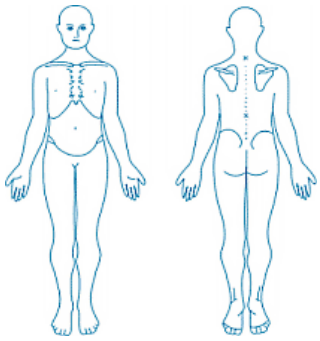
GenerateShen Wellness/ Dr. Akemi Rico PT
New Patient Intake Form

Name: _____ **Date:**_____
Date of Birth:_____ **Age:**_____ **Email:** _____
Address:_____ **City, State, Zip** _____
Home Phone #: _____ **Work:** _____ **Cell:** _____
Occupation: _____ ☐ **Please check here if we can email you updates and a newsletter.**
Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** **Height:** _____ **Weight:** _____ **Allergies:** _____
Emergency Contact Name:_____ **Phone:**_____ **Relationship:**_____
Physician: (Name) _____ **(Phone)** _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐Yes ☐ No
Chief Complaint: _____
How long have you had this condition?_____
Is it getting worse? ☐Yes ☐No **Does it bother your:** ☐Sleep ☐Work ☐Other _____
What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you experiencing pain right now? ☐Yes ☐ No
Describe your pain: ☐Dull ☐Sharp ☐Stabbing ☐Shooting ☐Burning ☐Other_____
What makes your pain better? ☐Heat ☐Pressure ☐Movement ☐Cold ☐Massage ☐ Rest

Family Medical History:

☐Arteriosclerosis ☐Cancer ☐Diabetes ☐Seizures ☐Asthma ☐Heart Disease ☐Stroke
☐Alcoholism ☐High Blood Pressure ☐Other: _____

Are you currently on any medications? ☐No ☐Yes If Yes, Please List: _____
Do you take any vitamins/supplements? ☐No ☐Yes If Yes, Please List: _____

Lifestyle:

☐Alcohol # per day_____ ☐Stress ☐Marijuana ☐Regular Exercise:
Type _____ Frequency_____
Type _____ Frequency_____
☐Tobacco # per day_____ ☐Drugs ☐Occupational Hazards

Your Past Medical History: (Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐ AIDs/HIV	☐ Diabetes	☐ Measles	☐ Thyroid Disorders	☐ Major Trauma:
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Tuberculosis	_____
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Thyroid Fever	_____
☐ Appendicitis	☐ Goiter	☐ Pneumonia	☐ Ulcers	_____
☐ Arteriosclerosis	☐ Gout	☐ Polio	☐ Venereal Disease	_____
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	☐ Whooping Cough	☐ Other: _____
☐ Birth Trauma (your own birth)	☐ High Blood Pressure	☐ Scarlet Fever	☐ Surgery (Please List All) _____	_____
☐ Cancer	☐ Herpes	☐ Seizures	_____	_____
☐ Chicken Pox	☐ Hepatitis	☐ Stroke	_____	

Musculoskeletal: (Please check all that apply)

☐ Neck/shoulder pain ☐ Upper Back Pain ☐ Joint Pain ☐ Limited Range of Motion

☐ Muscle pain ☐ Low Back Pain ☐ Rib Pain ☐ Muscle Spasm

Other: _____

Gynecology:

Are you pregnant? ☐ Yes ☐ No

Duration of flow_____ ☐ Irregular Periods ☐ Painful Periods ☐ PMS

Vaginal Discharge (Color)

_____ ☐Vaginal Sores ☐Vaginal Odor ☐Clots

Date Last Period began_____

Length of cycle (Day 1 to Day 1)_____

Pregnancies_____ # Live Births_____

Premature Births_____ Age at Menopause_____

Please List Any Other Pertinent Information:

_____

_____

_____

I agree that the information I provided on this intake is true. It is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.

Signature of Patient_____

Date_____

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder

☐ Depression / Stress
☐ Headaches / Migraines
☐ Red / Dry / Itchy Eyes
☐ Visual Problems / Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping / Twitching
☐ Neck/Shoulder Pain / Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS/Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable / Angry

Heart/Small Intestine

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia / Sleep Problems
☐ Vivid Dreams / Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety / Nervous or Restless

Spleen/Stomach

☐ Body Heaviness
☐ Hard to get up in Morning
☐ Muscles Often Feel Tired
___ Energy Level: 1-10 (low to high)
☐ Edema (☐ Hands ☐ Feet)
☐ Easily Bruising / Bleeding
☐ Bad Breath
☐ Sweetish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea / Vomiting
☐ Gas / Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion / Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking / Worry

Lung/Large Intestine

☐ Bloody Cough
☐ Dry Cough
☐ Chronic Cough
☐ Cough with Sputum
☐ Nasal Discharge
☐ White ☐ Yellow ☐ Green
☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth / Nose / Throat
☐ Skin Rashes / Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies / Asthma
☐ Low Immunity
☐ Catch Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis / Spastic Colon
☐ Do you crave: Pungent / Spicy
☐ Grief / Sadness

Kidney/Urinary Bladder

☐ Urinary Problems (i.e. night-time) _____
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Low or Excess Sex Drive (circle which)
☐ Dark Circles under Eyes
☐ Thyroid Problems _____
☐ Poor Memory
☐ Hair Loss / Grey Hair
☐ Hearing Problems / Tinnitus
☐ Cavities
☐ Hot Flashes / Night Sweats
☐ Impotence or Premature Ejaculation (circle which)
☐ Do you crave: Salt
☐ Fear

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 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, 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 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 the 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 the 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/certified 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, bleeding, Gua-Sha, 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 or in writing. The herbs may have an unpleasant smell and/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 and Gua-Sha. 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 disposable sterile 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 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
(or Patient Representative) X

(Date)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE

(Date)

GenerateShen Wellness/ Dr. Akemi Rico PT: Notice of Privacy Practice

*GenerateShen Wellness/ Dr. Akemi Rico PT also referred to as GenerateShen Wellness

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by **GenerateShen Wellness***, to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how **GenerateShen Wellness***, collectively we, us may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting us at the telephone number or address below.

DEFINITIONS

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories. *Your Authorization* – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself. *Uses and Disclosures for Payment* – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan. *Uses and Disclosures for Health Care Operations* – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan. *Family and Friends Involved in Your Care* – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim. *Business Associates* – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. *Other Products and Services* – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan. *Other Uses and Disclosures* – We may make certain other uses and disclosures of your PHI without your authorization.

* We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
* We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
* We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
* We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
* We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
* We may disclose your PHI to the proper authorities for law enforcement purposes.
* We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
* We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
* We may use or disclose your PHI for research purposes, but only as permitted by law.
* We may use or disclose PHI to avert a serious threat to health or safety.
* We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
* We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
* We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from **GenerateShen Wellness*** at the address below. We may charge you a fee for copying and postage. Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below. Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the
same 12-month period. Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voicemail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below. *Complaints* – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below.
You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION
If you have questions or need further assistance regarding this Notice, you may contact:

GenerateShen Wellness (323) 954-8800
5486 Wilshire Blvd Los Angeles, CA 90036.

EFFECTIVE DATE
HIPAA Privacy Requirements Compliance Guide. This Notice is effective April 14, 2003.

I have read and understand the above stated Notice of Privacy Policy.

Name(or legal party)_____Date _____