

PATIENT CONFIDENTIAL INFORMATION

Referring source: _____

Primary Physician: _____

I : Personal Information:

Name: (First) _____ (Middle) _____ (Last) _____

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

Home Phone : () _____ Cell phone : () _____ Biz phone : _____

Age: _____ Date of Birth: _____ / _____ / _____ Sex: M / F Marital: M _ S _ D _ W _ Other _____

Social Security # : _____ Driver's License No: _____

Email: _____ (Only use for notice)

In case of emergency contact:

Name: _____ Relationship: _____ Email: _____

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

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

II. Responsible party : (Who is financially responsible for the account?)

Name: [] self _____ Relationship to patient: _____

Address: [] same as patient's _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # : _____ Home Phone : () _____

Employer: _____ Work Phone : () _____ Ext _____

Patient's Authorization

I hereby authorize TrendCare, Inc / Acupuncturist, to give me and/or my dependents reasonable and proper medical care by today's standards and to apply for benefits on behalf of myself and/or dependents for all services rendered. I certify that the information I have reported herein is correct and authorize the TrendCare or Acupuncturist to release all necessary information (including medical records) to secure the payment of benefits. I hereby assign directly to TrendCare or Kuan-chung Chou all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance claims submitted, and permit a copy of this authorization to be used in place of original. This authorization may be revoked by either me or above named carriers at any time in writing.

* I also acknowledge that I received a copy of HIPPA Privacy Act.

* I already review and agree to follow the rule of Acupuncture Procedure / Policy, First Times Acupuncture Need to Known and security camera recording policy.

* Patient must fill the "Patient Progress Form" for insurance medical records every visit. If patient didn't do it, your insurance may reject to pay your treatment.

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

X _____
Authorized Signature of Subscriber/Beneficiary or Guardian

Date _____/2021

First Name _____ Last Name _____ date: ____ / ____ /2021

Current Medical History

Chief Complaint (Submit This diagnosis to Insurance company) _____

2nd complaint _____

What is your condition due to / initial cause?

A) MOTOR Vehicle accident, date: _____ , Reason: _____ Police Report: _____

B) Work injury, date: _____ , C): Other Accident(specify), _____ date: _____ D): Unknown _____

How long have you had your problem? _____ How often _____

Since the date of accident, the symptoms are A)Improve, B)Getting worse , C) About same, D)Come and go with activites, E) Constant

Do you have Pregnancy/peacemaker/heart disease/Respiratory/Allergies/Fractures/ Metal or Machine inside the body /Other _____

Female only: Are you pregnant? Y/N, First day of last menstrual period: _____

Has a physician given you a diagnosis for this condition? _____ Name: _____ Date: _____

X-ray/MRI/ lab tests for this condition? : Area: _____ Any fractures? Y/N, What were the finding of the examination? _____

Prior Automobile Accident or Work related injuries before this accident? No / Yes _____

Prior Episodes? Y N , if Yes please explain: _____

Please describe your activities of daily living & work Activities: _____

Does your pain radiate to another part of your body? : _____

Have you ever received any previous physical; therapy or chiropractic care ?No Yes _____

Do it cause by Car Accident Y/N ? _____ When: _____ :

What reduces your complaints / pain? A)Rest, B)Medication , C) Hot/cold pack or shower, D)Other: _____

What makes your condition WORSE ? _____

Is it worse at certain times of year? _____ Certain weather? _____

What treatments or medication are you currently using? _____ effective? _____

What treatments or medication have you tried in the past? (Chemotherapy, Steroids,) _____ effective? _____

Is there anything else about your health/medical history that we should know about? _____

Past Medical History

Surgeries/Medical Procedures : _____ date _____

Past Physical Traumas (car accident, fall, , broken bones or dislocations .) _____

Past Emotional Traumas (divorce, death in family, .) _____

Check any of the following conditions you have or have had in the past:

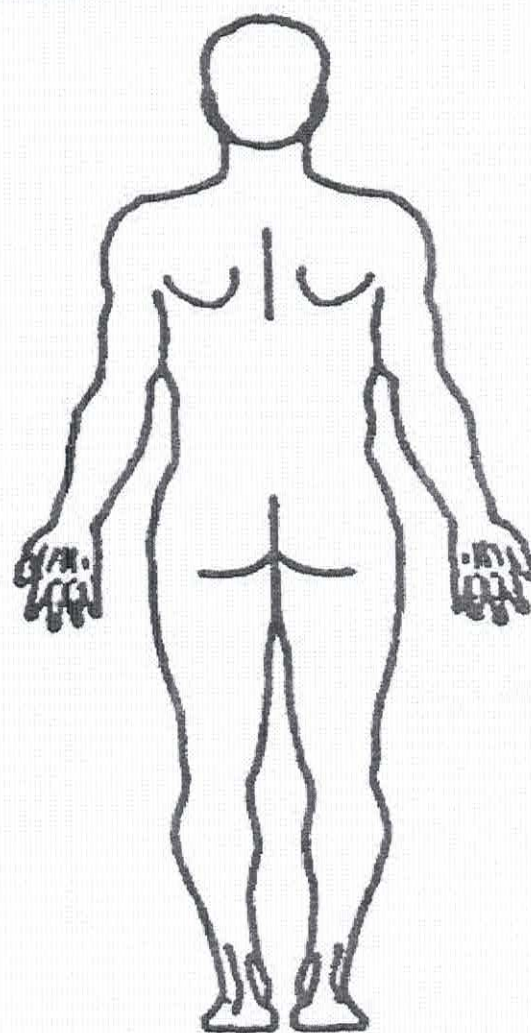
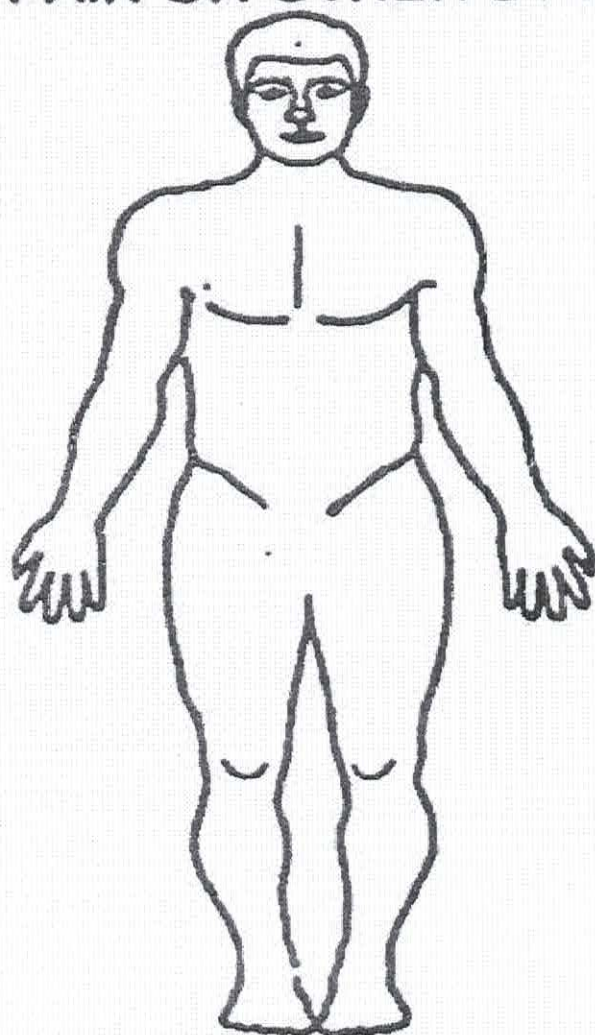
☐ Appendicitis	☐ Blood clots	☐ Heart disease	☐ Mononucleosis	☐ STD's
☐ Alcoholism	☐ Bronchitis	☐ Headaches	☐ Multiple sclerosis	☐ Stroke
☐ Allergies	☐ Chicken pox	☐ Hepatitis	☐ Mumps	☐ Thyroid disorder
☐ Antibiotic use	☐ Cancer	☐ Herpes	☐ Nervous disorder	☐ Tuberculosis
☐ Appendicitis	☐ Diabetes	☐ Hypertension	☐ Osteoporosis	☐ Vascular disease
☐ Arthritis	☐ Depression	☐ IBS	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Emphysema	☐ Jaundice	☐ Parasites	☐ Other _____
☐ Birth trauma	☐ Gall bladder disorder	☐ Kidney disorder	☐ Phlebitis	
☐ Bleeding disorder	☐ Glaucoma	☐ Liver disorder	☐ Pneumonia	
	☐ Gout	☐ Measles	☐ Seizures	

First Name _____

Last Name _____

date: ____ / ____ / 2021

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



Ache ^ ^ ^ ^	Numbness = = = =	Pins & Needles 0 0 0 0	Burning X X X X	Stabbing / / / /

Please indicate the pain locations on model's body and the numb between 0 and 10 that best describes your pain.

A) Pain location: _____ Pain intensity: _____ (1 – 10, 10 is unbearable) Pain frequency: Occasional/Intermittent/Frequent/Constant _____ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: _____ (%)	B) Pain location: _____ Pain intensity: _____ (1 – 10, 10 is unbearable) Pain frequency: Occasional/Intermittent/Frequent/Constant _____ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: _____ (%)
C) Pain location: _____ Pain intensity: _____ (1 – 10, 10 is unbearable) Pain frequency: Occasional/Intermittent/Frequent/Constant _____ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: _____ (%)	D) Pain location: _____ Pain intensity: _____ (1 – 10, 10 is unbearable) Pain frequency: Occasional/Intermittent/Frequent/Constant _____ (? times/per day/week) Dull / Sharp / Dull to Sharp Range of motion: _____ (%)

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 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 a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages 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, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at <https://www.namadr.com> or by calling 1-800-358-2550 to request a copy of the rules.

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

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

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

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

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

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

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

PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE:

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE