



# PATIENT'S PERSONAL HISTORY

**CONFIDENTIAL**

8950 Villa La Jolla Dr, Ste C126 La Jolla, CA 92037 Ph: (858) 546-1530

Name		Marital Status	
Sex M    F	Patient's Date of Birth	E-mail	
Telephone (Home) (    )	Primary <input type="checkbox"/>	Telephone (Mobile) (    )	Primary <input type="checkbox"/>
Address			
City		State	Zip

Employer	Occupation		
Telephone (Bus.) (    )			
Address	City	State	Zip

Insurance Company	Insured's Date of Birth
<p><b>If you would like us to courtesy-bill your insurance company electronically on your behalf, please give your insurance card to the receptionist to make a copy.</b></p>	

Emergency Contact	Relationship
Primary Phone (    )	Secondary Phone (    )

How were you referred to our office?:			
Have you ever had acupuncture?: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, condition treated	
Have you ever been diagnosed with any of the following?:    Hepatitis: <input type="checkbox"/> Yes <input type="checkbox"/> No    HIV Virus: <input type="checkbox"/> Yes <input type="checkbox"/> No    AIDS: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are currently under another physician's care for any medical conditions, please give your doctor's name and the medical condition:			
Doctor	Medical Condition		
Doctor	Medical Condition		
If you are currently taking any prescription medications, please list each of them:			
Medications			
List Any Substances You Are Allergic To:			
List any conditions you would like us to focus on:			

## CONSENT FOR ACUPUNCTURE

I, the undersigned, realize that acupuncture may be considered an investigative procedure in the United States of America.  
I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



# PATIENT PROFILE

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Name:	Date:
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It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms, thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience, use two checks for those which occur often, and three checks for symptoms that are a major concern.

**WATER ELEMENT**

- Hearing loss
- Dizziness
- Lower back ache
- Neck pain
- Sinus congestion
- Edema
- Emotional instability
- Aversion to cold
- Hair thinning or loss
- Premature aging
- Frequent urination
- Kidney stones
- Prespire very easily
- Weakness of legs / knees
- Asthmatic cough
- Rapid weight change
- Loose teeth
- Reduced sexual energy
- Thyroid problems
- Diabetes

**WOOD ELEMENT**

- Headaches
- Migraines
- Ringing in the ears
- Eczema
- Herpes simplex
- Warts
- Nervousness
- Convulsion, spasms
- Irritability
- Constipation
- Hemorrhoids
- Hepatitis
- Ulcer
- Vomiting

- Gallstones
- Indecisive
- Fullness below ribs
- Shoulder pain/tension
- Neck pain/tension
- Insomnia 11PM - 3 AM

**FIRE ELEMENT**

- Dry Scalp
- Skin eruptions, rashes
- Cysts, tumors
- Ear infections
- Sore throat, tonsilitis
- Lymphatic swelling
- Hot palms and soles
- Heart palpitations
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleed
- Facial redness
- Itching / burning skin
- Hot hands
- Hot feet
- Thirst
- Vivid dreaming
- Dark urine
- Flatulence
- Food allergy
- Stomach ache
- Stomach ulcer
- Diarrhea
- Anemia
- Halitosis
- Sores in mouth
- Heartburn
- Strong appetite
- Weak appetite

- Nausea
- Abdominal bloating
- Low body weight

**METAL ELEMENT**

- Bronchitis
- Asthma
- Shallow breathing
- Cough
- Sinus congestion
- Nasal infections

**OTHER**

- Fatigue
- Athralgia
- Sciatica
- Nerve pain
- Cold hands
- Cold feet
- Tendonitis
- Bursitis

**PAIN** (describe below)

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**OTHER COMMENTS**

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# 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 that travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that 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 _____	
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____

## ACUPUNCTURE INFORMED CONSENT TO TREAT

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 be 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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. 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.

ACUPUNCTURIST NAME: Jeneanne Paden, L.Ac.

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)



## FEES, INSURANCE AND PAYMENT AGREEMENT

8950 Villa La Jolla Dr, Ste C126 ♦ La Jolla, CA 92037 ♦ Ph: (858) 546-1530

Name:	Date:
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The fees charged at Acupuncture Fertility Center, Inc. and Galena AcuSpa are comparable to those charged by other specialists with similar qualifications in this geographic area.

The fees for office services are payable at the time of the visit, except in cases explained below. For your convenience we accept cash, personal checks, Mastercard, Visa, Discover and American Express.

All of our providers are considered "out-of-network" providers. If you carry health insurance covering any service that we offer, we can provide you with the necessary paperwork for you to receive reimbursement, or we can courtesy bill your carrier electronically on your behalf. Amounts billed by our office that are not reimbursed by your insurance company are the responsibility of the patient or their legal gaurdian.

**If you choose to have acupuncture at your doctor's office during your IVF transfer, you will be solely responsible for these fees, and an insurance claim will not be submitted by our office.**

If you are part of an industrial accident, on your first visit you must provide us with the proper paperwork signed by your employer, supervisor or medical referral with authorization from your Workers Compensation Carrier. We cannot treat you until we have proper authorization. Office visits will be billed directly to your Workers Compensation Carrier.

In cases where payment becomes overdue, we reserve the right to apply a finance charge at an interest rate of 1.5% per month for every month the account remains overdue.

If you agree to the above terms, please sign in the space provided below.

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Patient's Signature

## Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Acupuncture Fertility Center, Inc. dba Galena AcuSpa dba Acupuncture Fertility Center Notice of Privacy Practices. I further acknowledge that a paper copy of the current notice will be on file at all locations and will be available to me at my request during office hours, and that a current copy of the notice is available to me at [www.acufertility.com](http://www.acufertility.com).

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

Date: \_\_\_\_\_

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

Phone: \_\_\_\_\_

If patient is a minor, parent or legal guardian must sign below:

Parent or Legal Guardian of Minor Patient: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.  
IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK OUR STAFF.**

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Acupuncture Fertility Center, Inc. understands that your medical information and your health is personal and should be confidentially maintained. We are committed to protecting medical information about you. We are also committed to providing you with the best possible care. In order to serve you properly, we create a record of the care and services that we provide to you. This notice applies to all records that we generate to serve you. The following policy will be followed by everyone of our employees to ensure your information is confidentially maintained. This notice will explain the ways we use information about you in order to make sure that you receive all the care you need.

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 08/01/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, healthcare operations and payment. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may disclose medical information in the form of a patient status report to your worker's compensation carrier or insurance company representative so that they may monitor how you are progressing.

**Healthcare Operations:** We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by reasonable alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Jeneanne Paden, L.Ac.  
c/o Acupuncture Fertility Center  
8950 Villa La Jolla Dr, Ste C126  
La Jolla, CA 92037  
(858) 546-1530  
E-mail: [jypaden@acufertility.com](mailto:jypaden@acufertility.com)