ACUPUNCTURE & HERBS
CURATOR WELLNESS

Vanessa M. Ho L. Ac. Dipl. O.M. MSOM
CURATOR WELLNESS ACUPUNCTURE
1445 N. Gardner St., Los Angeles, CA 90046
(323)207-9585 | info@curatorwellness.com

Acupuncture New Patient Information

Please take the time to fill out this questionnaire. The information you provide will assist us in formulating a complete health profile for you.
All of your answers are absolutely confidential.
If you have any questions, please ask.

Today's Date _____

Name DOB Age Height Weight

Address Unit City State Zip

Cell Phone Home Phone Email

Employer & Occupation: _____ Relationship Status: _____

Emergency Contact:_____ Phone: _____

Who can we thank for referring you to us? _____

Have you ever seen an Acupuncturist Before? ◯ Yes ◯ No If yes, when?_____

If yes, who did you see?_____ What for? _____

Primary Care Physician:

Name: _____ Phone:_____

Other Practitioners involved in your care:

Name: _____ Phone:_____

Name: _____ Phone:_____

May we communicate with your other physicians about your care and treatment? ◯ Yes ◯ No

Cancellation Policy:

If you need to change or cancel your appointment, please notify us within a minimum **24 hours** notice. Our time is valuable, as well as yours! Failure to do so will result in a **$75** charge.

☐ **I read and understand the cancellation policy.**

Signature: _____ **Date:** _____/_____/_____

Health Information

Main Issue(s) you are seeking treatment for? : _____

How long have you had this problem?_____

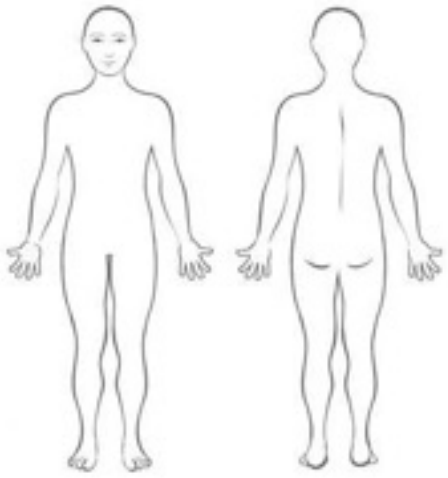
What aggravates your symptoms? (weather, activity, massage, heat/cold,stress…)_____

What relieves your symptoms? (ice/heat, massage, rest, activity…)_____

Any diagnosis from a medical professional and approximate date of diagnosis (if applicable):_____

_____

Please mark any areas of pain or discomfort:



Check any sensations/pain characteristics:

☐ Sharp	☐ Severe
☐ Burning	☐ Stabbing
☐ Moving	☐ Shooting
☐ Tingling	☐ Throbbing
☐ Dull	☐ Numbness

Other: _____

Please list the areas below with the 1-10 pain scale and brief history:

(1: barely noticeable pain; 10: excruciating pain)

_____

_____

_____

Medical History

Please list any Surgeries, Hospitalizations, and Significant traumas (Car accidents, Broken Bones, loss of loved ones, etc.):

Date	Event

Please list any prescription medications or over-the-counter medications you take currently, or have taken in the last 3 months:

Medication	Dosage	Reason	How long

Please list any vitamins, supplements, or herbal medicines you are taking (with dosages):

_____

_____

Please list any allergies or adverse reactions, especially to food or drugs:

_____

_____

Please check any of the following that have ever affected you:

☐	Addiction	☐	Diabetes	☐	Herpes	☐	Rheumatism
☐	AIDS/HIV	☐	Eating Disorders	☐	High Cholesterol	☐	Seizures
☐	Alcoholism	☐		☐	Hypertension	☐	Stroke
☐	Anemia	☐	Emphysema	☐	Hypotension	☐	STD
☐	Arteriosclerosis	☐	Epilepsy	☐	Kidney Stones	☐	Thyroid Problems
☐	Arthritis	☐	Fibromyalgia	☐	Malaria	☐	Tonsilitis
☐	Asthma	☐	Gallstones	☐	Meningitis	☐	Tuberculosis
☐	Breast Lumps	☐	Glaucoma	☐	Mononucleosis	☐	Ulcers
☐	Bursitis	☐	Goiter	☐	Multiple Sclerosis	☐	Urinary Problems
☐	Cancer	☐	Gout	☐	Nephritis	☐	Whooping Cough
☐	Candida	☐	Heart Disease	☐	Neuralgia	☐	
☐	Chronic Fatigue	☐	Hernia	☐	Paralysis	☐	
☐	Colitis/Bowel Disease	☐	Hepatitis __A__B__C__E	☐	Prostate Problems	☐	

Other: _____

Family Medical History: Please Check Any that Apply to Immediate Family Members

☐ Cancer ☐ Seizures ☐ High blood pressure ☐ Stroke ☐ Diabetes

☐ Heart Attack ☐ Hepatitis ☐ Asthma ☐ Other_____

Please Check Any Symptom You Currently Experience, Leave Blank if Not Applicable:

General

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Shortness of Breath	☐	☐	Weight Loss / Gain
☐	☐	Poor Coordination	☐	☐	Loss of Appetite
☐	☐	Vertigo/Dizziness	☐	☐	Increase in Appetite
☐	☐	Bleed/Bruise Easily	☐	☐	Strong Thirst
☐	☐	Hot/Cold Intolerance	☐	☐	Swollen/Sore Lymph Nodes
☐	☐	Nervousness/Irriatbility	☐	☐	Frequent Infections
☐	☐	Fever	☐	☐	Autoimmune diseases
☐	☐	Chills	☐	☐	Chronic Pain
☐	☐	Tremors	☐	☐	Mood Changes

Skin & Hair

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Rashes / Hives	☐	☐	Psoriasis
☐	☐	Eczema	☐	☐	Itchy Skin
☐	☐	Dry Skin	☐	☐	Loss of Hair/ Thinning
☐	☐	Oily Skin / Acne	☐	☐	Pre-mature Greying

Other Skin & Hair: _____

Head, Ears, Eyes, Nose & Throat

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Earaches / Recurrent Infections	☐	☐	Facial Pain
☐	☐	Ringing in the Ears (Tinnitus)	☐	☐	Sore / SwollenThroat
☐	☐	Hearing Loss	☐	☐	Tooth Pain or Problems
☐	☐	Headaches / Migraines	☐	☐	Sores on Lips / Tongue
☐	☐	Concussion	☐	☐	Teeth / Jaw Clenching
☐	☐	Sense of lump/mass (globus) in throat with swallowing	☐	☐	Gum Problems

Head, Ears, Eyes, Nose, Throat (cont)

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Vision Loss	☐	☐	Sinus Pressure
☐	☐	Blurry Vision	☐	☐	Nose Bleeds
☐	☐	Eye Floaters	☐	☐	Runny Nose
☐	☐	Itchy / Dry Eyes	☐	☐	Sneezing / Congestion
☐	☐	Red Eyes	☐	☐	Peculiar Smells
☐	☐	Night Blindness	☐	☐	Peculiar Tastes
☐	☐	Glaucoma	☐	☐	Cataracts

Other Head, Ears, Eyes, Nose & Throat: _____

Cardiovascular/Circulatory

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Chest Pain	☐	☐	High Cholesterol
☐	☐	High Blood Pressure	☐	☐	Poor Circulation
☐	☐	Low Blood Pressure	☐	☐	Varicose Veins
☐	☐	Irregular Heartbeat	☐	☐	Swelling / Edema
☐	☐	Shortness of Breath	☐	☐	Fainting
☐	☐	Palpitations	☐	☐	Clotting Disorders
☐	☐	Heart Murmur	☐	☐	Sudden Loss of Consciousness

Other Cardiovascular/Circulatory: _____

Respiratory

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Pain on Inhaling	☐	☐	Shallow Breathing
☐	☐	Chest Tightness	☐	☐	Bronchitis
☐	☐	Cough	☐	☐	Emphysema
☐	☐	Asthma	☐	☐	Frequent Colds / Flu
☐	☐	Wheezing	☐	☐	Coughing Blood

Other Respiratory: _____

Digestive / Gastrointestinal

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Heartburn	☐	☐	Gas / Bloating	☐	☐	Black Stool
☐	☐	Chronic Bad Breath	☐	☐	Abdominal Pain / Cramps	☐	☐	Light-Colored Stools
☐	☐	Nausea	☐	☐	Diarrhea	☐	☐	Hemorrhoids
☐	☐	Vomiting	☐	☐	Constipation	☐	☐	Rectal Pain
☐	☐	Hiccups	☐	☐	Chronic Laxative Use	☐	☐	Hiatal Hernia
☐	☐	Acid Reflux	☐	☐	Mucus or Blood in Stool	☐	☐	Burning Anus
☐	☐	Belching	☐	☐	Food in Stool	☐	☐	Indigestion

Other GI: _____

Musculoskeletal/Neurological

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Joint Pain / Swelling	☐	☐	Sciatica
☐	☐	Muscle Aches / Weakness	☐	☐	Knee Pain
☐	☐	Neck Pain / Tightness	☐	☐	Scoliosis
☐	☐	Shoulder Pain	☐	☐	Sprains / Strains
☐	☐	Hand / Wrist Pain	☐	☐	Hernia
☐	☐	Back Pain (Upper/Mid/Low)	☐	☐	Seizures
☐	☐	Hip Pain	☐	☐	Tremors
☐	☐	Tingling / Numbness	☐	☐	Paralysis
☐	☐	Balance Problems	☐	☐	Abrupt Loss/Change of Consciousness
☐	☐	Parkinsons	☐	☐	Multiple Sclerosis

Other Musculoskeletal/Neurological: _____

Genito-Urinary

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Pain on Urination	☐	☐	Urgent/Frequent Urination
☐	☐	Blood in Urine	☐	☐	Kidney Stones
☐	☐	Unable to Hold Urine	☐	☐	Frequent UTIs
☐	☐	Decreased Urine Flow	☐	☐	Frequent STDs
☐	☐	Incomplete Urination	☐	☐	Genital Pain and/or Itching
☐	☐	Night Time Urination	☐	☐	Yeast Infections
☐	☐	Cloudy Urine	☐	☐	Sores on Genitals
☐	☐	Decreased Libido	☐	☐	Increased Libido

Other Genito-Urinary:_____

Reproductive

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Prostate Problems	☐	☐	Penile Discharge
☐	☐	Erectile Dysfunction / Impotence	☐	☐	Ejaculatory Pain
☐	☐	Testicular Lumps	☐	☐	BPH

Other Reproductive:_____

Have you had a Prostate Exam? ☐ Y ☐ N If yes, When? _____

Results?_____

Gynecological (If you have gone through menopause, please describe your last menstruation)

Is there a possibility that you're pregnant? ☐ Y ☐ N Date of Last Pap Smear?_____

Age of First Period: _____ Approximate Date of Last Menstrual Period: _____

Approximately how many days are there from the start of one period to the next? _____

Average length of menstrual flow: _____ days

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Painful Periods	☐	☐	Vaginal Discharge
☐	☐	Irregular Periods	☐	☐	Breast Lumps
☐	☐	Menstrual Cramping	☐	☐	Breast Pain
☐	☐	Bleeding Between Periods	☐	☐	Mastitis
☐	☐	PMS	☐	☐	Fibroids
☐	☐	Endometriosis	☐	☐	PID
☐	☐	Hot Flashes	☐	☐	Night Sweating

Other Gynecological: _____

_____

Menstrual Flow: ☐ Heavy ☐ Light ☐ Clots ☐ Painful ☐ Pleasant

Color of Flow (Choose all that apply): ☐ Dark/Black ☐ Brown ☐ Dark Red ☐ Bright Red ☐ Pale/Pink ☐ Other

PMS Symptoms: _____

Menopause: Age of Menopause _____ Menopausal Symptoms: _____

Pregnancy: # of Pregnancies _____ # of Live Births (include dates) _____

# of Miscarriages_____ # of Abortions_____ # of Premature Births _____

Are you currently pregnant or breast feeding? _____

Have you ever or are you currently taking birth control? If yes, when and/or for how long?_____

_____

Psychological/Mood

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Sadness / Depression	☐	☐	Easily Susceptible to Stress
☐	☐	Anxiety	☐	☐	Panic Attacks
☐	☐	Irritability	☐	☐	Extreme Fear
☐	☐	Quick Temper	☐	☐	Extreme Grief
☐	☐	Mood Swings	☐	☐	Extreme Anger
☐	☐	Loss of Control	☐	☐	Seeing a Therapist
☐	☐	Happy / Joyful	☐	☐	Suicidal Thoughts / Attempts

Other Psychological/Mood: _____

Lifestyle, Personal & Social History

About how many hours per night do you sleep? _____ Do you Wake Rested? ☐ Y ☐ N

☐	Difficulty Falling Asleep	☐	Vivid Dreaming
☐	Difficulty Staying Asleep / Waking Often	☐	Night Sweating
☐	Snoring	☐	Wake Early & Can't Go Back to Sleep
☐	Sleep Apnea	☐	Sleep Walking

Energy Levels: (Typical Day) ☐ Up and Down ☐ Low ☐ Normal ☐ Excessive ☐ Low After Eating

Do you follow a certain way of eating? (Vegan, Vegetarian, Paleo, etc.)_____

Do you crave any particular foods or flavors? _____

Do you prefer: ◯ Warm ◯ Cold Drinks?

Water _____ / day (8 oz glasses) Coffee/Caffeinated Tea _____ / day (cups) Soda _____ / day

Alcohol: ☐ Y ☐ N Type and amount per week: _____

Cigarettes/Tobacco: ☐ Y ☐ N How many/day? _____ Since When? _____

Recreational Drugs: ☐ Y ☐ N Type and amount per week: _____ Since When? _____

Exercise: _____ / per week Activities: _____

What are your hobbies / things you enjoy doing in your free time? _____

_____

What are your goals / intentions with receiving Acupuncture Treatment? _____

_____

Please feel free to list / describe any other issues you would like to discuss: _____

_____

_____

The information on this form is correct and accurate to the best of my knowledge

Signature:_____ Date: _____/_____/_____

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

CURATOR WELLNESS ACUPUNCTURE

1445 N. Gardner St., Los Angeles, CA 90046

(323)207-9585 info@curatorwellness.com

I understand that I am the decision maker for my health care. Part of this practice'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 Vanessa Minchi Ho, L.Ac., Dipl.O.M., MSOM 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 Vanessa Minchi Ho, L.Ac., Dipl.O.M., MSOM including those working at the clinic 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 Curator Wellness Acupuncture 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.

ACUPUNCTURE INFORMED CONSENT TO TREAT

CURATOR WELLNESS ACUPUNCTURE

1445 N. Gardner St., Los Angeles, CA 90046

(323)207-9585 info@curatorwellness.com

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: _____ DATE: _____

PATIENT SIGNATURE: _____

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

HIPAA Notice of Privacy Practices

CURATOR WELLNESS ACUPUNCTURE

1445 N. Gardner St., Los Angeles, CA 90046

(323)207-9585 info@curatorwellness.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact us at the above contact information above.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Our Obligations
We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information
Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment

with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who
may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report
to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic
violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our practice.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about

your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to us. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our practice.

Changes to This Notice
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints
If you believe your privacy has been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact us. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____
Patient or Guardian Signature

_____
Date

ACUPUNCTURE & HERBS
CURATOR WELLNESS
Vanessa M. Ho L. Ac. Dipl. O.M. MSOM 1445 N. Gardner St., Los Angeles, CA 90046
CURATOR WELLNESS ACUPUNCTURE (323)207-9585 | info@curatorwellness.com

Terms and Conditions of Service

Admission and Medical Services Agreement

The patient or the patient's representative consents to the admission of the patient to Curator Wellness Acupuncture if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

Medical Consent

I have read and fully understand and consent to any Oriental Medical treatments or procedures that are given by Curator Wellness Acupuncture. The patient accepts the full responsibility to follow up the medical advice given at Curator Wellness Acupuncture. The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

Financial Agreement

We are currently out-of-network with insurance providers, a superbill for reimbursement will be provided upon request. Submission of these claims is the patient's responsibility. Please allow a period of three(3) business days processing time for any superbill requests.

The patient or patient's representative agrees to pay Curator Wellness Acupuncture for services rendered in accordance with the regular rates and terms of Curator Wellness Acupuncture. When this agreement is executed by the patient, the patient's representative, or a financial guarantor, all shall be jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

Missed Appointments & Cancellation Policy

Your appointments are very important to us and to you. We do understand that sometimes schedule adjustments are necessary; in these cases, we respectfully request at least 24 hours notice for adjustments to your appointments and for cancellations. All our policies are designed to benefit our patients to provide the best service to our established and future clientele.

This is important to understand as a patient since canceling an appointment without sufficient notice and time means that another client on our waiting list who may need our services misses their opportunity for treatment.

We ask that all new and current patients supply a credit card to keep on file. **In the event that we do not receive at least 24 hours notice for schedule adjustments and cancellations, a flat rate of $65 will be applied to your card or alternatively billed out to you.**

If we are given notification at least **24 hours before your appointment**, no charges will be incurred.

Credit Card Authorization

I authorize Curator Wellness Acupuncture to charge the following credit card for the full amount of costs and fees due for services rendered and missed or canceled appointments. I understand that it is my responsibility to notify Curator Wellness Acupuncture by phone or email at least 24 hours in advance of my scheduled appointment time to cancel or reschedule. If I do not provide at least 24 hours notice, I will be subject to cancellation fees.

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card #:_____ CVV/CVC:_____Exp.Date:_____
Name as it appears on card:_____
Card Billing Address:_____
City:_____State:_____Zip Code:_____Phone #:_____
Cardholder Signature:_____Date:_____

I (The Client) have read and agree with the above Terms and Conditions of Service.
Full payment is due at the time of your service. We accept cash and credit card.

Signature: _____ Date: ____/____/_____