American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001 Fax: 877/248-2746

HEALTH STATUS
(Acupuncture)

For questions, please call ASH Networks at 888/226-8879

Patient Name _____ Birthdate _____ Sex M / F
Last First

Address _____ City _____ State _____ Zip _____

Subscriber Name:_____ Subscriber ID #: _____Group #:_____

Phone # (Home):_____Work #: _____Employer _____Occupation_____

Social Security #:_____ Primary Health Plan: _____ Patient/Member ID #: _____

2nd Health Plan:_____ Primary Care Physician: _____ PCP phone #: _____
(Required) (Required)

Please describe your current health problem(s):_____

How and When it began:_____

If you are undergoing acupuncture treatments, describe your progress: _____

☐ Worsened ☐ No change ☐ 25% improved ☐ 50% improved ☐ 75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? ☐Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

Are you currently under the care of a physician? ☐ No ☐ Yes, please explain _____

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) _____

Past	Present	
☐	☐	Alcohol/tobacco/drug dependence
☐	☐	Abnormal menstruation
☐	☐	Allergies
☐	☐	Angina
☐	☐	Arthritis/ rheumatoid arthritis
☐	☐	Artificial joints
☐	☐	Asthma
☐	☐	Blood disorder
☐	☐	Breast lumps
☐	☐	Cancer/tumor
☐	☐	Convulsions/seizures
☐	☐	Diabetes
☐	☐	Diarrhea/constipation
☐	☐	Excessive thirst
☐	☐	Fainting or dizziness
☐	☐	Fatigue

Past	Present	
☐	☐	Frequent urination
☐	☐	Headache
☐	☐	Heart attack
☐	☐	Heartburn or indigestion
☐	☐	High blood pressure
☐	☐	Hospitalizations/surgical procedures_____ _____
☐	☐	Kidney disease
☐	☐	Liver problems
☐	☐	Pacemaker
☐	☐	Painful menstruation
☐	☐	Palpitation/arrhythmia
☐	☐	Peptic ulcer
☐	☐	PMS
☐	☐	Pregnancy, months ____
☐	☐	Prostate problems
☐	☐	Rapid weight gain/loss

Past	Present	
☐	☐	Sinusitis
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	**Medications** _____ _____ _____
☐	☐	Other:_____ _____

If a family member has had any of the following, please mark the appropriate box and explain:

☐ Arthritis ☐ Lupus
☐ Cancer ☐ Mental disorders
☐ Heart disease
☐ Hypertension
☐ Other: _____ _____

Comments:_____

I certify that the above information is complete and accurate. 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. I understand that my ASH Networks Acupuncture Provider or an ASH Networks Clinical Services Manager may need to contact my PCP if my condition needs to be co-managed. Therefore, I give my authorization to ASH Networks to contact my medical doctor if necessary.

Patient signature: _____ **Date:** _____

Oasis Healing Arts, LLC

PATIENT CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Oasis Healing Arts, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Oasis Healing Arts, LLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. Oasis Healing Arts LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Oasis Healing Arts, LLC at 7028 Greenleaf Ave. Suite K, Whittier, CA 90602.

With my consent, Oasis Healing Arts, LLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory and exam results.

With my consent, Oasis Healing Arts, LLC may mail to my home or other designated location any items that assist the practice of carrying out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

I have the right to request that Oasis Healing Arts, LLC restricts how it uses or disclosures my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Oasis Healing Arts, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made that disclosure in reliance upon my prior consent. If I do not sign this consent, Oasis Healing Arts, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

If applicable, Print Name of Legal Guardian

Financial Agreement & Appointment Policy

We at Oasis Healing Arts would like to welcome you to our office and to assure you that you will be receiving the very best natural and holistic care for your condition. To familiarize you with the financial policies of our office, we would like to explain how medical bills and appointment changes will be handled.

Late Cancellations/ Missed Appointments

Your scheduled appointment is valuable time we purposefully arrange between you and your doctor. However, we understand that unplanned issues come up and you may need to cancel your appointment. If you are unable to keep your appointment, please call our office at least 24 hours ahead of time so that the appointment time can be made available to other patients who may desire / require care. **Failure to do so will result in a $30 late cancellation/ missed appointment fee.** Patients who cancel late or who miss **three or more appointments will be dismissed from the practice.**

(please initial) _____

Explanation of Insurance Coverage

Many insurance policies cover acupuncture care, but this office makes no representation that your insurance company does. Because of the variance in benefits from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, copayment/ coinsurance, and any unpaid balance in this office. Deductibles and co-payments/coinsurance are due at the time services are rendered unless other arrangements have been made in advance with the doctor.

Assignment of Benefits

" I hereby authorize payment of benefits by my health insurance carrier, _____, directly to Oasis Aealing Arts, LLC. A photocopy of this signature is as valid as the original. By signing below, I am authorizing the above."

Release of Information

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

I have read and agree to the above.

_____ _____

Patient's Signature Date

Oasis Healing Arts
7028 Greenleaf Ave. Suite K, Whittier, CA 90602
(562) 789-1588 www.OasisHealingForYou.com

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, 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 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, 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 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. 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 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 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 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.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

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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 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)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE