BLUE JASMIN ACUPUNCTURE, HERBS & YOGA
KRYSTAL PEARSON L.AC. / 805.701.3369
921 East Main Street Suite M, Ventura, CA 93001
www.bluejasminacupuncture.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. HOW WE MAY USE AND SHARE HEALTH DATA ABOUT YOU:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. DISCLOSURES WHERE WE DO NOT HAVE TO GIVE YOU A CHANCE TO AGREE OR OBJECT:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. DISCLOSURES WHERE WE HAVE TO GIVE YOU A CHANCE TO AGREE OR OBJECT:

a) Client directories - You can decide what health data, if any, you want to be listed in client directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. OTHER USES OF HEALTH DATA: OTHER USES NOT COVERED BY THIS NOTICE OR THE LAWS THAT APPLY TO US WILL BE MADE ONLY WITH YOUR WRITTEN CONSENT.

V. YOU HAVE THE FOLLOWING RIGHTS RELATING TO THE HEALTH DATA WE KEEP ABOUT YOU:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of Client or Representative _____ Date _____ Print Client Name _____ Client Birth Date _____

BASIC INFORMATION

First/Middle Name: Last Name:

Address: (Street, City, State, ZIP) ☐ Is it okay to send coupons, birthday cards, etc.?

Phone Number: Alt. Phone:

E-mail Address: ☐ Subscribe for special promotions & discounts

Age: Date of Birth: Sex: ☐ M ☐ F ☐ Non-Binary Marital Status: ☐ M ☐ S ☐ D ☐ W

Occupation: Employer:

Employer Address:

MINORS: List Parent Names & Addresses

CASE HISTORY

Chief Complaint:

Accident / Injury / Other: Incident Date: Have you seen another doctor? ☐ Y

If yes, when?

Doctor's Name: Address:

EMERGENCY CONTACT

Emergency Contact:

Relationship to You: Phone:

Address:

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.

Client Signature Date How did you hear about us?

(Parent Signature if client is a minor)

CLIENT HEALTH HISTORY

First & Last Name: Sex: M F Date of Birth:

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the client physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

When and where did you last receive healthcare? Have you had acupuncture before? Y N

For what reason?

Please identify the health concerns that have brought you to the acupuncture clinic in order of importance below:

CONDITION: **PAST TREATMENT:**

A.

How does this condition affect you?

B.

How does this condition affect you?

C.

How does this condition affect you?

D.

How does this condition affect you?

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

(Females) Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?

Do you have any infectious diseases? Y N If so, please identify?

FAMILY HISTORY

Check those applicable:

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILDREN
Age (if living)						
Health (G=Good, P=Poor)						
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Asthma/Hay fever/Hives	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Age (at death)						
Cause of Death						

Height: Current Weight: Past Maximum: When:

Blood Pressure: What is your most recent blood pressure reading? When was this reading taken?

Hospitalizations & Surgeries:

REASON:	WHEN:

X-Rays / CAT Scans / MRI's / NMR's / Special Studies:

REASON:	WHEN:

Please check any that you experience now and any that you have experienced in the past

EMOTIONAL

- ☐ Mood Swings
- ☐ Nervousness
- ☐ Mental Tension
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder

ENERGY & IMMUNITY

- ☐ Fatigue
- ☐ Slow Wound Healing
- ☐ Chronic Infections
- ☐ Chronic Fatigue Syndrome

HEAD / EYE / EAR / NOSE / THROAT

- ☐ Impaired Vision
- ☐ Eye Pain / Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness / Redness
- ☐ Headaches
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ Teeth Grinding
- ☐ TMJ / Jaw Probelms
- ☐ Hay Fever

RESPIRATORY

- ☐ Pneumonia
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Ashtma
- ☐ Tuberculosis
- ☐ Shortness of Breath

Please check any that you experience now and any that you have experienced in the past

CARDIOVASCULAR

- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Swelling of Ankles
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Palpitations/Fluttering
- ☐ Stroke
- ☐ Heart Murmurs
- ☐ Rheumatic Fever
- ☐ Varicose Veins

GASTROINTESTINAL

- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea/Vomitting
- ☐ Abdominal Pain
- ☐ Passing Gas
- ☐ Heartburn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis B or C
- ☐ Hemorrhoids
- ☐ IBS

GENITO-URINARY TRACT

- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Impaired Urination
- ☐ Blood in Urine
- ☐ Frequent Urination at Night
- ☐ STDs

FEMALE REPRODUCTIVE

- ☐ Irregular Cycles
- ☐ Breast Lumps/Tenderness
- ☐ Nipple Discharge
- ☐ Heavy Flow
- ☐ Vaginal Discharge
- ☐ Premenstrual Problems
- ☐ Clotting
- ☐ Bleeding between Cycles
- ☐ Menupausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Painful Periods
- ☐ Morning Sickness

Age of First Menses ☐
# of days of Menses ☐
Length of Cycle ☐
Birth Control Type ☐
# of Pregnancies ☐
# of Miscarriages ☐
# of Abortions ☐
# of Live Births ☐

MALE REPRODUCTIVE

- ☐ Sexual Difficulties
- ☐ Prostate Problems
- ☐ Testicular Pain/Swelling
- ☐ Penile Discharge

MUSCULOSKELETAL

- ☐ Neck/Shoulder Pain
- ☐ Muscle Spasms/Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Sciatica
- ☐ Joint Pain

If so, where? ☐

NEUROLOGIC

- ☐ Vertigo/Dizziness
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy

ENDOCRINE

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Mellitis
- ☐ Night Sweats
- ☐ Feeling Hot or Cold

Other

- ☐ Anemia
- ☐ Cancer
- ☐ Rashes/Eczema/Hives
- ☐ Cold Hands/Feet
- ☐ Autoimmune Disorders

LIFESTYLE

Do you typically eat at least three meals per day? ☐ Y ☐ N If no, how many? ☐

Exercise Routine: ☐

Spiritual Practice: ☐

How many hours per night on average do you sleep? ☐ Do you wake up feeling rested? ☐ Y ☐ N

How much education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

Occupation: ☐ Employer: ☐

Do you enjoy work? ☐ Y ☐ N Why/Why not? ☐

Nicotine/Alcohol/Caffeine use: ☐ How many 8oz glasses of water do you drink a day? ☐

Television Habits: ☐ Reading Habits: ☐

Any major physical or emotional traumas? ☐ Y ☐ N Explain: ☐

Interests & Hobbies: ☐

Do you use essential oils? ☐ Y ☐ N Are you interested in taking herbs? ☐ Y ☐ N

FINANCIAL POLICY

Initial Consultation & Acupuncture Session (90 mins) | $175

Follow-up Acupuncture Sessions (60 mins) | $125

Relaxation Acupuncture Session (90 mins) | $150

Fire Cupping Treatment (30 minutes) | $85

Deep Meditation Integration Acupuncture Session (120 mins) | $185

Telehealth Remote Session (30 mins) | $95

Private Yoga Session (90 mins) | $175

Acupuncture Housecalls | $225 for new clients & $175 thereafter- for Ventura only.
(Additional fees apply for other cities.)

Fees are payable by cash, check or credit card at the time that services are rendered.

If a check is returned, you will be charged a $25 fee.
Please be courteous and respectful of other clients who are waiting for appointments and cancel 24 hours in advance of your scheduled appointment time to avoid charges.

If you miss an appointment without cancelling 24 hours in advance, you will be charged the entire fee for the scheduled appointment. Thank you for understanding.

Client Signature
(Parent Signature if client is a minor)

Date

Printed Name

We are located on the second floor of the Beachside Business Center. The address is 921 East Main Street Suite M near the cross street Kalorama. There is a parking lot for your convenience. Our Suite is the third door on the left once you get to the top of the stairs The building is located right next door to Ventura Locksmiths. We unfortunately do not have a waiting area. Please arrive right at your scheduled appointment time and have a seat on the bench outside of the office. I will be out to greet you when i finish with the previous client. Thank you & we look forward to seeing you soon!

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 California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide 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) 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 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 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 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