COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

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 recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient		Parent / Guardian		Witness	
Signature:	_____	Signature	_____	Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

PATIENT INFORMATION
(Please Print)

PERSONAL INFORMATION

Patient's Name: _____ Sex: ___M ___F
Last First Middle

Date of Birth ____/____/____ Marital Status: ___ Single ___Married ___ Divorced ___Others Occupation _____

Address _____ City _____ Zip _____

E-mail _____ Home Tel _____ Work Tel _____ Mobile _____

Employer _____ Tel _____

Address _____ City _____ Zip_____ Fax _____

Emergency Contact Name _____ Relationship _____
Last First Middle

Address _____ City _____ Zip _____ Phone _____

Work Related Injury _____ Yes _____ No **Personal Related Injury** _____ Yes _____ No **Date of Injury** ____/___/___

INSURANCE INFORMATION

Primary Carrier_____ **Secondary Carrier** _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____ Fax _____ **Claim No** _____

IF SOMEBODY OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW.

Insured's Name: _____ Sex: ___M ___F SS# _____/_____/_____
Last First Middle

Relationship to Patient _____ Spouse _____ Child _____ Other **Date of Birth** _____/_____/_____

Address _____ City _____ Zip_____ Phone _____

ATTORNEY INFORMATION

Attorney Name _____ Law Firm _____

Address _____ Phone _____ Fax _____

ASSIGNMENT OF BENEFITS

I hereby understand and agree to assign the full insurance benefit payments to which I am entitled directly to the provider. **This assignment may not be superseded by any other claim for assignment of benefits and may only be revoked in a writing signed by both assignor and assignee**. A photocopy of this authorization is accepted with the same authority as the original.

FINANCIAL AGREEMENT

I understand that I/we are personally responsible for all services rendered in our office and that all fees are charged directly to me/we (except Worker' Compensation). In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

I have fully read, understood and agree with the terms contained in this agreement and having no questions provide my signature.

Patient/Guardian Signature:_____ Today's Date: _____

INITIAL PATIENT VISIT FORM

Patient Name: _____ Date: ____/____/____

Please provide the following medical information to the best of your ability.

What problems are you here for today?	List any allergies to medications:

Past Medical History:

1. Please check the "Yes" or No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes	☐	☐	_____	Stomach or intestinal problems	☐	☐	_____
Hypertension (high blood pressure)	☐	☐	_____	Allergy problems/therapy	☐	☐	_____
Thyroid problems	☐	☐	_____	Kidney problems	☐	☐	_____
Heart disease/cholesterol problems	☐	☐	_____	Neurological problems	☐	☐	_____
Respiratory problems	☐	☐	_____	*Reproductive problems*	☐	☐	_____
Bleeding disorder	☐	☐	_____	Other medical diagnosis	☐	☐	_____

2. Please list any operations (and dates) you have ever had (including tonsils and adenoids):

3. Please list any current medications:

4. Pleases check any of the treatment you have had for your current problem(s):

☐ *Physical Therapy* ☐ *Chiropractic* ☐ *Nerve Block* ☐ *Massage* ☐ *Traction* ☐ *Others:* _____

Social History:	Yes	No	**Please list details below**
Do you smoke? List how much?	☐	☐	_____
If no, did you smoke previously?	☐	☐	_____
Do you drink alcohol? List how often?	☐	☐	_____

Family History:

1. Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.
   If yes, please indicate which relative(s) have the problems.

	Yes	No	
Heart problems/murmurs	☐	☐	_____
Allergy	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Bleeding disorder	☐	☐	_____
Anesthesia problems	☐	☐	_____

Review of Systems:

1. **Please check the "Yes" or "No" box to indicate if you have any of the following symptoms.**
2. **For any "Yes" response, please check the "current" box if this symptom relates to the reason for your visit today.**

		Yes	No	Current		Yes	No	Current
GENERAL	Chills	☐	☐	☐	Fever	☐	☐	☐
	Fatigue	☐	☐	☐	Weight gain/ loss	☐	☐	☐
	Insomnia	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ALLERGY	Environmental allergy	☐	☐	☐	Sneezing fits	☐	☐	☐

INITIAL PATIENT VISIT FORM

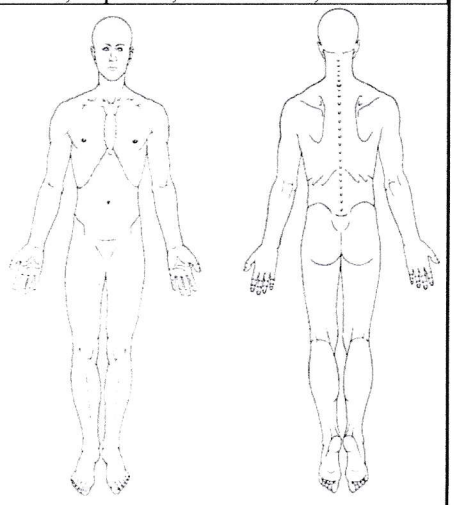
Patient Name: _____ WT: _____ HT: _____ Date: ____/____/_____

		Yes No	Current		Yes No	Current
EYES	Eye pain/pressure	☐ ☐	☐	Vision changes	☐ ☐	☐
ENT	Hearing loss	☐ ☐	☐	Ear noises	☐ ☐	☐
	Dizziness	☐ ☐	☐	Lightheadedness	☐ ☐	☐
	Nasal congestion	☐ ☐	☐	Sinus pressure or pain	☐ ☐	☐
	Hoarseness	☐ ☐	☐	Problem snoring, apnea	☐ ☐	☐
	Throat clearing	☐ ☐	☐	Throat pain	☐ ☐	☐
RESPIRATORY	Cough	☐ ☐	☐	Coughing blood	☐ ☐	☐
	Wheezing	☐ ☐	☐	Shortness of breath	☐ ☐	☐
CARDIAC	Chest pain	☐ ☐	☐	Palpitations	☐ ☐	☐
	Wake short of breath	☐ ☐	☐	Ankle swelling	☐ ☐	☐
GASTROINTESTINAL	Difficulty swallowing	☐ ☐	☐	Heartburn	☐ ☐	☐
	Stomachache	☐ ☐	☐	Adnominal pain	☐ ☐	☐
	Poor appetite	☐ ☐	☐	Thirsty/drink lots of water	☐ ☐	☐
	Constipation	☐ ☐	☐	Diarrhea	☐ ☐	☐
	Nausea/vomiting	☐ ☐	☐	Rectal bleeding	☐ ☐	☐
URINARY	Frequent urination	☐ ☐	☐	Painful urination	☐ ☐	☐
	Blood in urine	☐ ☐	☐	Prostate problems	☐ ☐	☐
HEMATOLOGY/	Swollen glands	☐ ☐	☐	Night/Daytime Sweating	☐ ☐	☐
LYMPHATIC	Bleeding problems	☐ ☐	☐	Easy bruising	☐ ☐	☐
ENDOCRINOLOGY	Feel warmer than others	☐ ☐	☐	Feel cooler than others	☐ ☐	☐
SKIN	Rash	☐ ☐	☐	Hives	☐ ☐	☐
	Itching	☐ ☐	☐	Skin or hair changes	☐ ☐	☐
GYNECOLOGY	Menstrual Pain	☐ ☐	☐	Early/Late/No Period	☐ ☐	☐
(FEMALE ONLY)	Pregnant	☐ ☐	☐	No Period	☐ ☐	☐
	Menopausal	☐ ☐	☐	Prolonged Period	☐ ☐	☐
PSYCHOLOGY	Depression	☐ ☐	☐	Anxiety or panic	☐ ☐	☐

If you have any pain and related condition(s), please check the appropriate boxes below and mark on the figure.

Location of Pain	Level (1-10)	Constant/ intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/ Tingling	Spasms	Weakness
Headache		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Jaw		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Middle back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower back		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Chest		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulders		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Arm		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Elbows		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Forearm		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Wrists		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Hands		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Buttocks		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Hip		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Thighs		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Knees		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Legs		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Ankles		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐
Foot		☐ / ☐	☐	☐	☐	☐	☐	☐	☐	☐

Please mark your conditions on the figure below
Pain: *X*, Spasm: S, Numbness: *N*, Weakness: W



Reviewed by:

Dragon Acupuncture & Herb Center Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Communications: We may use or disclose your health information to provide you with appointment reminders, payments, EOBs, (such as voicemail messages, text, emails or letters).

Change of Ownership. In the event that our business is sold or merged with another organization, your health information/record will become the property of the new owner.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.2 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Min Shi, Ph.D., L.Ac.
Telephone: (949)727-0898 Fax: (888)682-8119, E-mail: dragonacupuncture@hotmail.com

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

AAC-FED A2004

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 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.

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. 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.

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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

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