Health Medicine Center
PATIENT REGISTRATION INFORMATION

1620 Riviera Ave., Walnut Creek, CA 94596 Phone: 925-935-7500
Fax: 925-935-7770 www.healthmedicinecenter.net

Last Name: First Name: Middle Initial: DOB:

Address: City: State: Zip:

Primary Phone: Secondary Phone: Driver's License#:

Soc SS#: E-mail: Best way to contact you:

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Other Employer:

Occupation: Emergency Contact Name: Phone:

Primary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please continue below)

Soc SS#: Relationship: Birth Date:

Secondary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please continue below)

Soc SS#: Relationship: Birth Date:

WE WILL ASK TO MAKE A COPY OF YOUR DL AND INSURANCE CARDS AT THE TIME OF YOUR FIRST VISIT

CONSENT FOR CARE

I, _____ hereby grant permission to the practitioners of Health Medicine Center (HMC) to perform examinations and therapeutic services, and discuss modalities & options that are considered necessary or advised for my diagnosis and care. I understand that the nature of the recommended treatments for my care will be explained to me. I can choose to comply with or deny any treatment. Practitioners who may treat me include, but are not limited to: medical doctors, nutritionists, acupuncturists, body workers, psychologists, nurses, and chiropractors. I understand that the chart of my treatments will be kept confidential under strict HIPAA rules. I authorize the practitioners of HMC to keep a collective record, which may be discussed by practitioners who have provided or may provide care for me. I further understand that I may view my medical record at any time.

AUTHORIZATION TO RELEASE INFORMATION: Health Medicine Center will release all necessary information in order to process any claims to insurance companies when requested by me, or mandated by Medicare. I understand that no personal or medical information will be released without my prior authorization and signature, unless it is requested through a subpoena.

_____ _____

Print Name of Patient Signature of Patient Date:

_____ _____

Print Name of Parent / Guardian Signature of Parent / Guardian Date:

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

1620 Riviera Ave., Walnut Creek, CA 94596, Phone: 925-935-7500, Fax: 925-935-7770, www.healthmedicinecenter.net

PLEASE INITIAL BELOW

_____ Emergencies: Our staff will make every effort to receive calls and respond promptly to any emergency during regular business hours. Dr. Saputo can also be reached via e-mail at drlen@doctorsaputo.com from 9 AM to 10 PM every day of the week. If you do not receive an immediate response, please call 911, or go to the nearest emergency room.

_____ Appointments: HMC requires a minimum of 24 hours notice to cancel or reschedule an appointment as a courtesy to other patients. Fees will be charged for missed or late appointment cancellation without 24 hours notice. This is calculated at 50 % of the regular fee of the time scheduled. A pattern of missed appointments may result in discharge from the practice.

_____ Telephone Consultations: Telephone consultations are available for most conditions, except for new illnesses and symptoms that require physical examinations. Phone consultations will be charged per time needed and require credit card payment via phone. There is no insurance billing for phone consultations.

_____ Financial Responsibility: The patient or responsible party will accept financial responsibility for all charges, whether or not paid by insurance. This includes all services rendered on my behalf or my dependants.

_____ Payment methods: HMC accepts cash, checks, Visa, and MasterCard.

_____ Medical records: The patient's medical record is the property of the practice. Copies of pertinent medical information are available upon 3-day prior request at a fee of $15.00. Records will be kept for the duration of time required by law.

_____ HMC has no contract with any insurance company. As such, HMC does not recognize a specific carrier's use of terms, co-payments, deductibles, or coinsurance. Patients are expected to pay full fees at the time of visit.

I acknowledge that the above information is true and correct. I have read and understand all the terms of this policy and by my initials above and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Print Name of Patient Signature of Patient Date:

HIPAA Policy Acknowledgment

Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

You have the right to determine whether detailed messages may be left, including any protected health information, on the phone numbers of your choice. Please provide the following numbers where we can reach you and a decision as to whether or not a message may be left.

Primary Phone: _____ Confirm Appointments OK? YES NO
Detailed Message OK? YES NO

Secondary Phone: _____ Confirm Appointments OK? YES NO
Detailed Message OK? YES NO

E-mail: _____ Confidential Information OK? YES NO

Other person authorized to share your medical information: _____

Relationship to patient: _____ Phone: _____

I have read the Privacy Notice and understand my rights presented in the notice.

By way of my signature, I provide the Health Medicine Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____ _____
Patient's Name (print) **Patient's Signature** **Date**

_____ _____
Authorized Facility Signature **Date**

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reason:

6 year consent form / must be updated if not seen in a 2 year period

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Updated 11-1-17

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 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.

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 bind 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 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 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 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 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 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 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 A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

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

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

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 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, 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 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 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.

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 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.

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT INTAKE FORM – ACUPUNCTURE

Patient Name: _____ **Date:** ___/___/ 2012 **DOB:** _____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Treatment #: _____

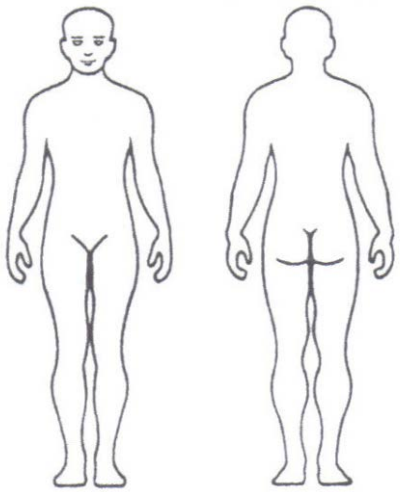
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

_____

_____



CURRENT COMPLAINT I_____I
(HOW YOU FEEL TODAY): 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

IF THIS IS A FOLLOW UP VISIT, ANY CHANGES AFTER LAST TREATMEN?:

_____

_____

CURRENT COMPLAINT I_____I
(HOW YOU FEEL TODAY): 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

PLEASE MARK ANY AREAS OF PAIN OR CONCERNS.

RATE / DESCRIBE THE FOLLOWING:

APPETITE: _____ DIGESTION: _____ STOOL: _____ URINATION: _____

HOT/COLD: _____ EXERCISE: _____ SWEAT: _____ THIRST: _____

SLEEP: _____ EMOTIONS: _____

MENSES – LMP: _____ DAYS IN CYCLE: _____ COLOR: _____ PAIN: _____ PMS: _____ PREG._____

MDs /OTHER's DIAGNOSIS: _____ ,_____, _____ MEDICATIONS: _____

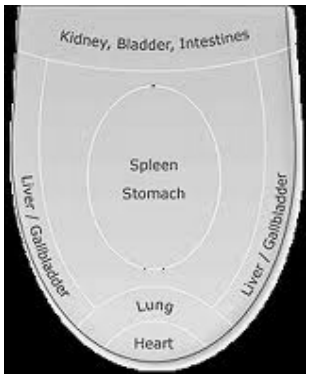
_____ SUPPLEMENTS: _____

INTAKE BY PRACTIONERS:

COLORS, SOUNDS, SMELLS, GAIT, SPIRIT: _____

PULSE – OVERALL QUALITY: _____ RIDE SIDE: DISTAL _____ MIDDLE _____ PROXIMAL _____
LEFT SIDE: (CUN) (GUAN) (SHI)

PHYSICAL EXAM: _____



_____

NEURO-MUSCULO-SKELETAL: _____

_____

LAB / IMAGING RESULTS: _____

_____

ASSESSMENT:

HEIGHT: _____ WEIGHT_____ BP:_____ /_____ P: _____ R:_____ TEMP: _____ PACEMAKER: _____

	OM DIAGNOSIS	OM DIFFERENTIAL DIAGNOSIS	SUPPORTING SYMPTOMS AND SIGNS
1)			
2)			
3)			

WESTERN ICD-9 DIAGNOSIS:

1) _____ #: _____ 2) _____#: _____

TREATMENT:

CURRENT TREATMENT PLAN: # VISITS: _____ OUT OF_____ FREQUENCY: _____TIMES / _____

TREATMENT PLAN GOAL: _____ % IMPROVEMENT IN REGARDS TO: _____

OM TREATMENT PRINCIPLE(S): _____

ACUPUNCTURE / MOXA / CUPPING / MASSAGE: (POINTS, MODALITIES USED, REASONING):

_____

_____

_____

_____

HERBAL FORMULAS, SUPPLEMENTS (FORMULA / HERB NAME(S), DOSAGE, ADMINISTRATION, REASONING):

_____

_____

DIETARY & LIFESTYLE RECOMMENDATIONS:

_____

LAB / IMAGING ORDERS: _____

CPT CODES:

1) _____ #: _____ 2) _____#: _____

REFERRALS TO OTHER HEALTHCARE PROVIDERS: _____

CLINIC INSTRUCTOR'S NOTES: _____

Dr. Marcia Straehley Stone, LAc, PhDc, Hypnotherapy
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