Welcome

The Living Point
Oriental Medicine and Acupuncture

Patient Information

Patient Name
Address:
City: State: Zip
Gender: ☐M ☐F Age: Birth Date:
☐Single ☐Married ☐DP ☐Separated ☐Widowed ☐Divorced
Patient SS#:
E-Mail Address:
Occupation:
Employer:
Employer Address:
Employer Phone:
Spouse's Name:
Spouse's Birth Date: SSN:
Spouse's Occupation:
Spouse's Employer:
Who may we thank for referring you?

Insurance

Who is responsible for this account?
Relationship to Patient:
Insurance Co.
Subscriber #
Is Patient covered by additional insurance? ☐Yes ☐No
Subscriber's Name:
Subscriber Birth Date: SS#:
Subscriber Relationship to Patient
Insurance Co.
Subscriber #

Accident Information

Is condition due to an accident? ☐Yes ☐No
Type of accident: ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other:
Attorney Name (if applicable):
Attorney Phone: Fax:

Phone Numbers

Home:
Work: Ext:
Cell:
Best time and place to reach you:

Emergency Information

IN CASE OF EMERGENCY, CONTACT:
Name:
Relationship: Home Phone:
Work Phone: Ext.:
Cell Phone:

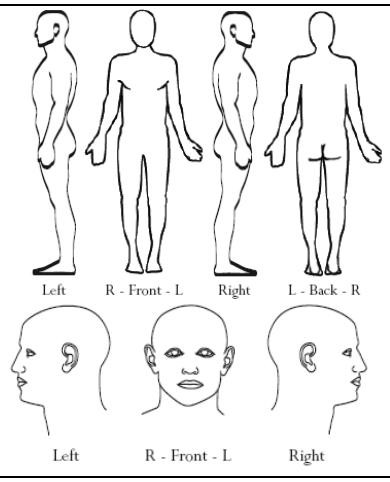
Patient Condition

Your Reason for this Visit:

When did your symptoms appear?

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other:

How often do you have the symptoms? _____ times per ☐ day ☐ week ☐ month ☐ Constantly ☐ Frequently ☐ intermittently ☐ occasionally

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other

Activities or movements that are painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other:

What treatment have you already tried for this condition? ☐None
☐MD / allopathic / Western medicine ☐Surgery ☐Medications ☐Chiropractic
☐Injections ☐ Physical Therapy ☐Naturopathic ☐ Other:

Name and phone of other practitioners who have treated you for your condition:

Date of Last: Physical Exam:	Blood Test:	Urine Test:	Spinal Exam:
Spinal X-Ray:	Chest X-Ray:	Dental X-Ray:	MRI/CT-Scan:

PATIENT NAME:	TODAY'S DATE:

Medical History

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

☐ Allergies	☐ Chronic Fatigue Syndrome	☐ High Blood Pressure	☐ Parkinson's disease	☐ Tonsillitis
☐ Anemia	☐ Diabetes	☐ High Cholesterol	☐ Pinched Nerve	☐ Tuberculosis
☐ Aneurysm	☐ Emphysema	☐ Kidney Disease	☐ Pleurisy	☐ Tumors/growths
☐ Appendicitis	☐ Epilepsy	☐ Liver Disease	☐ Pneumonia	☐ Typhoid Fever
☐ Arteriosclerosis	☐ Epstein Barr Virus	☐ Measles	☐ Polio	☐ Ulcers
☐ Arthritis ☐ Rheumatoid ☐ Osteo	☐ Fibromyalgia	☐ Migraine Headaches	☐ Prostate Problem	☐ Vaginal Infections
☐ Asthma	☐ Glaucoma	☐ Miscarriage	☐ Prosthesis	☐ Whooping Cough
☐ Bleeding Disorders	☐ Goiter	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other (specify below)
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	☐
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Stroke	☐
☐ Cancer	☐ Hepatitis ☐**B** ☐**C**	☐ Osteoporosis	☐ Seizures	☐
☐ Chicken Pox	☐ Herpes Zoster ("shingles")	☐ Pacemaker	☐ Thyroid disorders	☐

List any Injuries and/or Surgeries you've had	Date
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	

Exercise	Work Activity
☐ None	☐ Sitting
☐ Moderate	☐ Standing
☐ Daily	☐ Light Labor
☐ Heavy	☐ Heavy Labor

Habits	
☐ Smoking	Packs/Day:
☐ Alcohol	Drinks/Week:
☐ Coffee/Caffeine drinks	Cups/day:
☐ High Stress	Reason:

Medications	Allergies	Vitamins / Herbs / Minerals

I certify that the information on this 2-page form is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage.

Patient Signature: Date:

PATIENT NAME:	TODAY'S DATE:

Restricted Medical History

The following medical history information has additional restrictions placed upon its release to third parties, and will not be disclosed to others unless you explicitly authorize it or we are otherwise ordered by legal authorities to release it:

Please check any of the following conditions you currently have, or have had in the past:

Addictions ☐ **Yes** ☐ **No** If yes, too what substance? If you have stopped using this, when did you stop?
AIDS / HIV ☐ **Yes** ☐ **No** If Yes, Please give date of first diagnosis _____ and date of most recent lab work _____
Alcoholism ☐ **Yes** ☐ **No** If Yes, how long? Are you alcohol-free now? ☐ **No** ☐ **Yes:** since when?
Anorexia ☐ **Yes** ☐ **No**
Bulimia ☐ **Yes** ☐ **No**
Mental Health Disorder ☐ **Yes** ☐ **No** If Yes, please describe:
Suicide Attempt ☐ **Yes** ☐ **No** If Yes, how long ago?
Sexually Transmitted Disease(s) ☐ **Yes** ☐ **No** If yes, please indicate which ones and when they occurred ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Genital Warts / HPV ☐ NGU ☐ Syphilis ☐ Other
Domestic Violence or Abuse victim ☐ **Yes** ☐ **No**

Acupuncturist's Notes Regarding Information on this Page

Please leave the section below blank for your acupuncturist to fill out; these notes will also be restricted.

The Living Point
Acupuncture and Oriental Medicine
Drs. Conor and Zena Logan DACM, Dipl OM (NCCAOM), L.Ac.
Call / Voicemail / Text to 323-213-9220
Email: health@thelivingpoint.com | Website: www.thelivingpoint.com

2019 Clinic Policies

Welcome to The Living Point. We thank you for choosing us as the providers of your acupuncture and herbal health care.

In order to provide our patients with the highest quality health care in a timely and respectful manner, we ask that you adhere to the following policies.

Please initial acceptance to each item below:

_____ Let us know of any changes to insurance coverage since your last appointment.

_____ Cancelation policy: We require 24 hours notice for cancelation of your appointment. I understand I may be charged $65 for a missed or canceled appointment without 24 hours notice. Frequent cancelations may result in termination of treatment.

_____ Late patients will have less time for their appointment(s) and will be charged in full.

Patients 20 minutes or more late may have their appointment canceled. These instances are considered late cancellations and are subject to being charged the full fee for service.

_____ Financial terms: Upon verification of health plan/insurance coverage and policy limits, we will bill your insurance carrier for you. You will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment. Co-payments are to be paid at the time services are rendered.

_____Out of pocket expenses: Insurance plans vary and your policy may not cover all treatment modalities that we may prescribe for you. You are not required to pay for or accept any treatment that must be paid for out of pocket. We will discuss each treatment with you individually and why we recommend it and give you the option to opt in or out of the treatment(s). Rates are as follows:

- Cash rate: $150 for initial consultation and treatment, $95 per subsequent treatment.
- Cupping/gua sha: Cupping is rarely covered by insurance plans. The cost to add cupping to a treatment is $20.
- Electrical stimulation: Electric stimulation attached to acupuncture needles, in 15-minute increments (or fractions thereof) is $15.

- Herbal formulas: Patent herbal formulas are $25 per bottle. We can supply you with an itemized receipt to provide proof of purchase if you are using a health spending account. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened.

- Massage/Tui Na: These modalities may not be covered by your insurance plan. 15 minutes of massage or Tui Na treatment is $25.

_____ If a problem arises with collecting payment on an insurance claim, we will re-bill your insurance company. However, if the cost of collections become over and above what is usual and customary, we will contact you to arrange payment.

_____ There is a $35 fee for each returned check.

_____ Confidentiality: All information shared between you and your acupuncturist is held confidential under HIPAA compliance laws unless:

1. You authorize release of information with your signature (or that of parent/guardian.)
2. You present a danger to yourself or others, or child or elder abuse is suspected. We are required by law to inform potential victims and legal authorities so that protective measures can be taken.

____ **Expectations of Treatment**:

After examining you we formulate a differential diagnosis that is specific to you. We do not practice one-size-fits-all medicine. You can expect improvement in your health and/or pain with treatment over the course of the treatment period. How much improvement you experience is not only up to us, it's up to you and your level of compliance with our suggestions and strategies for you. Your health is a cooperative arrangement between you and us with you as the primary driver of change in your case. This specifically relates to coming to appointments as prescribed, compliance in taking herbal medications and, particularly, in implementing diet, exercise, and lifestyle practices as we recommend them. If you have questions or concerns about this, we are happy to discuss it with you.

_____ As a patient of The Living Point, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

Patient Name_____ Date_____

Signature _____

THE LIVING POINT ACUPUNCTURE AND ORIENTAL MEDICINE
Dr. Conor Logan DACM, Dipl OM (NCCAOM), L.Ac. Lic. No. AC16258
Dr. Zena Logan DACM, Dipl OM (NCCAOM), L.Ac.. Lic. No. AC17122
323-213-9220

The Living Point
Acupuncture and Oriental Medicine
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Informed Consent to Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, Gua Sha, Tui Na massage, electrical stimulation, and herbal therapy.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body. I am aware that certain adverse side effects may result. Potential risks include, but are not limited to: temporary bruising, swelling, bleeding, numbness and/or tingling, soreness at the needling site that may last a few days, and the possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks of acupuncture include dizziness, fainting, or nerve damage. Infection is possible, although this clinic uses alcohol and sterile, disposable needles, and maintains a safe and clean environment.
Moxibustion is the application of heat indirectly to the skin. Potential risks of moxibustion include burns, blistering, or scarring.

Electro-acupuncture: I understand that I may be asked to have electro-acupuncture administered with acupuncture treatment. I am aware that certain adverse side effects may result, including, but not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Herbs: I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic and some herbs are inappropriate during pregnancy. Some possible side effects of herbs include nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

Cupping/Gua Sha: I understand that cupping is performed by creating suction on the skin with a plastic or glass cup. I am aware that bruise marks may result with the treatment and that these marks will disappear in about a week. I understand that Gua Sha is the act of scraping the skin with a tool and oil which may also result in bruising or a red rash appearance which is considered a normal and desired result of this treatment.

Tui Na Massage: I understand that I may be given Tui Na massage as part of my treatment to modify or prevent pain perception, to normalize the body's physiological functions, and to enhance the effects of other treatments. I am aware that certain adverse side effects may result from this treatment including, but not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment.

Pregnancy: I will notify my acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that can induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing processes.

I understand that I can discuss risks and benefits further with my acupuncturist before signing this document, should I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on him or her to exercise their professional judgment in my best interest during the course of treatment, based upon the facts known at the time of care.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or course of treatments.

I understand that I may refuse any of the above mentioned treatments at any time.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.
By signing this form, I acknowledge any inherent risks and give my consent for treatment, payment, and healthcare operations received, incurred, or carried out at this practice.

X_____

Patient Signature (or parent or guardian signature) Date

PATIENT NAME:

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 or 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 o 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 the 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 provided 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 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 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 is (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.

PATIENT SIGNATURE (or patient Representative)	**X**	DATE:
	(indicate relationship if signing for patient)	
OFFICE SIGNATURE	**X**	DATE:

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