DAVID KIM'S ACUPUNCTURE

PATIENT INTAKE FORMS

ACUPUNCTURE | PHYSICAL MEDICINE

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IMPORTANT: *Please complete these questionnaires as thoroughly as possible, AND be honest with yourself. Some of the questions may seem unrelated to your condition, BUT they may play a significant role in diagnosis and treatment.* ***All information is strictly confidential. Please PRINT clearly or TYPE.***

Demographic – *General information for Patient Tracking*

Patient Name		**Date of Birth (DOB)**	**Date of Service (DOS)**
Sex ❑ Male ❑ Female	Age	Height	Weight

Marital Status

❑ Single ❑ Married ❑ Partnership ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor ❑ I don't want to say

Language Preference ❑ English ❑ Spanish ❑ Other:		**Do you have specific communication requirements?** ❑ No ❑ Yes – *what?*	
Address		**City**	**State, Zip**
Mobile Phone	Home Phone	Email Address	
Employer		Occupation	Work Phone
Emergency Contact		**Relationship**	**Mobile Phone**

☯ Are you presently under a doctor's care?

❑ No ❑ Yes – *for what?*

☯ Have you ever had Acupuncture or Herbal Medicine?

❑ No ❑ Yes

☯ What are **<u>your health goals</u>** for visiting our office?

❑ Some relief from my symptoms. ❑ Find and correct the root cause of my health problem.

Health Insurance – *Please have your photo ID and Heealth Insurance card(s) handy.*

Primary Insurance Company	**Plan Name**	**Member ID**	**Group No.**
Subscriber (If other than self)		Date of Birth	Relationship

Nurse Notes:

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

Subjective | History of Present Illness (HPI) – *Tell us about your Chief Complaints*

What are the **chief complaints**? (*please be specific*)

On a scale of "1 to 10," **rate the intensity** of the symptom. (0=*no pain*, 10=*extremely painful*)

• on Average	• at Worst
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

What happened, or **why** do you think the symptom **occurred**? (*please explain briefly*)

❑ Traumatic ❑ Repetitive ❑ Auto accident ❑ Post-surgical ❑ Falls ❑ Sports injury
❑ Work-related ❑ Oestoarthritis ❑ Unspecified ❑ Collective stress ❑ Unknown

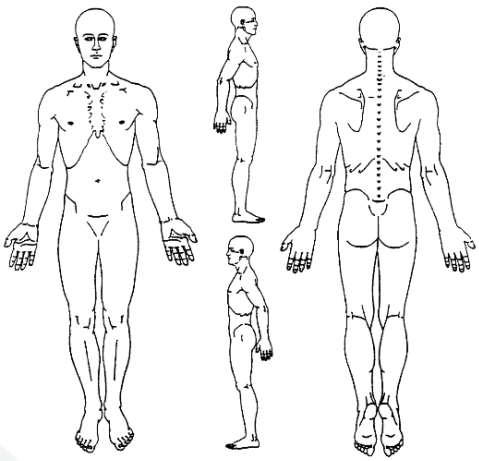
How frequently do you **feel** the symptom? (*times per day, week, or month*)

❑ ( ) minutes ❑ ( ) hours ❑ ( ) days ❑ Occasional ❑ Intermittent ❑ Continuous

What aggravates the symptom? (*e.g., Prolonged driving, Forward flexion, Lifting*)

What alleviates the symptom? (*e.g., Ibuprofen, Tylenol, Resting, Massage*)

Use the diagram to **indicate areas of pain**.
*(please draw a **circle** or mark with **x**)*



Check the **types of pain**? (*check all that apply*)

❑ Dull/Nagging ❑ Sharp/Stabbing
❑ Pin/Needles ❑ Burning
❑ Numbness ❑ Tingling
❑ Throbbing ❑ Moving/Shooting
❑ Joint Swelling ❑ Spastic
❑ Cramping/Aching ❑ Fixed/Heaviness
❑ Radiating to _____
❑ Other:

How are the symptom **interfering with** the following areas of **your life**?

• Sleep & Emotional	• Work & Exercise	• Housework & Self-care	• Hobbies & Social Life
❑ No problem ❑ Disturbed: _____% ❑ Cannot sleep	❑ Usual work ❑ _____% of usual work ❑ Laid off: ( ) months	❑ No effect ❑ Need help _____ % of time ❑ Can't do anything by myself	❑ Normal ❑ _____% restricted ❑ No social life

Check to indicate if you **have done** any of the following **lab**, **imaging**, or **exams**: (*check all that apply*)

• Imaging/Tests	• Date	• Results (*describe any abnormal findings including areas of imaging*)
❑ X-ray		
❑ MRI		
❑ CT/CAT Scan		
❑ Ultrasound		
❑ Mammogram		
❑ Pap Smear		
❑ Blood Exam		
❑ Nerve Tests		

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

Past Medical, Family & Social History (PFSH)

Check to indicate if **you have ever diagnosed with** any of the following **conditions**: (*check all that apply*)

❑ AIDS/HIV	❑ Diabetes (H.Ac1:_____)	❑ Hypertension (HBP)	❑ Multiple Sclerosis (MS)	❑ Psychiatric Care
❑ Anemia	❑ Epilepsy	❑ Infertility	❑ Neuropathy	❑ Skin Disorder
❑ Autoimmune Disorder	❑ Gall Bladder Disease	❑ Kidney Disease	❑ Pacemaker Defibrillator	❑ Stomach Ulcers
❑ Bladder Disease (UTI)	❑ Gout: _____	❑ Liver Disease	❑ (Semi-) Paralysis	❑ Stroke: _____
❑ Bleeding Disorder	❑ Heart Disease	❑ Low Blood Pressure	❑ Parkinson's Disease	❑ Suicide Attempt
❑ Cancer: _____	❑ Hepatitis	❑ Lung Disease	❑ Prostate Problem	❑ Thyroid Disease

List any past or future **operations**, **hospitalizations**, and significant **trauma**, including when it occurred.

• Surgeries (*e.g., ACL reconstruction, Spinal fusion*)	• Date	• Trauma (*e.g., Accident, Falls, Assaults, Stroke*)	• Date

List current **medications** and **vitamins** that you take.

• Medications/Vitamins	• Dosage	• Uses

List your current **exercise** and **sport activities**

• Exercise/Activities	• How often?

Do you **use** the following?

	No	Quit	Yes. I currently…
• Tobacco	❑	❑	❑ ( ) cigarettes per day (*age started*:)
• Alcohol	❑	❑	❑ ( ) drinks per week (*type*:)
• Recreational Drugs	❑	❑	❑ ( ) times per month (*type*:)

Check to indicate if your **family have ever diagnosed with** any of the following **conditions**: (*check all that apply*)

• Medical Conditions	• Mother	• Father	• Brothers	• Sisters
❑ *If deceased,* cause of death				
❑ Cancer(s):				
❑ Diabetes (DM)				
❑ Heart Disease				
❑ High Blood Pressure (HBP)				
❑ Stroke				
❑ Autoimmune Disorders				
❑ Mental Illness				
❑ Other (*e.g.*, Cholesterol)				

What are the **major stressors** in your life?

List known **allergies** and **drug reactions**:

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

Review of Systems (ROS) – *Classification of symptoms according to the Five Elements Theory*

Check to indicate if **you have** any of the following **signs and symptoms**: (*check all that apply*)

Constitutional & Gerneral

❑ Low blood pressure	❑ High blood pressure	❑ Poor circulation
❑ Night sweats	❑ Sweat easily	❑ Get colds, flu easily
❑ Slow to heal	❑ Usually cold, warm	❑ Numbness in hands
❑ Headaches	❑ Prefer warm drinks	❑ Prefer cold drinks
❑ Overweight	❑ Rapid weight loss	❑ Rapid weight gain
❑ Numbness in feet	❑ Thyroid imbalance	❑ Pacemaker

Liver & Gall Bladder

❑ Irritability	❑ Depression	❑ Migraines
❑ Gall Bladder stones	❑ Lump in throat	❑ Clenching of teeth
❑ Ringing in ears	❑ Eczema, Shingles	❑ Joint pain
❑ Visual problems	❑ Dizziness	❑ Red, dry, itchy eyes
❑ Muscle cramping	❑ Soft, brittle nails	❑ Genital pain, itchy
❑ Insomnia	❑ Herpes zoster	❑ Impatient, Anger

Heart & Small Intestine

❑ Heart palpitation	❑ Chest pain	❑ Thirsty
❑ Lymph swelling	❑ Dry scalp	❑ Anxiety
❑ Tongue ulcers	❑ Hot palms, soles	❑ Aversion to heat
❑ Easily startled	❑ Restlessness	❑ Vivid dream
❑ Cysts, Tumor	❑ Gum problems	❑ Sore throat
❑ Bitter taste	❑ Facial redness	❑ Anemia

Spleen & Stomach

❑ Achy, heavy limbs	❑ Fatigue after eating	❑ Excess worry
❑ Bad breath	❑ Low, High appetite	❑ Insulin sensitivity
❑ Nausea, Vomiting	❑ Gas, Belching	❑ Acid regurgitation
❑ Crave sweets	❑ Muscle weakness	❑ Easily bruising
❑ Intestinal cramping	❑ Hypoglycemia	❑ Diarrhea, IBS
❑ Heartburn	❑ Constipation	❑ Difficulty focusing

Lung & Large Intestine

❑ Dry mouth, nose	❑ Cough with phlegm	❑ Nasal discharge
❑ Eczema, Psoriasis	❑ Skin rashes, hives	❑ Sinusitis
❑ Loose stools	❑ Flatulence	❑ Mild fever on & off
❑ Stiff neck, shoulder	❑ Sinus congestion	❑ Itchy painful throat
❑ Melancholy	❑ Wheezing, SOB	❑ Asthma, Allergies
❑ Smoke cigarettes	❑ Bronchitis	❑ Constipation

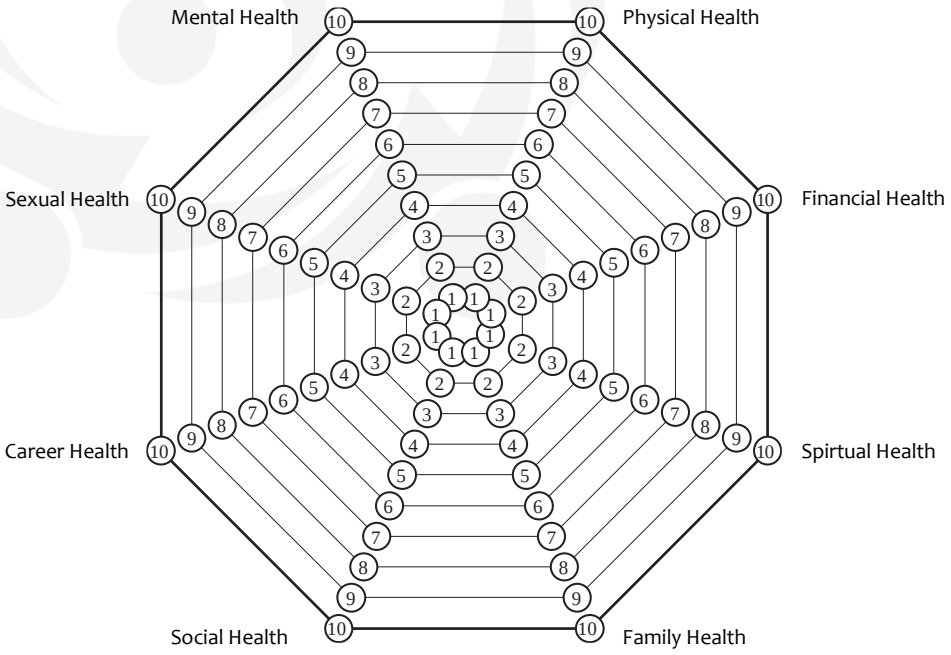
Kidney & Urinary Bladder

❑ Urine problems	❑ Bladder infection	❑ Sciatica, back pain
❑ Poor memory (LT)	❑ Loss, thinning hair	❑ Tinnitus
❑ Premature gray	❑ Cold hands & feet	❑ Ankle swelling
❑ Low bone density	❑ Aversion to cold	❑ Low, High sex drive
❑ Cavities, tooth loss	❑ Craving salty foods	❑ Impotence
❑ Dark, puffy eyes	❑ Hot flashes	❑ Infertility, Sterility

Web of Wellness

Health and wellness are a balance of many factors. Using the diagram to the right, check to indicate your level of satisfaction in each area of your life.

1 = *unsatisfied*
5 = *neutral*
10 = *delighted*



On a scale of "1 to 10," **how committed** you are to correcting the symptom.

not committed 1 2 3 4 5 6 7 8 9 10 *very committed*

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate:

It is understood that any dispute as to medical malpractice, including 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 the 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, 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 designed to secure 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 backup 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, agent, 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 chosen 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 prorate 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 other person or entity shall stay 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 the patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), the 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 AGREE 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/Guardian Signature	Date
Office Signature	Date

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

INFORMED CONSENT AND DISCLOSURE

By signing below, I do now request and voluntarily consent to the performance of acupuncture treatments and the other procedures within the scope of the practice of acupuncture on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist, **Dr. Seon Nam Kim** (a.k.a. David S. Kim Goodman) or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturist including those working at the office or any other clinic, whether signatories to this form or not.

I understand that acupuncturists practicing in the state of California are not primary care providers and that this clinic's practitioners recommend regular primary care by a licensed physician. I understand that methods of treatment may include, but are not limited to (electro-) acupuncture, acupressure, moxibustion, TDP (thermal design power or infrared) lamp, Gua-Sha, cupping, TENS (electrical stimulation), Tui-Na (Chinese massage), tapping, plum blossom, bleeding, pricking, taping, Chinese herbal formula, and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single-use needles through the skin. Treatments can occasionally produce mild but temporary discomfort, usually achiness, tingling, shooting, heaviness, or soreness at the acupuncture site. Treatment can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past three hours, and I will report to my acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, and infection. These risks have an extremely low incidence, primarily when a licensed acupuncturist appropriately administers acupuncture.

Electro-acupuncture/TENS: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupoints. A slight tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the area treated for up to a day after treatment. I understand that I must inform my practitioner if I am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure/Tui-Na: These procedures are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery prior to the procedure. I understand that there may be muscle soreness or achiness, as well as the possible aggravation of symptoms existing prior to the treatment during or after the procedure.

Moxibustion/TDP lamp: These heat therapies are used to warm areas of the body to promote health. Moxa requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the rare possibility of skin contact or mild burns exists. DKA clinic does not perform direct moxibustion where burning material contacts the skin.

Gua-Sha: This technique is light scraping on the skin in a small area using a smooth-edged instrument. It often results in bruising of the treated area. The bruising, which is not painful, usually resolves in three-seven days.

Cupping: This method involves a localized suction produced by heating a small glass /clay cup or pupping a small plastic cup. There is a possibility of local non-painful bruising from the suction. Very rarely, a slight burn or blister may appear due to the damp heat and pressure.

Tapping/Plum blossom/Bleeding/Pricking: All involve multiple needle pricks at a localized site. Slight bleeding or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.

Taping: This is a definitive rehabilitative taping technique that is designed to facilitate the body's natural healing process while providing support and stability to muscles and joints without restricting the body's range of motion—latex-free, water-proof, and wearable for days at a time. Common side effects include a mild skin rash or itching. If experienced, remove the tape immediately.

Herbal formula: Natural herbs have been used safely for centuries. The herbs may have an unpleasant smell or taste. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomfort related to the use of any prescribed herbs, I understand that I should stop the herbs and that I am responsible for informing my acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administrating guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications prior to any herbal treatment is initiated.

I understand the clinical and administrative staff may review my patient records and lab records. However, all my files 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 conditions and for any future conditions) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart conditions, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as **Dr. Seon Nam Kim** (a.k.a David S. Kim Goodman) is not a primary care physician.

I have read and understood all of the above information and am fully aware of what I am signing. I give my permission and consent to acupuncture treatment.

Patient/Guardian Signature	Date

Patient Name	Date of Birth (DOB)	Date of Service (DOS)

BILLING, PAYMENTS & CANCELLATION POLICY

BILLING POLICY

I understand that it is my responsibility to provide the office of **David Kim's Acupuncture**, accurate billing information at the time of check-in, and to notify the provider of any changes in this information.

I understand that it is my responsibility to know my specialist co-pay (which can be different from my Primary Care co-pay) and to pay it at the time of services rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service. They are required to report to the carrier any enrollees failing to pay co-pay.

I understand that if I present a nonsufficient funds (NSF) check for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

I understand that I will be billed for any amount due by me (co-pays, coinsurance amounts, or deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further follow that if I have not made payment before the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

I understand that the provider will obtain the necessary prior authorizations before rendering treatment. I further understand that prior approval is not a guarantee of payment and that I am responsible for any bills not paid by my insurance carrier.

INSURANCE DISCLAIMER

Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. As a courtesy to you, we will bill your insurance company. Please provide a copy of your insurance card whenever your plan renews or changes.

I understand that If my plan requires precertification, it is my responsibility to inform the office in writing when it is necessary. I further understand that it is my responsibility for missing insurance company precertification requirements.

I understand that insurance verification is not a guarantee of coverage or payment. I also know that it is my responsibility for my bill and that if attempts to collect payment from my insurance company (or responsible party) are not successful, I will remit the balance due upon notification.

I understand that If my plan changes due to COBRA or other policy changes, it is my responsibility to inform the office in writing of these changes. I further understand that if care is discontinued or I am released from further service at the office, all outstanding balances will be due at the time of leave.

CANCELLATION POLICY

At **David Kim's Acupuncture**, we are excited to have you as a patient, and your appointment time is reserved for you. Please be on time, and if you are running late, please call the office at **714-486-2873**. A minimum of 24-hour notice is required to cancel or reschedule your appointment to void the cancellation fee. It allows us to schedule another patient who would benefit from our care.

By voluntarily signing below, I understand and accept that a $30 cancellation fee will be charged to my account for the first occurrence, and the full cost of the visit for additional incidents.

FEE PAYMENTS

I understand and agree that all services rendered me are either billed to my insurance company (or responsible party) or charged to me. Balances overdue by 60 days may be subject to an 18(%) APR finance charge or $5 per month service charge if payments are not received. Our fees are based on the usual and customary guidelines for the area. Our standard Service Fees* are:

Initial Evaluation (E/M)

- 99203 - New Outpatient (30 min.): $90/unit
- 99204 - New Outpatient (45 min.): $120/unit
- 99205 - New Outpatient (60 min.): $150/unit
- 99214 - Established Outpatient (25 min.): $80/unit
- 99215 - Established Outpatient (40 min.): $110/unit

Office Consults

- 99242 - Outpatient (30 min.): $90/unit
- 99243 - Outpatient (45 min.): $120/unit
- 99244 - Outpatient (60 min.): $150/unit
- 99245 - Outpatient (80 min.): $180/unit

(Electro-) Acupuncture

- 97810 - Initial (15 min.): $60/unit
- 97811 - Additional (15 min.): $30/unit
- 97813 - (Electro-) Initial (15 min.): $70/unit
- 98714 - (Electro-) Additional (15 min.): $35/unit

Adjunctive Procedures & Modalities

- 97010 - Hot/Cold Packs: $5/unit
- 97020 - Infrared Heat Lamp: $15/unit
- 97110 - MSAT/Therapeutic exercise (15 min.): $35/unit
- 97240 - Therapeutic Massage (15 min.): $45/unit
- 97140 - Manual Therapy Technique (15 min.): $45/unit

We accept Cash, Debit/Credit card. If requested, receipts will be issued upon payment. *(* Discount available according to the California Prompt Pay Act.)*

I have read and understood all of the above information and am fully aware of my financial obligation as pertains to **David Kim's Acupuncture**.

Patient/Guardian Signature	Date