ART OF WELLNESS PATIENT INFORMATION SHEET

First Name | Last Name | Middle | ○M ○F Gender | Age | Date of Birth (__/__/__)

Address | Unit# | City | State | Zip Code

Email | Phone # ○ Cell ○ Home | Driver's license #

Social Security # (__/__/__) | Marital status | Spouse's Name | Spouse Cell phone #

Occupation | Employer Name | Work Address | Work phone #

Emergency Contact's Name | Relationship | Cell phone #

Physician Name | Specialty | Phone # | Address

Insurance Carrier | Member # | Name of Insured | Relation to Insured

How did you hear about us? ○ **Google** ○ **Yelp** ○ **Friend/ Family Referral** ○ **Physician Referral** ○ **Other** _____

Referring Friend/Family Member or Physician's Name | Address | Phone #

OFFICE POLICIES

1. Art of Wellness is required by HIPPA law to maintain the privacy and confidentiality of your protected health and personal information. This policy is available by request. Please see the receptionist for more information.
2. If you need to cancel your appointment, please inform us at least **24 hours** before your appointment. A missed appointment will be **charged at full rate** (See fee schedule below).
3. There is a service fee of $35.00 for every returned check from the bank.
4. We are out of network providers and do not bill any insurance directly. Please contact your insurance company to verify out-of-network acupuncture benefits. Upon request, we can provide you with a superbill form via email that you may send to your insurance company for reimbursement.
5. By signing below, you authorize the release of your medical records or any information necessary to process a claim with your insurance company in case they contact us.
6. We require immediate payment for Herbal pick-up/shipments when you place the order. There are no returns on any herbs.

Fee Schedule as of June 2025

Doctor's Name	New Patient Consultation	Returning Patient Consultation	Acupuncture Treatment	Cupping	Herbs	Same-day Cancellation
Dr. Qineng Tan	$165	$145	$155	$45	$60	$155
Dr. Xiaomei Cai	$165	$145	$155	$45	$60	$155

X_____ Signature of Patient

X_____ Signature of Parent/ Guardian (Minors Only)

_____ Date

Patient Medical Information & History

What is your chief complaint?_____

Do you have a tendency to faint? **Yes** ○ **No** ○ Are you H.I.V. positive? **Yes** ○ **No** ○

Do you have a pacemaker? **Yes** ○ **No** ○ Have you ever had hepatitis? **Yes** ○ **No** ○

Experience abnormal bleeding? **Yes** ○ **No** ○ Are you pregnant? **Yes** ○ **No** ○

Have you had acupuncture before? **Yes** ○ **No** ○ If yes, when?_____ For what condition were you treated?_____

Medication Info: Please list all current medication (add another sheet if need)

Start Date	Medication Name	Purpose/Indication	Dose	How Often	Last Dose

Symptom History: **(+)** ***Frequently experience*** **(›)** ***Sometimes experience*** **(** ***No Mark*****)** ***Never experience***

Cardiovascular
___Heart Palpitations
___Shortness of Breath
___High Blood Pressure
___Chest Pain/Pressure
___Irregular Heartbeat
___Dizziness
___Leg Cramp
___Cold Hands/Feet

Respiratory
___Dry Cough
___Cough with sputum
___Cough with blood
___Sore Throats
___Nasal Problems
___Poor sense of smell
___Nose Bleeds
___Asthma/Wheezing
___Pneumonia
___Hay Fever
___Bronchitis
___Allergies
___Itchy Skin

Gastrointestinal
___Indigestion
___Bloating
___Gas/Belching
___Abdominal Cramps
___Gall Stones
___Constipations
___Diarrhea
___Blood in bowels
___Black/Tarry bowels
___Excessive Appetite
___Colitis/Diverticulitis
___Heartburn
___Acid Reflux
___Fatigue
___Edema/Swelling
___Bad Breath
___Muscle Fatigue

Genitourinary
___Frequent Urination
___Painful Urination
___Bloody Discharge
___Venereal Disease
___Pain in Genital Area
___↑sex drive
___↓sex drive
___Kidney Stone
___Kidney Failure
___Neuritis

Musculoskeletal/Nervous
___Back Pain
___Neck Pain
___Arthritis
___Muscle Pain/Cramps
___Painful Joints
___Disc Problem
___Epilepsy
___Scoliosis
___Headache/Migraine
___Muscle Twitching
___Joint Tightness/Stiffness
___Soft/Brittle Nails
___Achy Bones

Skin
___Ulceration
___Rash
___Edema
___Eczema
___Psoriasis
___Herpes
___Acne

Males Only
___Prostate Problems
___Pain in Testicles
___Low Sperm Count

Females Only
___Pre Menstrual Pain
___Menstrual Pain
___Irregular Menstrual Cycles
___Swelling/Pain in Breast
___Lower Back/Sacrum pain
___Heavy Bleeding
___Excessive Vaginal Discharge

Miscellaneous
___Vision Problems
___Sensitivity to weather change
___Blood Clotting
___Itchy Eyes
___Poor Memory
___Ringing in Ears
___Memory Loss
___Hearing Loss
___Night Sweats
___Hair Loss
___Depression
___Insomnia
___Red Eyes
___Diabetes
___Cancer
___Chills
___Fever

OTHER:
_____
_____
_____
_____
_____
_____
_____
_____

Initials:_____
Date:_____

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 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, 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 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 **X** (Date)

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

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE **INFORMED CONSENT** ON **REVERSE** SIDE

ART OF WELLNESS

ACUPUNCTURE INFORMED CONSENT TO TREAT

Chinese Medicine is a healing system that includes multiple therapeutic modalities. This medical system facilitates the body's innate healing capability and requires participation in taking personal responsibility in assisting one's own health recovery. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is attained. The patient is a partner with the acupuncturist in the healing process.

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 who I am legally responsible) by the acupuncturist in Art of Wellness 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 Art of Wellness, 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 be an unpleasant smell or taste. I will immediately notify the acupuncturist 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 reaction from cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothrax). 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. If any discomfort persists and if I am or become pregnant, I will notify the acupuncturist who is caring for me.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

There are risks involved in any procedure of treatment. I do not expect the acupuncturist to be able to anticipate all risks and complications related to my condition and I understand that not all medical conditions can be successfully treated by acupuncture and Chinese medicine. I understand that an acupuncturist is not a medical doctor. I desire to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist deems appropriate and in my best interests, based upon facts then known. I also understand that, whenever necessary, I must continue to seek treatment with a medical doctor for any conditions which cannot be resolved by acupuncture and Chinese Medicine.

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 Name _____ (Print)

(Date)

PATIENT SIGNATURE **X**

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