Lotus Integrative Medicine
Santa Monica

2222 Santa Monica Blvd, Suite 105
Santa Monica, CA 90404
(310) 828-8258 phone, (310) 828-5258 fax
www.lotussm.com, info@lotussm.com

New Patient Welcome Letter

Dear New Patient,

Welcome! Thank you so much for your interest in our integrative medical center. At Lotus we do our best in every way possible to assure that you receive the best quality care. We want you to know that everyone on our staff is trained to:

- Make sure that our customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that we'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call us at 310.828.8258 and any one of us will be happy to help you.

Please understand your appointment time is reserved for you. We recognize there may be occasions when you need to cancel or reschedule an appointment. If you need to cancel or reschedule your appointment for any reason, **we require a minimum of 24-hour advanced notice to avoid cancellation/rescheduling fees in the full amount of your scheduled visit**. Thank you for respecting this policy.

Again, welcome to Lotus Integrative Medicine Santa Monica. You have taken an important step on the road to more vibrant health. We look forward to serving you.

Yours Sincerely,

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, Worker's Compensation (and your employer as well in this instance), and/or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 310.828.8258.

Kindly,

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I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Name: _____

Patient Signature: _____

Date: _____

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by healthcare practitioners at Lotus Integrative Medicine Santa Monica for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Lotus Integrative Medicine Santa Monica may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Healthcare practitioners at Lotus Integrative Medicine Santa Monica are not required to agree to the restrictions that I may request. However, if healthcare practitioners at Lotus Integrative Medicine Santa Monica agree to a restriction that I request, the restriction is binding upon healthcare practitioners at Lotus Integrative Medicine Santa Monica.

I have the right to revoke this consent, in writing, at any time except to the extent that Lotus Integrative Medicine Santa Monica has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Lotus Integrative Medicine Santa Monica's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lotus Integrative Medicine Santa Monica. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.lotussm.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Lotus Integrative Medicine Santa Monica with respect to my identifiable health information.

Lotus Integrative Medicine Santa Monica reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative and Relationship

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Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance 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:

■ **Brendan Armm, DAOM, LAc, Dipl OM**

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, acupressure, shiatsu, Chinese herbal medicine, exercise prescriptions, and nutritional counseling. I also 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 agree to immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. Because of the possibility of interaction of drugs with herbal formulas, I will inform the practitioner of **any medications** or recreational drugs I may be taking, including dietary supplements and herbs. Herbal formulas and acupuncture treatment may have effects on pregnancy. Patients must inform the practitioner of any possibility pregnancy. I hereby state my understanding that as per California Prop. 65, herbal supplements may contain chemicals known to the State of California to cause cancer, birth defects, and/or other reproductive harm.

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 effects and risk may occur. The herbs are nutritional supplements (which are from plants, animals, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I further understand that results are not guaranteed and realize that a series of treatments and some long-term maintenance may be necessary depending on the severity and chronic nature of problem. It has been made clear to me that any herbal supplement is intended only for my consumption as prescribed and directed by my qualified practitioner on staff and under no circumstances is any herbal supplement intended to replace medication(s) prescribed by my medical doctor.

I have also been informed that 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 acknowledge that I understand that acupuncture is NOT a substitute for the traditional medical management of my condition but rather it is considered complementary and alternative medicine. I agree to discuss the progression of my symptoms with my primary care physician should acupuncture not relieve these symptoms. I have read 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. This consent form is intended to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Patient's Name **(please print):** _____

Patient's Signature: _____ **Date:** _____
(or patient representative, indicate relationship)

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Acupuncture is a technique using small, sterile, stainless steel needles at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used in this clinic. The location of the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding of the skin, hematoma, a bruise at the needling site, or fainting. Momentary euphoria or light-headedness may occur after acupuncture treatment.

Electrical stimulation of the acupuncture needles, involves using a small, battery-powered stimulator attached by wires to the acupuncture needles. A slight throbbing or tingling sensation may be felt during and for a few hours after the use of this stimulation. This modality is usually employed for pain management and other specific conditions.

Moxibustion is the application of indirect heat supplied by burning the herb *Folium Artimesiae Vulgaris*, (commonly know as mugwort) over a single acupuncture point or a group of points. This generally produces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidents, a minor burn may occur at the site of moxibustion. The attending acupuncturist can readily address this.

Cupping uses round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to several days. These marks may resolve on their own and are not indications of complications or injury.

Qi gong Chinese for “energy work,” is a non-invasive healing modality that predates the use of acupuncture needles, and incorporates the same therapeutic basis as acupuncture.

Herbal supplements are used to facilitate the body’s own restorative process. These herbs are usually taken in tea form by boiling dried plants in their natural forms. Chinese herbal teas tend to taste bitter because they are made mostly from roots and barks. On rare occasions, temporary gastric upset may occur. If any discomfort persists, and is accompanied by hives or shortness of breath, contact our attending acupuncturist immediately.

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Patient Payment Responsibility Agreement and Cancellation Policy

Dear Patient,

This letter is to keep you informed of the policies regarding your payment responsibilities. As a patient you are responsible for the total charges incurred from each visit to your practitioner. Charges are to be paid at the time of each visit. We recognize and appreciate that health care can involve major financial commitment. We aim to provide you with effective and affordable health care.

Visa, MasterCard, American Express, Checks and Cash are all acceptable forms of payment.

Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. We will provide you with the appropriate super-bill with the appropriate codes needed for you to seek reimbursement from your insurance company. You will need to mail the super-bill provided, to your insurance company and your insurance company will reimburse you for all the amounts covered within your policy. If this concerns you, before your first appointment contact your insurance company or refer to your insurance contract agreement regarding coverage for Acupuncture and/or Alternative and Complementary medical services. Items to note are: 1) the service covered, 2) which diagnosis are covered, 3) how many visits are allowed per calendar year, 4) the amount of your deductible, 5) any limitations. If you have insurance that does not cover acupuncture and Oriental medical care, use of a Health Savings Account (HSA) or flexible spending account may cover this care. Check with your employer to determine if one of these options is available to you. Answers to these questions will help clarify treatment and financial responsibility.

All patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule an appointment. If you cancel/reschedule your appointment with less than 24 hours' notice, or fail to show for your appointment without notification your credit card will be charged for the cost of your office visit. This charge will not be billable to your insurance.

- Regretfully, we have been forced to institute this policy.
- Assuring that all established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule with adequate advance notice, it is more *likely that another patient in need will be able to use your time-slot.* When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.
- Patient visits require us to block out large time slots, making last minute cancellations and rescheduling even more problematic. We spend an inordinate amount of time and energy with each and every one of our patients because we are committed to providing the highest quality care.

Payment for all pharmacy items is due at the time of the visit. Many insurance companies do not cover herbal pharmacy items.

We bill for phone consultations. They require the same time and expertise as office visits. Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely your doctor will bill for the phone consultation.

By signing this payment agreement and cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card if any of the above stipulations apply to you.

Name of Patient or Legal Guardian:_____

Signature: _____ Date: _____

Type of card: Visa MC AMEX Card Number: _____

Expiration: _____ Security Code: _____ Billing Zip Code: _____

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PATIENT INFORMATION

Last Name: _____ First Name: _____

☐ Parent/Guardian of patient? Name and Relationship to Patient: _____

Today's Date: _____/_____/_____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Physical Address: _____ Apt. _____ City: _____ State: _____ Zip: _____

Billing Address: _____ Apt. _____ City: _____ State: _____ Zip: _____

Home Phone ( ) _____-_____ Work: ( ) _____-_____ Cell/Alternate.: ( ) _____-_____

Fax: ( ) _____-_____ E-mail: _____

your information is confidential

Employer: _____ Occupation: _____

Employer Address: _____ Telephone: ( ) _____-_____

INSURANCE INFORMATION

Company Name: _____ Policy Holder's Name: _____

EMERGENCY CONTACT

Name: _____ Relationship to you _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: ( ) _____-_____ Evening: ( ) _____-_____ Cell/Alt: ( ) _____-_____

REFERRED BY (specify)

☐ NAME _____ ☐ WALK-IN

☐ INTERNET: Search Engine / Browser (ex Google, Doctible, Yelp, …etc.) ☐ RCVD EMAIL, Re:_____

_____ ☐ WORKSHOP, Title: _____

☐ FLYER, From: _____ ☐ OTHER: _____

Has any other family member already been a patient at the center? _____

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Health History Questionnaire

SUCCESSFUL HEALTH AND PREVENTATIVE MEDICINE ARE ONLY POSSIBLE WHEN THE DOCTOR HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

Are you currently receiving healthcare?

If yes, where and from whom? _____

If no, when and where did you last receive medical or health treatment? _____

_____

Either way, what was the reason? _____

GOALS

What would you most like to achieve through your work at Lotus Integrative Medicine Santa Monica?

1. _____
2. _____
3. _____
4. _____
5. _____

MAJOR SYMPTOMS

Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1. _____
2. _____
3. _____
4. _____

Use the following illustration to indicate painful or distressed areas:

X = mild XX = moderate XXX = strong

Circle quality of pain or distress:

ache

burning

numbness

pins & needles

stabbing

other: _____

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GENERAL

Height: _____ Weight: _____ Weight 1 yr ago: _____
Max Weight: _____ When: _____
When during the day is your energy the best? _____The worst? _____

ALLERGIES

List anything that you are allergic to such as certain foods, medications, herbs/supplements, dusts/environment/molds, chemicals or soaps, household items, plants/pollens, insect stings, etc., and indicate how each affects you:

Allergic to:	Effect:
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS AND NUTRITIONAL SUPPLEMENTS *prescription and over the counter medications*

… include vitamins, herbal supplements, laxatives, cortisone, pain relievers, appetite suppressant, antacids, antibiotics, tranquilizers, thyroid medications, sleeping pills, prednisone, hormone replacement therapy, birth control

_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____

PAST MEDICAL HISTORY

Please list any hospitalizations, operations, significant injuries, etc.:

_____Date: _____ _____Date: _____
_____Date: _____ _____Date: _____
_____Date: _____ _____Date: _____

Do you have any known contagious diseases at this time? **Y** **N** If yes, what? _____

Circle or fill-in the blank for the symptoms that pertain to you

Mental /Emotional Treated for emotional problems Depression Mood Swings Anxiety Considered/Attempted Suicide Tension Poor concentration Memory Problems Insomnia Mental heaviness, sluggishness or fogginess Anger easily Restlessness

Endocrine Hypothyroid Heat or cold intolerance Hypoglycemia Diabetes Excessive thirst Excessive Hunger Fatigue Seasonal Depression

Immune Last tetanus booster? _____ Vaccinations Reactions to vaccinations Chronic Fatigue Syndrome Chronic Infections Chronically swollen glands Slow wound healing

Neurological Seizures Paralysis Muscle weakness Numbness or tingling Loss of memory Easily stressed Vertigo or dizziness Loss of balance

Musculoskeletal Joint pain or stiffness Arthritis Broken bones Weakness Muscle spasms or cramps Sciatica Prolapsed organs (previously diagnosed) General feeling of heaviness in body Sore, cold or weak knees Low back pain

Vascular Easy bleeding or bruising Anemia Deep leg pain Cold hands/feet Varicose Veins Thrombophlebitis Swollen hands/feet Numbness of hands and feet

Skin Rashes Eczema/Hives Acne/Boils Color change Perpetual hair loss Night sweats Lumps

Head Headaches Head injury Migraines Jaw/TMJ problems

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Eyes/Ears Spots in eyes Cataracts Impaired vision Glasses or contacts Blurriness Eye pain/strain Color blindness Tearing/dryness Double vision Glaucoma Blood shot/dry eyes Ringing in ears Deafness Earache

Nose and Sinus Frequent colds Nose bleeds Stuffiness Hay fever Sinus Problems Loss of smell

Mouth and Throat Frequent sore throat Copious saliva Teeth grinding Sore tongue/Lips Gum problems Hoarseness Dental cavities Jaw clicks

Neck Lumps Swollen glands Goiter Pain/Stiffness

Respiratory Cough Sputum Spitting up blood Wheezing Asthma Bronchitis Pneumonia Pleurisy Emphysema Difficulty breathing Pain on breathing Shortness of breath Shortness of breathing at night Shortness of breathing lying down

Cardiovascular Heart disease Angina High blood pressure Low blood pressure Murmurs Blood clots Fainting Phlebitis Rheumatic fever Palpations/Fluttering Swelling in ankles Chest pains

Gastrointestinal # of Bowel Movements? _____ per day or week (circle) Is this a change? _____
Are they well-formed, loose, hard, thin, in pieces, incomplete, sticky, etc.? _____
The color is normal, dark, black, light, green, red, etc.? _____
Pain/Cramps Belching/Gas Constipation Diarrhea Alternating Const./Diarrhea Black stools Gall bladder disease Jaundice Ulcer Liver disease Hemorrhoids Trouble swallowing Heartburn Bad breath Mouth sores/canker sores Bleeding, swollen, painful gums Change in thirst Change in appetite Nausea Vomiting Vomiting blood Blood in stool Bitter taste in the mouth

Urinary Color is: _____ Amount is: _____ Odor Pain Difficulty Urgency Burning Increased frequency Frequency at night Inability to hold urine Frequent infections Kidney stones

Other: _____

Male Reproduction Are you sexually active?_____Birth control?_____What type?_____
Low libido Hernias Testicular masses Testicular pain Prostate disease Breast lumps Venereal disease Discharge/sores Chlamydia Gonorrhea Impotence/ Erectile dysfunction Condyloma Premature ejaculation Herpes Syphilis

Female Reproduction Are you sexually active?_____Birth control?_____What type?_____
Age of 1st menses? _____ Are cycles regular? _____Length of cycle?_____Date of last menses?_____
Average number of days of flow? _____ Date of last Pap?_____Date of last Mammogram? _____
PMS symptoms?_____
The flow is (circle): Normal heavy light The color is (circle): Fresh red Dark Purple Light brown Brown
Number of pregnancies? _____ # of live births? _____ # of miscarriages? _____ # of abortions?_____
Are you pregnant now? _____ Age of menopause (if applicable) _____ Do you do breast exams?_____
Low libido Bleeding between cycles Painful menses Clotting Heavy/Excessive flow Discharge Breast tenderness/lumps Nipple discharge Endometriosis Hot flashes Ovarian cysts Difficulty conceiving Cervical Dysplasia Menopausal Symptoms Abnormal Pap Pain during intercourse Sexual difficulties Chlamydia Gonorrhea Herpes Condyloma Syphilis

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PSYCHO-SOCIAL HISTORY

EXERCISE/ACTIVITY

How many hours of exercise/activity do you get per week? _____ What types of exercise do you do? _____
_____

Yes No (circle)

Y **N** Do you smoke? If yes, how much? _____ How long? _____
Y **N** Are you a previous smoker? If yes, when did you quit? _____
Y **N** Do you drink alcoholic beverages? If yes, how much? _____ How long? _____
Y **N** Do you use illicit/illegal drugs? If yes, what type? _____ How often? _____
Y **N** Do you live alone? If no, who else lives with you? _____
Y **N** Have you traveled abroad in the past year? If yes, where? _____

DIET

Please describe your typical food intake:

Morning	Afternoon	Evening
_____	_____	_____
_____	_____	_____
_____	_____	_____

Foods you crave: _____ Foods you dislike: _____
Do you eat refined sugar/artificial sweeteners?_____ Do you add salt? _____
How much coffee do you drink each week? _____ Tea per week? _____ Soft drinks per week? _____

FAMILY HISTORY

	Father	Mother	Sibling	_____	_____	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)									
Health (**G** = good/**P** = poor)									
Age at death									
Check those applicable									
Cancer									
Diabetes									
Heart Disease									
High Blood Pressure									
Stroke									
Epilepsy									
Mental Illness									
Asthma/Hay fever/Hives									
Anemia									
Kidney Disease									
Glaucoma									
Tuberculosis									
Cause of death									

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SOCIAL HISTORY

SLEEP

Hours of sleep per night?_____ Do you sleep well? _____ Awaken rested? _____

What hours do you go to sleep? _____ What hours to wake? _____ Light Sleeper? ____

Do you have difficulty falling asleep? _____ Difficulty staying asleep?_____ Do you remember your dreams? _____

ENERGY

On a scale of 1-10 (10 = highest), please rank you energy? _____

INTERESTS

Main interests and hobbies?_____

_____

Do you have a religious or spiritual practice?_____ What?_____

Level of joy with your work?_____ Level of stress with your job? _____

Do you take vacations?_____ Spend time outside?_____ Have a supportive relationship?_____

Watch television? _____ hours/day?_____ Read? _____ hours/day?_____

How does your condition affect you?_____

_____

_____

What do you think is happening? Why?_____

_____

What do you feel needs to happen for you to get better?_____

_____

_____

What do you enjoy most about your life?_____

_____

How much effort are you willing to make at this time to improve your health? [ ]Minimal [ ]Some [ ]Complete

Thank you for completing these forms. Please bring in any and all medications, vitamins or supplements you are currently taking. If you have any questions, please ask! We look forward to working with you.

Warmly,

Lotus Integrative Medicine Santa Monica