



## WELCOME

**Dear Patient,**

On behalf of our staff, clinic supervisors, and students, we would like to welcome you to **Pacific College Clinic**. Our clinic strives to provide caring and efficient treatments for all our patients. To do this, we have a few guidelines.

### **Appointments:**

We strive to run “on-time.” Occasionally, however, an emergency will disrupt the schedule and we apologize in advance should that occur and delay your visit. Your prompt arrival for scheduled appointments will also help keep us running smoothly. Sometimes you may be late; understanding that, we will make every effort to accommodate you. However, if we are fully booked and you are 15 (or more) minutes late, you may receive a modified treatment/visit or need to be rescheduled. This decision will be at the discretion of the clinic and you will still be responsible for the full amount of the visit fee. Lateness will be treated in the same manner as missed appointments, as indicated below.

### **Cancellations:**

We understand that circumstances arise which may prevent you from keeping an appointment. While 48 hours (about 2 days) notice is preferred, 24 hours notice of cancellation is required. If cancellation occurs without proper notice, you will be charged the full cost of the visit for missing your scheduled appointment and must settle the balance before scheduling any further appointments.

### **Insurance:**

We currently do not bill insurance; however, we do accept Flex Cards. Otherwise, you may elect to bill the insurance company yourself and pay the “time-of-service” fee. The clinic staff can provide an itemized statement that can be submitted to your insurance company. Feel free to discuss what’s best for you with our office manager.

### **Pacific College’s Herbal Pharmacy**

The outcome of an herbal consultation is a personalized prescription that may be filled elsewhere or at our pharmacy. Prices at Pacific College’s onsite pharmacy are competitive with other locations and we offer several forms of herbs for your convenience, which are available at an average cost of \$9.00 - \$25.00 per week.

**Prescription Refills:**

If your prescription was written for refills, simply call us at least 24 hours before the day you would like to pick up your prescription. If all the proper ingredients for your prescription are in stock, payment for your prescription will be taken over the phone. Our clinic staff will call you as soon as the prescription has been filled and ready for pick up.

**The Initial Visit:**

Our first visit will be the longest. Please be sure to have eaten within 2-3 hours of your visit and wear loose, comfortable clothing. We request that you arrive at least 30 minutes prior to your appointment time to complete new patient paperwork.

**What to bring:**

- A complete list and dosage of your recent & current medications and/or supplements (herbal or nutritional) that you are taking.
- Medical records, including past x-rays, lab work or other diagnostic studies, if applicable.

**In Health,**

**Pacific College Clinic Staff**

Please sign to indicate that you have read and understood the information provided above:

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Patient Name (Printed)

\_\_\_\_\_

Date



# PACIFIC COLLEGE of HEALTH AND SCIENCE

## Our Mission

*We, the Pacific College of Health and Science Wellness Center, a nationally recognized educational facility, provide exemplary clinical training for our students, personalized Oriental medical treatments for our patients, and supportive services for our staff so that each experiences a higher degree of satisfaction.*

Thank you for selecting us for as your healthcare partner. To help us meet all your healthcare needs, please fill out this form to the best of your ability. If you have any questions or need assistance, please ask one of our clinical receptionists and we will be happy to help.

All information provided will be confidential.

Personal Information					
Name				Date	
Address				Apt./Unit	
City		State		Zip Code	
Home/ Cell Phone			Work Phone		
Gender Identified			Biological Sex		
Height		Weight		Birthdate	/ /
Who is responsible for your account?					
Emergency Contact		Relation		Phone	
How did you hear about us?					

Physician History			
Have you seen a primary care physician in the last year?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician's Name		Phone	
Approximate date of most recent examination/visit?			

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had:							
Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer				Diabetes			
Hepatitis				Heart Disease			
Infectious Disease				Diagnosed Psychological/ Emotional/ Behavioral Disorders			
Type:				Seizures			
COVID-19				Tuberculosis			
Rheumatic Fever							
Others							

Please indicate the use and frequency of the following:											
Substance	Yes	No	Amount	Substance	Yes	No	Amount	Substance	Yes	No	Amount
Coffee/Tea				Tobacco				Water			
Recreational Drugs				Alcohol				Soda Pop			



# PACIFIC COLLEGE *of* HEALTH AND SCIENCE

Please check the if any of the following statements are true:

I have known allergies to medications, latex, silicon, or any metal alloy:  Yes  No

If yes, what are your allergies: \_\_\_\_\_

I am taking blood thinners:  Yes  No

If yes, which blood thinner: \_\_\_\_\_

I am taking lithium:  Yes  No

If yes, which lithium product: \_\_\_\_\_

I have a pacemaker/defibrillator/brain shunt/cardiac stents:  Yes  No

I have metal implants:  Yes  No

<b>Medications:</b>					
Please list any prescription or over the counter medications or supplements and herbs you are currently taking:					
Rx/Supplement/Herb	Dosage	Reason for taking	How long?	Prescribed by?	Date Prescribed

What are the main health problems for which you are seeking treatment?

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What other forms of treatment have you sought?

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List any other health problems you now have:

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List any food sensitivities or allergies you may have:

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List any accidents, surgeries, or hospitalizations (include dates):

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<b>Mental Health Questionnaire</b>				
<b>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “x” to indicate your answer)</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself- or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
For Office Coding				
Total Score				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle one.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Office use only: Instructions <https://www.pcpc.org/sites/default/files/resources/instructions.pdf>



Gynecological History

Age of 1st period (menarche) \_\_\_\_\_
Age of last period (menopause) \_\_\_\_\_
Number of days between periods \_\_\_\_\_
Number of days of flow \_\_\_\_\_
Color of flow \_\_\_\_\_

Are you pregnant? [ ] Yes [ ] No
# of live births \_\_\_\_\_ # of abortions \_\_\_\_\_ # of miscarriages \_\_\_\_\_
Date of last: Gynecologic exam \_\_\_\_\_ Pap \_\_\_\_\_
Mammograms \_\_\_\_\_ Bone Density Scan \_\_\_\_\_
Results \_\_\_\_\_

Clots: [ ] Yes [ ] No Color \_\_\_\_\_ Size \_\_\_\_\_
Average number of pads/tampons you use per day: 1st day \_\_\_\_\_ 2nd day \_\_\_\_\_ 3rd day \_\_\_\_\_ 4th day \_\_\_\_\_ + days \_\_\_\_\_

Have you been diagnosed with:

[ ] Fibroids [ ] Fibrocystic Breasts [ ] Endometriosis [ ] Ovarian Cysts [ ] PID other \_\_\_\_\_

Birth Control Method:

Pain related to menses

Before/During/After \_\_\_\_\_
Location of pain \_\_\_\_\_
Nature of pain \_\_\_\_\_
Other symptoms related to menses:

Urogenital History

Date of last prostate check-up \_\_\_\_\_ PSA results \_\_\_\_\_ Manual prostate exam results \_\_\_\_\_
Lab results \_\_\_\_\_
Frequency of Urination: daytime \_\_\_\_\_ nighttime \_\_\_\_\_
Color of urine: [ ] clear [ ] murky odor: \_\_\_\_\_
Symptoms related to prostate:

Three horizontal lines for additional notes.

Sexually Transmitted Diseases:

[ ] Gonorrhea [ ] Syphilis [ ] HIV [ ] Chlamydia [ ] Herpes Date: \_\_\_\_\_

Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

**\* MYMOP2 \***

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: \_\_\_\_\_

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

SYMPTOM 2: \_\_\_\_\_

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity: \_\_\_\_\_

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks	4 - 12 weeks	3 months - 1 year	1 - 5 years	over 5 years
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Are you taking any medication FOR THIS PROBLEM? Please circle: YES/NO

IF YES:

1. Please write in name of medication, and how much a day/week

\_\_\_\_\_

2. Is cutting down this medication: Please circle:

Not important	a bit important	very important	not applicable
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IF NO:

Is avoiding medication for this problem:

Not important	a bit important	very important	not applicable
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# NOTICE OF PRIVACY PRACTICE

**THIS NOTICE CONTAINS IMPORTANT INFORMATION ABOUT PACIFIC COLLEGE CLINIC PRIVACY PRACTICES. 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.**

## 1. *What is this notice?*

To run its program, the Pacific College of Health and Science (PCHS) must collect, maintain, and use non-public personal information on patients it provides services to. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure. This notice describes what types of information we collect, explains when and whom we may disclose it, and provides you with additional important information as to our legal duties and privacy practices. It also describes your rights to access and control your non-public personal information (NPI).

PCHS is required to abide by the terms of this notice. However, we may modify the terms of this notice at any time, and the new notice will be effective for all NPI in our possession at the time of the change, and any created or received thereafter.

Information PCHS collects, uses and maintains on you is protected by Federal and state laws: the Health Insurance Portability and Accountability Act (HIPAA) and California State Public Health Law. PCHS does not disclose NPI to anyone, except with your authorization or otherwise permitted by law.

If you believe your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) have been violated you can submit a written complaint to the PCHS Privacy Office at the address below. You may also complain to the Secretary for Health and Human Services if you believe your privacy rights have been violated. There will be no retaliation for filing a complaint.

## 2. *What is “non-public personal information” (NPI)?*

Non-public personal information (NPI) is information that identifies you as an individual and relates to your participation in treatment, your physical or mental health/condition, the provision of treatment or healthcare to you or payment to the PCHS for the provision of services provided to you.

## 3. *How does PCHS protect NPI?*

At PCHS, we restrict access to NPI to members of our workforce (staff and trainees) who need to provide care or services to you or are directly engaged in important agency operations. We maintain physical and procedural safeguards to protect your information against unauthorized access and use. We also have established a Privacy Office that has overall responsibility for developing, educating our workforce about and overseeing the implementation and enforcement policies and procedures to safeguard your health information against inappropriate access, use and disclosure, consistent with applicable law.

## 4. *How does PCHS use non-public personal information (NPI) and for what purposes?*

Here are some examples of what we do with the information we collect and the reasons it might be used:

**Treatment:** We may use information about you to provide medical treatment and services to you. We may use and share NPI with our staff and trainees who are involved in providing care to you. For example, information obtained by our staff and trainees will be recorded and used to determine your course of treatment.

**Payment:** We may use and disclose NPI so that treatment and services you receive may be billed to and payment collected from you or a third party. For example, we may complete and submit your healthcare plan or insurance

# NOTICE OF PRIVACY PRACTICE

company a description of treatment provided to you. We also may use and disclose your NPI to obtain from other third parties that may be responsible for the costs, such as family members.

**Health Care Operations:** We may also use and disclose NPI to perform health care operations. This is necessary to make sure that all our patients receive quality care. For example, we may use NPI to review our treatment and services and to evaluate the performance of our staff and trainees. We may also use and share NPI with the institute's trainees and other faculty for review and learning purposes.

## 5. *What uses and disclosures do not require authorization?*

We may use and disclose NPI without your authorization for the following purposes:

**Business Associates:** We may contract with outside individuals and organizations that perform business services for us, such as billing, management consultants, accreditation organizations, quality assurance reviewers, accountants, or attorneys. In certain circumstances, we may need to share your information to a business associate to the amount of information that is the minimum necessary for the business associate to perform services for us. In addition, we will have a written contract in place with the business associate requiring it to protect the privacy of your information.

**As Required by Law:** We will disclose NPI when required to do so by federal, state, or local law.

**Public Health Activities/Risks:** We may disclose NPI to public health authorities that are authorized by law to collect information for the purpose of:

- Reporting child abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding the potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device we may be using has been recalled
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence)
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

**Health Care Oversight Activities:** We may disclose NPI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil administrative and criminal procedures or actions; or other activities necessary for the government to monitor compliance with civil rights laws and the health care system in general

**Lawsuits and Disputes:** We may use and disclose NPI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your NPI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court order protecting the information the party has requested.

**Law Enforcement:** We may disclose NPI if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct at PCHS or of victims of crime; in emergency situations to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator); or when required by law to do so.

# NOTICE OF PRIVACY PRACTICE

**Serious Threats to Health or Safety:** We may use and disclose your NPI when necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual in the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**Military:** We may use and disclose NPI if you are a member of the United States or foreign military forces (including veterans) and if required by the appropriate military command authorities.

**Protective Services for the President, National Security, and Intelligence Activities:** We may use and disclose NPI to federal officials for intelligence and national security activities authorized by law. We also may disclose your NPI to federal officials to protect the President, other officials, or foreign heads of state, or to conduct investigations.

**Worker's Compensations:** We may release NPI for worker's compensation or similar programs.

6. *What uses and disclosures of NPI require your authorization?*

**Individuals Involved in Your Care or Payment for Your Care:** We may release NPI to a friend or family member identified by you, that is helping you pay for your treatment or who assists in taking care of you.

7. *What are your rights governing the information that PCHS collects, uses, and maintains on you?*

**The Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your NPI that we maintain and have in our possession, including treatment records and billing records. If you request copies, we will charge you a fee for the costs of copying, mailing, labor, and supplies associated with your request. To inspect and copy your NPI, you must submit your request in writing to the address below.

Under certain circumstances we may deny your request to inspect and copy your NPI. If you are denied access to this information, you have the right to have that determination reviewed. A licensed health care professional chosen by PCHS will review your request and the denial. The person conducting the review will not be the person who denied your request. PCHS promises to comply with the outcome of review.

**The Right to Amend or Correct NPI:** If you feel that any NPI we have about you is not correct or incomplete, you may ask us to correct or amend that information. You have the right to request an amendment for as long as the information is kept (three years) by us. To request an amendment, your request must be made in writing to the address below. Additionally, you must provide a reason that supports your request.

PCHS reserves the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us
- Is not part of the medical information kept by us
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete

**The Right to an Accounting of Disclosures:** An accounting of disclosures is a list of the disclosures we have made, if any, of your NPI.

You have the right to request an accounting of disclosures made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It also excludes communications of NPI made to you or disclosures authorized by you.

Your request must be made in writing and state a time-period that cannot be longer than six (6) years and cannot include dates before June 9, 2020. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

San Diego Campus: 7445 Mission Valley Rd., Ste. 105 • San Diego, CA 92108 • 619-574-6932 Effective Date: 6/9/20

# NOTICE OF PRIVACY PRACTICE

**The Right to Receive Communications of NPI by Alternative Means or Alternative Locations:** You have the right to request that we communicate with you about your treatment and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We will accommodate all reasonable requests made in writing.

**The Right to Request Restrictions:** You have the right to request a restriction or limitation on the NPI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a limit on the treatment information we disclose about you to someone who is involved in your care or the payment for your care (like a family member or friend).

PCHS is not required to agree to your request, however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply.

Any request for a restriction on our use and disclosure of your NPI must be made in writing to the address below. Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

**The Right to Provide an Authorization for Other Uses and Disclosures:** We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your NPI may be revoked at any time in writing to the address below. After you revoke your authorization, we will no longer use or disclose your NPI for the purposes described in the authorization, except under the following circumstance:

- We have acted in reliance upon your authorization before we received your written revocation

**The Right to Obtain a Paper Copy of This Notice:** You have the right to obtain a paper copy of this notice of privacy practices at any time.

Privacy Office

(212) 982-4600

# NOTICE OF PRIVACY PRACTICE

My signature below indicates that a written copy of the institute's Notice of Privacy Practices was provided to me. I have also been informed that if I require additional information about this notice I may call the Privacy Office.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (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 have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 side effect of cupping. Unusual risks of acupuncture include 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.

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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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:

ACUPUNCTURIST NAME:

PATIENT SIGNATURE **X** (Date)  
(Or Patient Representative) (Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

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 and federal law, and not by a lawsuit or resort to court process except as California and federal law provide 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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 healthcare 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 healthcare provider and/or other licensed healthcare providers, preceptors, or 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at [www.adrservices.com](http://www.adrservices.com) or by calling 213-683-1600 to request a copy of the rules.

**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 healthcare 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 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 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 Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

# COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

**To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)**

**Initial  
Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. \_\_\_\_\_
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. \_\_\_\_\_
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. \_\_\_\_\_
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  - \*Fever
  - \*Dry Cough
  - \*Sore Throat
  - \*Shortness of Breath
  - \*Runny Nose
  - \*Loss of Taste or Smell\_\_\_\_\_
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. \_\_\_\_\_
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. \_\_\_\_\_
- I have been offered a copy of this consent form. \_\_\_\_\_

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent /	Witness
Signature: _____	Guardian	Signature _____
	Signature _____	Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____