

GENERAL:
_____ Fatigue
_____ Thirst
_____ Aversion To Cold
_____ Insomnia
_____ Frequent Dreams/Nightmares
_____ Depression
_____ Agitation
_____ Irritability
_____ History of Psychiatric Treatment
_____ Poor Memory
_____ Difficulty Concentrating
_____ Frequent Night Urination
_____ Frequent Day Urination
_____ Anemia
_____ Congenital Abnormalities
_____ Surgical Implants
_____ Lupus Erythematosis
_____ Jaundice
_____ Hernia
_____ Epstein Barr Virus (EBV)
_____ Rheumatic Fever
_____ Diabetes Mellitus
_____ Thyroid Disorder
_____ Cancer

EVOLVE WELLNESS CENTER
Financial Agreement

Welcome to Evolve Wellness Center, Inc. We appreciate you choosing us as your health care partner. It is our goal to restore and maintain your optimum health.

CANCELLATION POLICY:

We require 24 hour notice if you are unable to keep your appointment to allow time to offer your appointment to another patient. If a 24 hour notice is not given, you will be charged a missed appointment fee ($60).

INSURANCE:

Some insurance companies cover acupuncture services. We will call to verify coverage and check benefits for you. You are responsible for your deductible, co-payment, and any non-covered or excluded amounts under your policy. **Please remember that your insurance policy is a contract between you and your insurance company, and that our office is not a party to that contract.** Should your insurance carrier request additional information, we will gladly submit the paperwork to them to aid in the processing of your claims; however, you are ultimately responsible for the charges incurred at our office. If the situation would arise that the insurance payment has not been made within 60 days from the date of service, you will be asked to make payment on the outstanding portion of your account.

CASH:

For those patients who do not have insurance, or have an insurance policy that does not cover acupuncture services, payment is expected at the time of service. For your convenience, we accept personal checks, Visa, Master Card, American Express, and Discover.

I have read and understood the Evolve Wellness Center, Inc. Financial Agreement concerning the types of accounts with this office. I understand that all services that I have are my financial responsibility.

_____ _____

Patient Signature Date

EVOLVE WELLNESS CENTER

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Evolve Wellness Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Evolve Wellness Center's Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Evolve Wellness Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Evolve Wellness Center at 8430 Santa Monica Blvd., Suite 102, West Hollywood, CA 90069.

With my consent, Evolve Wellness Center may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Evolve Wellness Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements as long as they are marked personal and confidential.

With my consent, Evolve Wellness Center may email me appointment reminders and patient's statements. I have the right to request that Evolve Wellness Center restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.
By signing this form, I am consenting Evolve Wellness Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don not sign this consent, Evolve Wellness Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name or Legal Guardian (PRINT) Date

PATIENT NAME:

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 – PLEASE SIGN BOTH SIDES

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California Law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in court of law before a jury, and instead are accepting the useof 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 submision 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 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 call 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 backup 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 athird arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within the thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue 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 JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X (Or Patient Representative)

DATE: (Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 – PLEASE SIGN BOTH SIDES

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 I 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 or 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 things at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X (Or Patient Representative)	**DATE:** (Indicate relationship if signing for patient)

OFFICE SIGNATURE X	**DATE:**

PLEASE SIGN REVERSE SIDE ALSO