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. 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 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**

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

PATIENT INFORMATION FOR KAREN TAYLOR, L. Ac.

Date _____

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State ___ Zip _____
Phone (cell) _____ (home) _____ (work) _____ Ext _____
Occupation/Employer _____ Type of Work _____
Primary Care M.D. (name) _____ Phone _____
How did you hear about me? _____
Email_____
What is the main reason for your visit today? _____
_____
_____

Please describe what you hope to achieve with acupuncture and/or blood chemistry.
_____

What other therapies or activities are you using to help achieve your goals?
_____

Have you used Traditional Chinese Medicine for other ailments in the past? ____Yes ____No
If Yes, what ailments? _____
Did you get the results that you wanted?_____
How long did you undergo treatment before achieving your goals? _____

Please list anything else that you think may be important for me to know.
_____
_____

Please list any Herbs and Supplements you take now or regularly. List dosage if known.
_____
_____

MEDICATIONS Circle medication you now take: nerve pills muscle relaxers blood pressure insulin aspirin/similar morphine cortisone tranquilizers over-the-counter drugs antibiotics recreational drugs cholesterol meds other _____
How long have you been on this/these medications?_____
Are you experiencing any side effects? ___Yes ___No Please list_____
What are some stronger medications that you have used in the past?_____
Do you drink alcohol? ____ How much?_____ Do you smoke cigarettes? ____ How much? _____

-------- PLEASE CONTINUE ON OTHER SIDE --------

1200 High Street #110
Eugene, OR 97401

ADULT MEDICAL HISTORY

Surgeries that you've had as an adult (include cosmetic)_____
Hospitalizations_____
Major Illnesses _____
Injuries_____
Emotional Trauma_____
Other_____

CHILDHOOD MEDICAL HISTORY

Your mother's age at your birth? _____ Were you premature? _____ Cesarean? _____
Were you breastfed?_____ How many siblings do you have?_____
Overall, how was your health as a child?_____
_____
Were you ever hospitalized as a child?_____ At what age?_____
What for?_____
Please indicate Y (yes) or N (no) if you have or have ever had any of the following and specify age if known.

Yes/No		Age	Yes/No		Age
Y / N	Epilepsy	_____	Y / N	Mono	_____
Y / N	Pacemaker	_____	Y / N	Whooping Cough	_____
Y / N	Asthma	_____	Y / N	Pneumonia	_____
Y / N	Chickenpox	_____	Y / N	Broken bones	_____
Y / N	Tonsillitis	_____	Y / N	Head injuries	_____
Y / N	Mumps	_____	Y / N	Allergies	_____
Y / N	Measles	_____	Y / N	Acne	_____
Y / N	Rheumatic Fever	_____	Y / N	Emotional Trauma	_____
Y / N	Hepatitis	_____	Y / N	HIV+	_____
Y / N	Hemophilia	_____	Y / N	AIDS	_____
Y / N	Eating Disorder	_____	Y / N	Herpes/STD	_____

FAMILY MEDICAL HISTORY

Please indicate whether you or any of your family members have any of the following diseases. Indicate what your relationship is, i.e. mother, father's sister, mother's mother, father's uncle, etc.

		Relationship			Relationship
____	Heart Disease	_____	____	Liver Disease	_____
____	Stroke	_____	____	Kidney Disease	_____
____	Diabetes	_____	____	Depression	_____
____	Cancer	_____	____	Alcoholism	_____
____	High Blood Pressure	_____	____	Mental Illness	_____
____	Thyroid Disease	_____	____	Other	_____

I have read and understand the HIPPA Privacy Notice. _____(initial)
I understand that **24 hour cancellation notice is required**. If I cancel less than 24 hours in advance or do not show up for an appointment I will owe payment in full. _____(initial)

X PATIENT SIGNATURE_____ **DATE**_____

KAREN TAYLOR
LICENSED ACUPUNCTURIST
1200 HIGH STREET #110
EUGENE, OR 97401
OFFICE: 541-968-9122

PATIENT INSURANCE/REGISTRATION FORM

Client's Name: _____

Street Address: _____

City, State and Zip Code: _____
(If your mailing address is a P O Box, please list street address along with the P O Box.)

Client's Phone #: Home _____ Cell _____ Work_____

Marital Status/Partner Information: ___Married ___Single ___Divorced ___Widowed ___Partnered
Client's DOB: _____ O.D.L.#: _____ S.S. #: _____

EMAIL:_____
Nearest Friend or Relative not living with you in case of an emergency:

Name: _____ Relationship: _____

Address: _____

Phone #: Home _____ Cell _____ Work_____

INSURED INFORMATION: PRIMARY

Insurance Company: _____ Phone: _____
Claims Address: _____

Subscriber''s Name: _____
Relationship to client: Self _____ Spouse _____ Parent _____ Other _____
ID#: _____ Group #: _____
Employer: _____
Occupation: _____

INSURED INFORMATION: SECONDARY

Insurance Company: _____ Phone: _____
Claims Address: _____

Subscriber''s Name: _____
Relationship to client: Self _____ Spouse _____ Parent _____ Other _____
ID#: _____ Group #: _____
Employer: _____
Occupation: _____

ADDITIONAL INFORMATION:

By whom were you referred to this office? _____

Please list other health care providers that might be relevant to your treatment.
(This office will not contact these individuals unless you sign a release of information.)

_____, _____, _____

_____, _____, _____

Please list any medication(s) you are currently taking:

_____, _____, _____

_____, _____, _____

Have you ever had Acupuncture in the past? If so, when, and for what types of problems?

_____

_____

_____

_____

Please remember that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid by your insurance. You will be responsible to pay full charge for missed appointments not cancelled 24 hours in advance. Patient's or authorized person's signature: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits, Medicare, private insurance and other health plans to the party who accepts assignment below.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fees and cost of collections.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including; private insurance and other health plans to **Karen Taylor, L. Ac.**

This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance and hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ **DATE:** _____

RESPONSIBLE PARTY: _____ **DATE:** _____