PATIENT NAME

ARBITRATION AGREEMENT, INFORMED CONSENT, AND PATIENT FINANCIAL RESPONSIBILTY FORM

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 State and Federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as 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.

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 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 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 it not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ . Effective as the date of first professional services.

If any provision of 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 2 OF THIS CONTRACT.

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

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed 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 (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that the health care providers and staff affiliated with Light of Heart Acupuncture and Herbs Inc., and their affiliates and partners may access my patient records, lab reports, financial information, and other personal information in order to provide supporting services, including but not limited to billing, filing insurance claims, managing my patient records, analyzing and evaluating my treatments, coordinating cooperation among health care providers, contacting me about follow-up appointments and possible treatment options or alternatives that may benefit me, contacting my emergency contacts in case of an emergency, disclosing my information to the government authorities as required by federal, state, or local law, but all my records will be otherwise kept confidential and will not be released to other entities without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT FINANCIAL RESPONSIBILTY FORM

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for the medical and other services rendered to the patient and/or products purchased by the patient. We are pleased to assist the patient by filing insurance claims and billing his/her insurance providers, if we determine at our sole discretion that the patient's insurance policy is acceptable to us. The patient is required to provide us the most correct and updated information about his/her insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. The patient is responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures, treatments, services, and/or products not covered by his/her insurance plan. Payment is due at the time of services and/or sales. If the patient's insurance policy pays less than our fees, the patient is required to pay the difference within ten (10) business days upon our verbal or written notice. It's understood that our fees for cash-payment patients is discounted from our regular fees. When we bill the patient's insurance provider, we apply the regular fees. It's understood that the payment from the patient's insurance provider should be sent and payable to us. From time to time, the insurance providers might mistakenly send the payment to the patient directly. When it happens, it is the patient's responsibility to contact us promptly and return the payment to us within ten (10) business days. Patients may incur, and are responsible for the payment of additional charges, including but not limited to:

Charge for returned checks	Charge for extensive phone consolations and/or after-hours phone calls requiring diagnosis, treatment, and/or prescription.	Charge for extensive form completion.
Charge of missed appointments without 24 hours advance notice.	Charge for the copying and distribution of patient medical records.	Any costs associated with collection of patient balances.

By my signature below, I hereby authorize the health care providers and staff associated with Light of Heart Acupuncture and Herbs Inc., and/or their affiliates and partners to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other health care providers and/or entities required to participate in my care. By my signature below, I hereby authorize assignment of financial benefits directly to Light of Heart Acupuncture and Herbs Inc., their affiliates and partners, and/or any associated health care entities for serviced rendered as allowable under standard third contracts. I understand that I am financially responsible for charges not covered by this assignment.. By my signature below, I authorize Light of Heart Acupuncture and Herbs Inc., and their affiliates and partners to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FORM:

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