Welcome to WELLSTREAM ACUPUNCTURE

Feel Like Yourself Again!

Cindy Albon, LAc, DiplAc (NCCAOM), MSOM
2016 Hillhurst Ave., Los Angeles CA. 90027
(323) 620-4934 wellstreamacupuncture@gmail.com www.wellstreamacupuncture.com

Confidential New Patient Information

Name _____ Date _____
Phone #_____ Email _____
Address _____
City _____ State _____ Zip _____

Date of Birth _____ Birth Place _____
Age _____ Gender: M / F / T Ht _____' _____" Wt _____# Marital Status _____
Occupation _____ Employer _____

Emergency Contact _____ Cel # _____
Relationship to Patient _____

How did you hear about our clinic? _____

Primary Physician _____ Doctors Diagnosis_____

PRIVACY RIGHTS/HIPAA NOTICE

Our office is dedicated to providing health services with respect for privacy.

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. All health and general information discussed is private and confidential and will never go beyond Doctor and Patient.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your PHI is used. You ascertain that by your signature below, you have reviewed our notice of patient's rights under the law before signing this consent. We're happy to answer any questions you may have regarding HIPAA rules and regulations.

May we email, text or leave phone messages for appointment scheduling or to answer questions? __YES __NO

I hereby acknowledge that I have read WellStream Acupuncture's Notice of Privacy Practices.

Patient Consent (Please Print Name)_____

Patient Signature _____ Date _____

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released without patient permission pursuant to HIPAA regulations.

Primary Health Concern?_____

_____

How long have you had this problem? _____ Have you had this previously? _____
How does this problem interfere with your daily activities? _____

_____

What makes it better? _____ What makes it worse? _____
Is your condition: __ Constant __ Intermittent Pain Level: __ None __ Low __ Moderate __ Severe

Secondary Concerns you would like addressed? _____

_____

Other concurrent therapies _____
How are you responding to your present course of treatment? Better _____ Worse _____ Same _____

Surgeries/Hospitalization *(please list dates also)*

_____

_____

Significant Trauma/Accidents _____

Do you have? __ Pacemaker __ Metal Implants __ Pregnant

Allergies:

_____

Medications (prescription drugs **AND** vitamins, supplements, herbs). Use back if you need more room…

Name_____ Dosage _____ To Treat? _____
Name_____ Dosage _____ To Treat? _____
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Stress __ None __ Low __ Moderate __ High __Severe Please Explain Causes:

_____

_____

Exercise (type/frequency) _____
Habits: __ Cigarettes __ Coffee __ Tea __ Sodas __ Alcohol Drugs: _____

Do you? __ skip meals __ eat large meals __ eat when rushed __ work and eat __ eat but not hungry

Average Daily Diet:

Morning _____

Afternoon _____

Evening _____

Snacks _____

Restrictions? (no gluten/dairy, vegan, etc…)_____

YOUR **MEDICAL HISTORY**

__ Cancer __ HIV+ __ Diabetes __ Heart Disease __ High Blood Pressure __ Low Blood Pressure __ Stroke
__ Epilepsy __ Asthma __ Kidney Disease __ Anemia __ Bleeding Disorder __ STD __ Hepatitis __ Jaundice
__ Thyroid Disease __ Chronic Fatigue __ Sudden Weight Loss __ Sudden Weight Gain

Other _____

Dates of Illness _____

FAMILY **MEDICAL HISTORY**

__ Cancer __ Diabetes __ Kidney Disease __ Heart Disease __ High Blood Pressure __ Stroke __ Epilepsy
__ Low Blood Pressure __ Asthma __ Anemia __ Bleeding Disorder __ Hepatitis __ HIV+ __ Thyroid Disease

For the following Sections on body systems function, please check X for any problems that are ***new/acute OR chronic.*** *If you 'had it once' then skip checking that symptom. These questions help determine the energetic pattern of imbalance in your body to evaluate best treatment plan, and can be enlightening to you as well.*

MUSCULOSKELETAL PAIN

__ Neck __ Back __ Shoulder __ Elbow __ Wrist __ Hand __ Fingers __ Hip __ Knee __ Ankle __ Foot __ Toes
Other area _____ __ Bones sore/painful __ Loss of Grip __ Swollen Joints __ Weakness
__ Leg cramps at night __ Tingling in feet __ Loss of feeling in hands/feet __ Muscle spasm/cramps
__ Stiffness all over __ Osteo Arthritis __ Rheumatoid Arthritis __ Tendinitis __ Sciatica
Onset of Pain: _____ Better with? _____ Worse with? _____
Describe the pain (ie: burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull)
_____

HEAD, EYES, EARS, NOSE AND THROAT

__ Sinus Problems __ Mucus __ Nose Bleeds __ Runny Nose __ Congestion __ Frequent Colds __ Allergies
__ Sore Throat __ Dry Mouth __ Difficulty Swallowing __ Hoarseness/Loss of Voice __ Sensation of 'Lump' in Throat
__ Headaches (describe) _____
__ Dizziness __ Concussion __ Poor Memory __ Loss of Balance __ Head feels 'Heavy' __ Migraines
__ Eye Strain __ Eye Pain __ Floaters __ Blurred Vision __ Dry Eyes __ Watery Eyes __ Itchy Eyes
__ Ear Ache __ Ear Infections __ Hearing Loss __ Tinnitus/Ringing in Ears __ Grinding Teeth __ TMJ
__ Tooth Pain __ Facial Pain __ Facial Paralysis __ Bells Palsy Other _____

LUNG SYSTEM

__ Dry Cough __ Coughing Phlegm __ Painful Cough __ Cold/Flu __ Shortness of Breath __ Asthma __ Wheezing
__ Pneumonia __ Bronchitis __ Difficulty Breathing When Lying Down __ Coughing Blood __ Chest Feels Tight
Phlegm color? _____ Thick or Thin? _____ Other?_____

HEART SYSTEM

__ Insomnia __ Difficulty falling asleep __ Difficulty staying asleep __ Nightmares __ Restless __ Sleep Apnea
__ Wake Easily __ Wakes frequently __ Wakes early: Time? _____ __ Heavy Sleep __ Snoring
__ High Blood Pressure __ Low Blood Pressure __ Pain/Pressure Chest __ Irregular Heart Beat __ Palpitations
__ Night sweats __ Cold Feet __ Cold Hands __ Swollen Hands/Feet __ Weakness in limbs
__ Fevers __ Chills __ Tremors __ Vertigo __ Dizziness __ Fainting __ Fatigue

SKIN/HAIR

__ Hives __ Eczema __ Psoriasis __ Rosacea __ Shingles __ Itching __ Acne __ Oily Skin __ Dry Skin __ Thin Skin
__ Hair Thinning __ Alopecia __ Changes in Moles /Lumps __ Scars __ Bleeds/Bruises Easily __ Varicose/Spider Veins
Other_____

DIGESTIVE SYSTEM

__ Heartburn __ Nausea __ Vomiting __ Belching __ Abdominal Bloating __ Foul Breath __ Stomach Pain
__ Poor Appetite __ Excess Hunger __ Feel tired if miss meal __ Weight Gain __ Weight Loss
__ Strong Thirst: __ For cold? __ For hot? __ Crave Sweets __ Crave Salty __ Crave Sour
Other food craving? _____ Weird food cravings? _____

BOWEL MOVEMENT: Frequency(#/day) _____ Quality (loose/firm)_____ Color_____

__ Diarrhea __ Constipation __ Flatulence __ Hemorrhoids __ Black Stools __ Bloody Stools __ Mucous Stools
__ Pain/Cramps __ Sensitive Abdomen __ Foul Odor __ Colitis __ Irritable Bowel __ Chrohn's
__ Sudden Energy Drop? At :_____(time) __ Fatigue __ Restless __ Heavy Limbs __ Weak Limbs

URINARY SYSTEM

__ Urgency to Urinate __ Burning with Urination __ Pain with Urination __ Incontinence __ Blood in Urine __ UTI's
__ Kidney Stones __ Frequent Infections __ Strong urine smell __ Frequent Urination: __ Day __ Night
Urine color: _____ Urine Amount:: (little/lots/not sure _____
Other_____

REPRODUCTIVE SYSTEM (for Women)

__ Pregnant __ TTC __ IVF __IUI # of pregnancies ____ # of Deliveries ____ # Miscarriages _____ # of Abortions _____
Age Started menstrual cycle_____ Age Stopped _____ Last Monthly Period Date _____
Period Duration _____ days Length of Monthly Cycle _____ days Birth Control Method _____
__ Heavy Flow __ Medium Flow __ Light Flow __ Spotting Blood Color (pale/dark/red/brown, etc?) _____
__ Irregular Periods __ Missed Periods __No Periods __ Painful Periods __ Clots __ Cramps
__ Yeast Infections ___ Candida __ Vaginal Discharges: __ Yellow __ White __ Thick __ Thin __ Itching __ Odor
__ Breast Lumps __ Breast Tenderness __ PMS Symptoms __ Fibroids __Cysts __ PCOS __ Endometriosis
__ Low Backache __ Bloating __ Menopause __ Hot Flashes __ Low Libido Last PAP? _____
Other _____

EMOTIONAL & NEUROLOGICAL

__ Nervous __ Depressed __ Worried __ Angry __ Easily Irritated __ Impatient __ Stressed __ Anxious __ Panic Attacks
__ Indecisive __ Fearful __ Sadness/Grief __ Frequent Crying __ Mood Swings __ Suicidal __ Phobias __ Bi-Polar
Other Emotional: _____
__ Seizures __ Tremors __ Numbness/Tingling __ Neuropathy __Multiple Sclerosis __ Neuralgia (pain) __ Shingles
__ Always Cold __ Always Hot __ Poor Coordination Other _____

Most Favorite:

Climate (dry/wet/windy/hot/cold/humid)

_____

Season _____

Temperature _____

Food _____

Flavor (sweet/salty/sour/spicy/bitter/bland)

_____

Time of Day _____

Color _____

Least Favorite:

Climate (dry/wet/windy/hot/cold/humid)

_____

Season _____

Temperature _____

Food _____

Flavor (sweet/salty/sour/spicy/bitter/bland)

_____

Time of Day _____

Color _____

Thank you for completing this confidential health questionnaire.
Your honest, complete answers will assist me in providing you with the best possible health care.

WellStream Acupuncture Cindy Albon, LAc, DiplAc (NCCAOM), MSOM
2016 Hillhurst Ave. Los Angeles CA 90027 323.620.4934

OUR PATIENT CARE FINANCIAL AGREEMENT POLICY

Effective February 1, 2023

Thank you for choosing Cindy J. Albon, LAc, DiplAc (NCCAOM), MSOM of WellStream Acupuncture, as your holistic healthcare provider. I am committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy and being in agreement. Please let me know if you have any questions or concerns.

Missed Appointments and Cancellations

When we make an appointment, I am reserving my time just for you. Sufficient cancellation notice allows me to offer your time to another patient who may be waiting for an appointment. **For this reason, last minute cancellations or missed appointments without sufficient 24 hr notice will be charged the full amount.** For patients arriving 10-15 minutes late or more, you may receive a shortened session, or you may be asked to reschedule your appointment if there is not sufficient time to provide treatment. Please help us provide the best care to you by keeping your scheduled appointments in a timely manner. Late cancellations due to emergencies are understandable, in which case the cancellation fee will be waived.

Cash Rate Schedule

All sessions include AuriculoTherapy, Aromatherapy, and Binaural Sound Therapy

New Patient PAIN ONLY Consultation, Evaluation & Acupuncture: 160
New Patient Cosmetic or General Health Consultation, Evaluation & Acupuncture: 190
New Patient Fertility, Pregnancy, Induce Labor Consultation, Evaluation & Acupuncture: 250
New Patient Chronic, Complex or Cancer Health Consultation, Evaluation & Acupuncture: 250
Esoteric Sacred Geometry Acupuncture with Gemstones, Essential Oils and Guided Visualization: 225
Follow-up Acupuncture Treatment (established patient): 125
Add-Ons: E-stimulation: 20 Dry Cupping: 40 Moxibustion, GuaSha or Oil Cupping Massage: 50
Turn Breech Session: 275 – Includes Acupuncture with Moxibustion; Moxibustion Demonstration and Tutorial; and Instruction Handout with Moxa Supplies provided
Cosmetic Facial Rejuvenation Acupuncture Follow-up (established patient): 175
add on GuaSha Massage or Facial Cupping with Natural Serums: 60
Outcall Services: Please contact our clinic
Herbal Supplements: prices vary from $10 – 45
Herbal Supplements may be returned *unopened* for a full refund. No returns or refunds on custom extracts.
Rates are time based. Rates subject to change. The most current pricing may be on our website.
There is a $45 fee for all bank returned (bounced) checks.

Regarding Insurance

We are In-Network providers for Cigna and will claim bill insurance for you. For all other insurances, we are out of network, and will provide you with a coded statement ('Super Bill') for submittal to your insurance carrier for direct reimbursement. Your insurance coverage is an agreement between you and your insurance company which I am not party to and you are therefore ultimately responsible for charges incurred while under treatment in this office.

My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.

Payment is due in full at time of service. In order to avoid a late cancellation fee I agree, I agree to give at least 24 hrs notice of cancellation.

X _____ Date _____

Signature of Patient or Responsible Party

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 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 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.

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 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: Cindy Albon, LAc, DiplAc (NCCAOM), MSOM

(Date)

PATIENT SIGNATURE **X**

(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 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. 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 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, 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 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. 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 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 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 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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

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