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HolisticZen.com

Holistic Zen Acupuncture & Massage
WELCOME

Dear Patient,

We'd like to welcome you to Holistic Zen Acupuncture & Massage. We strive to provide all patients with outstanding compassionate health-care. In order to do this, we have a few guidelines:

*** APPOINTMENTS**
We strive to run on time. Occasionally, however, an emergency will disrupt the schedule and we apologize in advance should that occur and delay your visit. Your prompt arrival for scheduled appointments will also help keep us running smoothly. Sometimes you may be late; understanding that, we will make every effort to accommodate you. However, in the event that we are fully booked and you are 10 (or more) minutes late, you may receive a modified treatment/visit or need to be rescheduled. This decision will be at the discretion of HZAM and you will be responsible for the full treatment fee.

*** CANCELLATIONS**
We understand that circumstances arise which may prevent you from keeping an appointment. While 48 hours notice is preferred, **24 hours notice of cancellation is required.** If cancellation occurs without proper notice, you will be charged 50% of the cost of the visit for missing your scheduled appointment.

*** CONFIDENTIALITY**
The therapeutic relationship between a client and practitioner is important and personal. The client has a right to privacy and all treatments are confidential. In extreme circumstances confidentiality will be breached. The client will be notified.

*** SCOPE OF PRACTICE & REFERRALS**
Kayleen Walsh has a Bachelors Degree in Sociology, Psychology, and Women's Studies. She has also obtained a 1000 hr. certification in Massage Therapy at The Boulder College of Massage Therapy. Kayleen studied Shiatsu, Swedish, Neuromuscular, Integrative, and Tui Na. In addition, she has completed 30 hours of training in both Sports and Orthopedic massage and 47 hours of Pre-natal massage. Kayleen is a licensed Acupuncturist with a Master's in Traditional Oriental Medicine with advanced training in acupuncture, herbal and dietary consultations, cupping and gua sha. HZAM is passionate about health-care and works within a specific scope of practice. If at any time the patient's needs can not be met due to a lack of qualifications or experience a list of reputable professionals to further serve the client will be provided.

Holistic Zen Acupuncture & Massage: Policies, Procedures & Informed Consent

*PRIVACY AND DRAPING

The client should feel comfortable at all times. Clients are asked to undress to their comfort level. The practitioner leaves the room while the client disrobes and knocks before re-entering. The practitioner only undrapes the specific body part he/she is working on (all other parts of the body are covered).

* HYGIENE

Practitioners make a conscious effort to wear professional attire and maintain good hygiene. Clients will maintain a general sense of hygiene.

* INTOXICANT POLICY

Clients please do not arrive to an appointment under the influence of alcohol or drugs. The session will be terminated and full payment is required under these circumstances.

* CLIENT/THERAPIST RELATIONSHIP

Holistic Zen AcuMassage does not engage in relationships outside of the professional environment with clients. A dual relationship could potentially compromise the therapeutic relationship.

* SEXUAL MISCONDUCT

If the client or practitioner ever feels uncomfortable a session may be terminated and full payment is required. Boundary violations are not tolerated.

* CLIENT RIGHTS

Massage therapy is client-centered. HZAM strongly encourages every client to be an active participant in his or her health. We value and support open and honest communication.

*INSURANCE

It is the patient's responsibility to verify insurance benefits. If the patient's plan does not cover the costs of services the patient is responsible for the remaining balance.

*INFORMED CONSENT AGREEMENT

I hereby request and consent to the performance of bodywork and/or acupuncture or other procedures associated with Holistic Zen Acupuncture & Massage.

I understand that methods of the treatment may include but are not limited to: massage, acupuncture, moxibustion, cupping, gua sha, application of liniments, electrical stimulation, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have 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, cupping, and gua sha, or when treatment involves the use of heat. Bruising is a common side effect of cupping. Unusual risks of acupuncture include miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although HZAM 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. Herbs and nutritional supplements (which are from plant, animal, and mineral sources), which may be recommended, are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that the herbs may have an unpleasant smell or taste. 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 immediately notify HZAM of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have stated all my known physical conditions and medications, including pregnancy, and will keep HZAM up to date on any changes.

I do not expect HZAM to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioners to exercise judgement during the course of treatment which they think, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that HZAM may review my medical records and lab reports. My name and identifying information will not be disclosed and will be kept confidential. Your information will not be released to any party without written consent, in full compliance of HIPPA regulations.

By voluntarily signing below I show that I have read, or have read to me, this consent to treatment, have been told about the risks and benefits of treatment, and have had an opportunity to ask any 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 Signature **X** _____ Date **X** _____

* To be completed by patient's representative if the patient is a minor or is physically or legally incapacitated. Indicate relationship if signing for patient.

Please sign the next page if giving consent to treat a minor.

CONSENT TO TREAT A MINOR

Name of Minor:_____

Date of Birth:_____ Social Security Number:_____

In my absence, I _____,(relationship)_____

Give permission for any medical treatment deemed necessary for the care of my child

(minor's name), _____

While under the care of Holistic Zen AcuMassage.

X_____

Parent/Legal Guardian (print name)

X_____

Parent/Legal Guardian (signature)

_____

Witness

X_____

Date

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 law, and not by a lawsuit or resort to court process except as state and federal law 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, 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 treatment or services provided 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 staff 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 office or during outcalls whether signatories to this form or not.

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 counseling fees, witness fees, or other expenses incurred by a party for such party's 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 and 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 judgement 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 statue of the 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 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 a 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.

_____ _____ _____ _____

X PATIENT SIGNATURE **X**DATE OFFICE SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

My signature below indicates that the institute's NOTICE OF PRIVACY PRACTICES was provided to me. You can find this information on the last page of this welcome packet (or in a separate document online). I have also been informed that if I require additional information about this notice I may call Holistic Zen Acupuncture & Massage at: 760-274-3346

_____

X PATIENT NAME **X** DATE

_____

X PATIENT SIGNATURE **X** DATE

PATIENT REFUSED to SIGN:

_____

STAFF SIGNATURE DATE

Holistic Zen Acupuncture & Massage

NEW FERTILITY PATIENT HISTORY

A. FEMALE IDENTIFYING DATA

Date this form completed _____

Your name: _____ Partner's Name: _____

Age_____Birth date_____Height_____Weight _____

How long have you been trying to get pregnant? _____

Have you previously been pregnant? _____

Have you previously tried to get pregnant? _____

Reason for your visit today? _____

_____

B. PREGNANCY HISTORY

Times pregnant_____Term births_____Premature births _____

Miscarriages_____Elective abortion_____Adopted children _____

Pregnancies:

Pregnancy (include all pregnancies	When ? (Year)	How long to conceive	Sex and weight	Is current partner the father (Y/N)	Outcome (miscarriage, abortion, ectopic, vaginal delivery, cesarean section, stillbirth, complications if any.
First					
Second					
Third					
Fourth					
Fifth					

Comments: _____

Contraceptive Use

	From when to when	Reason discontinued	Complications
Intrauterine device (IUD)			
Oral contraceptives Type:			
Other			

C. MENSTRUAL HISTORY

Menstrual (hormonal) history

Date your last menstrual period began _____
Your age at your first period _____
Are your periods regular? _____
How many days from onset to onset? _____
How many days does your period last? _____
Do you bleed between periods? _____
Do you have premenstrual symptoms ☐ almost always ☐ rarely ☐ never
Have you ever needed medication to bring on your period? Yes ☐ No ☐
If yes, what medication: _____ When? _____
If you have a hormonal disorder, please specify and treatment _____

Pelvic pain/cramps: ☐ none ☐ during your period ☐ before your period ☐ after your period
☐ at mid-cycle ☐ during intercourse ☐ with urination ☐ with bowel movements
☐ cause you to miss usual activities ☐ cause you to miss work
Pelvic cramps/pain are: ☐ mild ☐ moderate ☐ severe ☐ getting worse ☐ improving
☐ not changing ☐ on the right side ☐ on the left side ☐ in the middle
What medications do you take for pain/cramps? _____
Do you have painful intercourse: ☐ Yes ☐ No

Do you have or have you had:

	Yes	No		Yes	No
Pelvic inflammatory disease (PID)	☐	☐	Vision problems	☐	☐
Intrauterine device (IUD)	☐	☐	Chronic headaches	☐	☐
DES exposure	☐	☐	Head injury	☐	☐
Breast discharge (galactorrhea)	☐	☐	Seizure disorder	☐	☐
Breast biopsy	☐	☐	Weight gain (> 10 pounds)	☐	☐
Thyroid disease.	☐	☐	Weight loss (> 10 pounds)	☐	☐
Increased facial or body hair	☐	☐	Special dietary habits	☐	☐
Loss of hair	☐	☐	Vomiting	☐	☐
Increased acne	☐	☐	Excessive stress	☐	☐
Decreased breast size	☐	☐	Autoimmune disease	☐	☐
Deepening of voice	☐	☐	Psychiatric treatment	☐	☐
Hot flashes or night sweats	☐	☐	Rh sensitized	☐	☐
Poor sense of smell	☐	☐			

If you answered yes to any questions, please explain _____

D. GYNECOLOGICAL HISTORY

Do you have or have you had:

	Yes	No		Yes	No
Abnormal uterus (shape, etc)	☐	☐	Ovarian cysts	☐	☐
Colitis or enteritis	☐	☐	Pelvic adhesions	☐	☐
Endometriosis	☐	☐	Uterine fibroids or myomas	☐	☐

Gynecologist: _____

Primary Care Physician: _____

Last Pap smear _____ Last mammogram _____

Any abnormal Pap smears?_____, dates _____ Any abnormal mammograms? _____

Do you have or have you had:

	Yes	No		Yes	No
Cryo (freezing) or surgery of the cervix	☐	☐	Chlamydia	☐	☐
Genital warts/condyloma	☐	☐	Gonorrhea	☐	☐
Vaginal discharge	☐	☐	Herpes: Genital	☐	☐
Recurring vaginitis	☐	☐	Mycoplasma/Ureaplasma	☐	☐
Trichomonas	☐	☐	Syphilis	☐	☐
Cervical stenosis	☐	☐	Cytomegalovirus (CMV)	☐	☐
Cervicitis	☐	☐	Recurrent urinary infections	☐	☐

	Yes	No
Use of lubricants	☐	☐
Douche before/after intercourse	☐	☐
Bleeding/spotting after intercourse	☐	☐
Sexual problems at this time	☐	☐

If yes, explain: _____

How many times per week do you have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

F. MEDICAL HISTORY

Past Medical History

	Yes	No		Yes	No
Anemia	☐	☐	Liver problems	☐	☐
Appendicitis	☐	☐	Lung disease	☐	☐
Arthritis	☐	☐	Lupus	☐	☐
Asthma	☐	☐	Migraine headaches	☐	☐
Bleeding disorders	☐	☐	Radiation exposure	☐	☐
Blood clots	☐	☐	Rheumatic fever	☐	☐
Blood transfusion	☐	☐	Toxic exposure	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Chronic bronchitis	☐	☐	Ulcers		
Diabetes	☐	☐			
Eating disorder	☐	☐	Chickenpox (varicella)	☐	☐
Gallbladder problems	☐	☐	Chickenpox vaccine	☐	☐
Heart disease	☐	☐	German measles (rubella)	☐	☐
Hepatitis A, B or C	☐	☐	Rubella immunization	☐	☐
High blood pressure	☐	☐			
Kidney disease	☐	☐			
Kidney infection	☐	☐			

If yes, explain _____

List all serious or chronic illnesses or injuries not already described _____

Medications: Please list all prescriptions and over-the-counter drugs used during the past year.

Medication	Dosage and frequency	From when to when	Reason for taking

Allergies

To what (drug or substance)?	When	What type of reaction?

G. PAST SURGICAL HISTORY

Operations and Hospitalizations

Date	Diagnosis	Operation	Where performed	Physician	Complications of anesthesia

H. FEMALE FAMILY HISTORY

Ethnic background (circle): African/American Asian Asian-Indian Caucasian Hispanic

Jewish Indian Mediterranean Middle Eastern Other _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish, Cajun, French Canadian	Tay Sachs				
Ashkenazi Jew	Ashkenazi Jewish Panel (11)				

Do any family members have:

	Yes	Who		Yes	Who
Cancer of the uterus /breast/ovaries			Hemophilia		
Birth defects, genetic (inherited)			Infertility		
Bleeding disorders			Irregular menstrual cycles		
Chromosomal disorders			Lack of sense of smell		
Connective tissue disease			Learning problems		
Cystic fibrosis			Mental retardation / Autism / Fragile X		
Delayed development			Metabolic disorders		
Down's syndrome			Miscarriages (2 or more)		
Early menopause < 40 yrs old			Muscular dystrophy		
Early puberty			Short stature		
Endometriosis			Spina bifida		
Excess body hair			Stillborn child		
Genital abnormalities			Spinal Muscular Atrophy		
Other					

Comments: _____

H. SOCIAL HISTORY

Cigarettes – packs smoked/day _____

Alcohol – type and number of drinks/week _____

Marijuana – amount _____

Other drugs – type and amount _____

Ever used intravenous drugs? _____

How much do you exercise? _____

Do you have a dog or cat? _____

Comments: _____

I. PREVIOUS EVALUATION

Have you had:

	Not Done	Result: Normal	Result: Abnormal	Approx date	Values (if known)
Basal body temperature (BBT)	☐	☐	☐	_____	_____
Urine LH surge	☐	☐	☐	_____	_____
Endometrial biopsy	☐	☐	☐	_____	_____
Blood tests:					
FSH	☐	☐	☐	_____	_____
LH	☐	☐	☐	_____	_____
Prolactin	☐	☐	☐	_____	_____
Thyroid tests (TSH, T4)	☐	☐	☐	_____	_____
DHEAS	☐	☐	☐	_____	_____

	Not Done	Result: Normal	Result: Abnormal	Approx date	Values (if known)
Testosterone	☐	☐	☐	_____	_____
Estradiol	☐	☐	☐	_____	_____
Progesterone	☐	☐	☐	_____	_____
Postcoital test	☐	☐	☐	_____	_____
Mycoplasma culture	☐	☐	☐	_____	_____
Chlamydia culture	☐	☐	☐	_____	_____
Antichlamydial antibodies	☐	☐	☐	_____	_____
Hysterosalpingogram (HSG)	☐	☐	☐	_____	_____
Ultrasound	☐	☐	☐	_____	_____
Kidney x-ray (IVP)	☐	☐	☐	_____	_____
Laparoscopy	☐	☐	☐	_____	_____
Hysteroscopy	☐	☐	☐	_____	_____
Karyotype	☐	☐	☐	_____	_____
Anticardiolipin antibodies	☐	☐	☐	_____	_____
Lupus anticoagulant	☐	☐	☐	_____	_____
Antinuclear antibodies (ANA)	☐	☐	☐	_____	_____
Coagulation screen	☐	☐	☐	_____	_____
Biochemistry/hematology panel	☐	☐	☐	_____	_____
Blood type	☐				
Other_____	☐	☐	☐	_____	_____

Comments: _____

K: PREVIOUS TREATMENT

	Approx dates taken	Outcome
Clomiphene (Clomid, Serophene)	_____	_____
HMG (Profasi)	_____	_____
Injectable gonadotropins	_____	_____

Progesterone _____ _____

K: PREVIOUS TREATMENT (continued)

	Approx dates taken	**Outcome**
Lupron	_____	_____
GnRH agonist (Synarel, Lupron)	_____	_____
Intrauterine insemination (IUI)	_____	_____
Insemination with donor sperm	_____	_____
In vitro fertilization (IVF)	_____	_____
ICSI	_____	_____
GIFT	_____	_____
Other _____	_____	_____

Please use the remainder of this page to explain any additional information you think the practitioner may need.