NATURAL SOLUTIONS ACUPUNCTURE INC.

2530 VISTA WAY F108
OCEANSIDE, CA 92054
(760) 435-9390

11848 BERNARDO PLAZA COURT #100
SAN DIEGO, CA 92128
(619)892-8611

PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birth date _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

_____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work phone_____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

c Diabetes c High blood pressure c Stroke
c Cancer c Heart disease c Kidney disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

How long has it been since you have had a complete medical exam? _____

HEALTH HISTORY…CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors / Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms or Hips
- □ Back Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

FOR WOMEN ONLY

- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant?_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____

NATURAL SOLUTIONS ACUPUNCTURE INC.

PROVIDER: MICHAEL WOODWORTH L.AC, D.OM
Full Body A.R.T. Provider

FINANCIAL POLICY

PRICING IS DETERMINED BY THE HANDS-ON TIME REQUIRED BY THE PROVIDER TO RENDER CARE AND NOT THE TOTAL TREATMENT TIME ITSELF. PLEASE UNDERSTAND THAT CASH AND INSURANCE PRICES DO DIFFER. INSURANCE COSTS ARE APPROXIMATELY 20% HIGHER DUE TO ADDITIONAL COSTS IN OUTSID SERVICES, TIME INVOLVED IN PROCESSING CLAIMS AND RECEIVING PAYMENT.

WE OFFER SEVERAL METHODS OF PAYING FOR YOUR CARE:

SELF-PAY. PAYMENTS ON ALL ACCOUNTS WITHOUT INSURANCE ARE DUE AT THE TIME OF SERVICE UNLESS YOU MAKE OTHER ARRANGEMENTS.

INSURANCE. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. WE DO, HOWEVER, BILL ALL PRIMARY INSURANCE AS A SERVICE TO OUR PATIENTS. AS A COURTESY TO OUR PATIENTS, WE WILL ALSO BILL SECONDARY INSURANCES ONE TIME.

YOUR COPAY WILL BE DO AT THE TIME OF YOUR VISIT AS WILL THE CASH PRICE OF YOUR TREATMENT IF YOU HAVE ANY REMAINING DEDUCTIBLE.

I have and read and understand the above policy listed: Initial _____

WE WILL EXTEND CREDIT FOR 45 DAYS ON APPROVED INSURANCE COMPANY BENEFITS IF SUCH BENEFITS ARE ASSIGNED TO THE CLINIC AND IF THE CLINIC HAS SUFFICIENT INFORMATION TO VERIFY COVERAGE AND SUBMIT A PROPER CLAIM**.**
AFTER 45 DAYS IF YOUR INSURANCE HAS NOT PAID YOUR ACCOUNT IN FULL WE REQUIRE THAT YOU PAY THE BALANCE.

I have and read and understand the above policy listed: Initial _____

EACH INSURANCE COMPANY HAS ITS OWN METHOD OF DETERMINING HOW MUCH THEY WILL PAY ON EACH CLAIM. PLEASE CONTACT ONE OF OUR RECEPTIONISTS OR BUSINESS OFFICE STAFF IF YOU HAVE QUESTIONS REGARDING THE INSURANCE COMPANIES WITH WHICH WE PARTICIPATE. WE DO ACCEPT PERSONAL INJURY AND WORKMAN'S COMPENSATION CLAIMS.

LIABILITIES. WE WILL EXTEND CREDIT FOR 45 DAYS ON LIABILITY ACCOUNTS ONLY IF WE HAVE THE NECESSARY INFORMATION TO EXERCISE OUR THIRD PARTY LIEN RIGHTS. IF YOU CANNOT PROVIDE THIS INFORMATION, YOUR ACCOUNT IS DUE AT THE TIME OF SERVICE UNLESS YOU HAVE MADE OTHER ARRANGEMENTS WITH A SPECIALIST IN OUR BUSINESS OFFICE. LIENS ARE TREATED AS INSURANCE CASES AND SHALL BE CHARGED UNDER THE INSURANCE FEE SCHEDULE.

I have and read and understand the above policy listed: Initial _____

CREDIT OPTIONS AVAILABLE THROUGH THE CLINIC. · WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. WE WILL REQUIRE A VALID CREDIT CARD BE KEPT ON ACCOUNT TO BE **AUTOMATICALLY CHARGED ON EITHER THE 1ST OR 15TH** OF THE MONTH FOR THE AMOUNT DUE.

I have and read and understand the above policy listed: Initial _____

IN RESPECT FOR OUR INTENTION TO OFFER HIGH QUALITY HEALTH CARE AT AFFORDABLE PRICES, WE ASK THAT YOU SCHEDULE 24 HOURS IN ADVANCE. WE ALSO ASK THAT IF IT IS NECESSARY TO CANCEL OR RESCHEDULE YOUR APPOINTMENT THAT YOU DO SO WITHIN 24 HOURS. THE TIME YOU SCHEDULED WAS RESERVED FOR YOU, IF YOU SHOULD FAIL TO KEEP THE APPOINTMENT IT NOT ONLY PREVENTS ANOTHER PERSON FROM RECEIVING CARE, BUT ALSO PREVENTS THE PRACTITIONER FROM UTILIZING THAT TIME PRODUCTIVELY.

ALL APPOINTMENTS THAT ARE RESCHEDULED OR CANCELLED WITH LESS THAN 24 HOUR ADVANCE NOTICE, AND **APPOINTMENTS MISSED WITHOUT 24 HOURS NOTICE, WILL BE CHARGED A $50 FEE FOR THAT APPOINTMENT**.

I have and read and understand the above policy listed: Initial _____

THANK YOU FOR YOUR UNDERSTANDING.

BY SIGNING BELOW YOU ACKNOWLEDGE UNDERSTANDING OF THE ABOVE AND AGREE TO THESE TERMS IN THE ADMINISTERING OF YOUR CARE.

SIGNATURE _____ DATE ___/___/_____

PRINTED NAME _____

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.

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 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 back-up for 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 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, 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 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

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 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)

Natural Solutions Acupuncture Inc.

INFORMED CONSENT AND DISCLOSURE

Provider: Michael Woodworth LAc

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the Provider of Acupuncture Services named above and/or other Provider of Acupuncture Services who may treat me. I understand that the Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the Provider of Acupuncture Services to exercise judgment during the course of the procedure, which the Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment

- Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- Traditional Chinese Herbal Supplements recommended are traditionally considered safe. However, some patients may experience gastro intestinal upset or other reactions to the herbs. I will inform the Acupuncture Provider immediately if I experience any side effects. I understand that some herbs may be inappropriate during pregnancy. I understand that I am fully responsible to inform the Acupuncture Provider of any discomfort related to the use of herbal supplements. Some herbs may be inappropriate during pregnancy. I accept full responsibility to Inform the Acupuncture Provider of a suspected or confirmed pregnancy, or if I am a nursing mother.
- Active Release Techniques / Acupressure/ Tui-Na involves rubbing, kneading, pressing, and stroking, etc. • which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- Indirect Moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact. But the possibility of skin contact and mild burns exists.
- Cupping involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- Gua Sha involves scraping over a small area by using smooth-edged instruments. There is a possibility that local bruising is likely to occur at the site where it is performed and typically lasts 3-5days.
- Tapping, Plum Blossom, Bleeding, Pricking all Involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- Electrical Stimulation/TENS uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- Treatment Using Control Points Ren 1/Du 1. In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my Provider of Acupuncture Services or an Acupuncture Clinical Services Manager may need to contact my medical physician when the Provider of Acupuncture Services have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke. pain/nausea related to cancer/tumor, chemotherapy related nausea; pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best Interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to my provider to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to the provider to contact my child's medical doctor if/when necessary

Patient Name (print) _____ Date: _____

Patient Signature _____