

Today's Date: _____

Tracy Ng, L.Ac., DAOM
202 Bicknell Ave., Santa Monica, CA 90405
Phone: 818.634.6256
Email: tracy.ng@mac.com

PATIENT BILLING AND CONTACT INFORMATION

Name _____

If patient is a minor, parent/guardian name(s) _____

Birth date _____ Age _____ Sex assigned at birth _____ Relationship status _____

Mailing Address _____

Home phone _____ Work phone _____

Cell phone _____

Email address _____

Occupation _____

Employed by _____

Supervisor name _____

Employer address _____

Employer Phone _____

Who is responsible for payment on this account? _____

Where should bills be sent (if different than above)?

Name _____

Address _____

Phone number _____

Who may we thank for your referral? _____

In case of emergency, who may we contact?

Name _____ Phone number _____

Relationship _____

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OFFICE POLICIES AND FINANCIAL AGREEMENT

The fees for office services, supplements and support are payable in full at the time of your visit, unless other arrangements have been made. The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this area.

If it is necessary for you to cancel or reschedule an appointment, we require a FULL 48 HOURS NOTICE to change your appointment without charge. *Any appointments canceled or rescheduled without 48 hours notice will be charged for a full office visit.* Please realize that we have reserved this time for you and that another person in need of care will be able to have time with the doctor when 48 hours notice is given. Please note that if you are more than 20 minutes late for your appointment, we will try our best but may not be able to accommodate you.

Please understand that we have no payment agreements with your insurance companies. Insurance benefits are a matter between you and your insurance company. We will be happy to supply you with any information you may need to assist you in procuring payment of your medical claims. Submission of medical insurance claims is the responsibility of the insured.

If you are a patient who has had a non-work-related accident, automobile, or other injury, it is your responsibility to provide us with the name and address of both the responsible insurance companies and that of your attorney.

We reserve the right to make a finance charge at an interest rate of 1.5% per month for every month that your account remains overdue after 30 days.

I have read, understand, and agree to the above policies.

Name (Print) _____

If patient is a minor, name of child for whom I am the parent or legal guardian _____

Signature _____ Date _____

INFORMED CONSENT

Tracy Ng, L.Ac., D.A.O.M. is a Licensed Acupuncturist and Doctor of Oriental Medicine. Dr. Ng is not a medical doctor. She does not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent herself as doing so. The services of a Doctor of Oriental Medicine cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. It is your right whether you choose to engage a medical practitioner or not to assist you in your care, and Dr. Ng assumes no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that acupuncture, herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success of effectiveness of any specific acupuncture, dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Tracy Ng, L.Ac., D.A.O.M. as I so choose. I hereby release Dr. Tracy Ng and the Office of Tracy Ng, D.A.O.M. from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Tracy Ng, L.Ac., D.A.O.M. and participate in a professional relationship with her pursuant to the statements herein.

Name (Print) _____

If patient is a minor, name of child for whom I am the parent or legal guardian _____

Signature _____ Date _____

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received or have been provided an opportunity to review a copy of the Notice of Privacy Practices.

Name

Signature

Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
☐ O.K. to leave message for appointment reminder calls
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only
- ☐ Work Telephone _____
☐ O.K. to leave message for appointment reminder calls
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only
- ☐ Written Communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number _____
- ☐ Email _____

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom, Address or Fax Number	Purpose of Disclosure	By Whom Disclosed	T=Tx Records P=Payment Info	F=Fax E=Email M=Mail

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

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, and 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 or preceptorship interns who now or in the future treat 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 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
(Or Patient Representative)

X

(Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 (Oriental massage), Oriental 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 Oriental 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.

PATIENT SIGNATURE · X
(Or Patient Representative)

Date

(Indicate relationship if signing for patient)

OFFICE SIGNATURE

Tracy Ng

Date

PLEASE SIGN REVERSE SIDE ALSO