Joyce Wellness Group
Acupuncture and Holistic Medicine

Preparing For Your Child's First Acupuncture Visit

You've decided to bring your child in for acupuncture treatment and now you're wondering what you're going to tell them about their initial visit. In order to help explain to your child what is involved with an acupuncture treatment we've got a few pointers to help you out.

BE HONEST WITH YOUR CHILD ABOUT WHAT THE VISIT IS FOR
If your child is old enough to understand what is going on with their body, explain to them why they are coming in for an acupuncture visit. Let them know you'll be discussing their problem with the acupuncturist.

TELL THEM ABOUT ACUPUNCTURE
Acupuncture helps the body heal itself. Our bodies are designed with great healing powers, but sometimes bodies need a little help to heal and that's what acupuncture does. It also helps the body heal faster. The acupuncturist is like a detective that is searching for the root cause of illness and then uses special spots called acupuncture points to begin the healing process. Not even the greatest surgeon can heal a cut, only the body can.

AVIOD WORDS LIKE PINCH, PRICK, POKE, POKEY, PINS OR NEEDLES
These words sound scary and may cause your child to be afraid of acupuncture.

TELL THEM THE ACUPUNCTURIST DOES "TAPS"
At our clinic, we call acupuncture for kids "taps" because the acupuncturist will do a lot of gentle finger tapping and rubbing to prepare the acupuncture point. The needles are swiftly tapped in and, for kids under age 8, immediately removed.

DON'T LIE TO THEM IF THEY ASK IF IT HURTS
When they are tapped in there is little to no discomfort during the procedure. They might feel a tiny amount of discomfort, but most don't. Hundreds of thousands of kids get acupuncture every year because it helps them feel better.

HELP THEM BE BRAVE!
Sometimes bringing a favorite toy, stuffed animal or blanket gives them comfort if they are feeling scared or apprehensive. Some kids dress up in costume on their first visit. We've seen pirates, Minnie Mouse, and Cowboys to name a few.

IF THEY DON'T WANT TO DO NEEDLES, WE HAVE OTHER OPTIONS
Sometimes even the bravest kids don't want to try taps right away. That's alright, we have other non-needle techniques we can use that have a similar therapeutic effect as acupuncture. Your child will never be forced to do taps or anything else against their wishes, but it is our sincere hope that they will cooperate with us during their treatment.

DECIDE AHEAD OF TIME IF YOU'RE GOING TO OFFER A REWARD FOR TRYING TAPS
It's their choice if they want to try taps, but sometimes a little motivation helps. Rewards have worked quite well for many parents to encourage their kids to try it. If you plan to offer a reward, figure out what you'll offer ahead of time so you're not caught off guard, but be ready to follow through. You may want to keep it a secret and use it as a last resort or it may work better to tell them about it ahead of time. We have stickers at the office for kids who cooperate so they'll get a little reward no matter what.

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OUR CLINIC PROTECTS YOUR HEALTH INFORMATION AND PRIVACY

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company and with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners. We will obtain your authorization before disclosing any information.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

- From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you -*e.g.* your name, address, Social Security number, etc.).

We value our relationship with you, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 310-803-5459.

Sincerly

Megan Joyce Acupuncture, Inc.

Joyce Wellness Group

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Acknowledgement of Receipt of Notice of Privacy Policy

This practice has attempted to provide each patient with a statement of privacy policies and protection of health care information.

I, _____ have read and reviewed, understand and agree to the statement regarding the privacy policy for health care information under the care of Megan Joyce Acupuncture, Inc.

Patient Signature _____Date_____

If you do not wish to be contacted in a certain manner, please specify in the space below. Otherwise, this statement authorizes Megan Joyce Acupuncture, Inc. and employees to contact you through any means provided on the Patient Information form.

_____

_____

Patient Signature _____Date _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 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 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, 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

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:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Bring this signed form with you for your initial office visit!

Joyce Wellness Group
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Pediatric Health History

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Today's Date:_____How were you referred to our office?_____

Name:_____Sex: ☐ Male ☐ Female

DOB:_____Age:_____Social Security#_____

Address:_____City:_____State:_____Zip:_____

Name of Mother:_____Phone#_____

Mother's E-mail:_____

Name of Father:_____Phone#_____

Father's E-mail: _____

Number of Siblings:_____Siblings Names/Ages:_____

Does child have health insurance? ☐ Yes ☐ No If YES, are acupuncture benefits included in the policy? ☐ Yes ☐ No

Health Insurance Company:_____ID #_____

Policyholder:_____DOB:_____

Primary Care Physician: _____Phone#_____

Other healthcare practitioners your child sees (include acupuncturist, massage therapist, medial doctor, nutritionist, osteopath, other specialists)

Name: Type of Practice: Phone#

_____

_____

_____

Is your child immunized? ☐ Yes ☐ No If YES, did you follow the 1) traditional schedule or 2) alternate schedule? (Circle one)

Did your child have any reaction to immunization? ☐ Yes ☐ No If YES, please explain:_____

_____

Please list your current health concerns for your child in order of their importance to you:

Concern: Date of Onset:

1._____

2._____

3._____

Injuries:_____

Surgeries and Hospitalization:

Year: Reason: Hospital:

_____

_____

Please list all medications (prescription or over-the- counter) currently taking: ☐ Aspirin/Tylenol ☐ ADHD Meds ☐ Antibiotics ☐ Insulin ☐ Antihistamines ☐ Vitamins/Supplements ☐ Other:_____

Birth History

Prenatal History:

Did mother have any problems or illnesses during pregnancy? ☐ Yes ☐ No If YES, please describe:_____

_____

Birth Details: ☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐ Vacuum ☐ Trauma? ☐ Born on time
☐ Before 37 weeks of pregnancy ☐ After 42 weeks of pregnancy

Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe:_____

_____

Your baby's diet from birth: ☐ Breast milk only ☐ Formulas ☐ Mixed If breastfed, how many months? _____

Past Medical History

Does your child have, or has she/he had:

☐ Yes ☐ No **Chicken Pox**
☐ Yes ☐ No **Ear Infections**
☐ Yes ☐ No **Problems with ears or hearing**
☐ Yes ☐ No **Nasal Allergies**
☐ Yes ☐ No **Problems with eyes or vision**
☐ Yes ☐ No **Asthma, bronchitis, croup, pneumonia**
☐ Yes ☐ No **Heart problems or murmur**
☐ Yes ☐ No **Anemia or bleeding problem**
☐ Yes ☐ No **Frequent abdominal pain**
☐ Yes ☐ No **Constipation requiring**
☐ Yes ☐ No **Bladder or kidney infection**
☐ Yes ☐ No **Bed wetting after age 5**
☐ Yes ☐ No **(girls) started menstruating?**
☐ Yes ☐ No **(girls) problems with periods?**
☐ Yes ☐ No **Chronic/recurrent skin problems**
☐ Yes ☐ No **Frequent headaches**
☐ Yes ☐ No **Seizures/other neurologic problems**
☐ Yes ☐ No **Diabetes or thyroid problems**

Family Health History

Have any family members had the following? If so, note relationship to child:

☐ Yes ☐ No **Deafness**
☐ Yes ☐ No **Nasal allergies/ Hayfever**
☐ Yes ☐ No **Eczema**
☐ Yes ☐ No **Asthma**
☐ Yes ☐ No **Tuberculosis**
☐ Yes ☐ No **Heart disease before age 50**
☐ Yes ☐ No **High blood pressure before age 50**
☐ Yes ☐ No **High cholesterol**
☐ Yes ☐ No **Anemia**
☐ Yes ☐ No **Bleeding Disorder**
☐ Yes ☐ No **Liver disease**
☐ Yes ☐ No **Kidney disease**
☐ Yes ☐ No **Diabetes before age 50**
☐ Yes ☐ No **Bed wetting after age 10**
☐ Yes ☐ No **Epilepsy or convulsions**
☐ Yes ☐ No **Alcohol or drug abuse**
☐ Yes ☐ No **Developmental disability**
☐ Yes ☐ No **Mental illness**

Social History & Development

☐ Yes ☐ No **Has your child had any trauma?**
☐ Yes ☐ No **Does your child enjoy school?**
☐ Yes ☐ No **Has your child repeated a grade in school?**
☐ Yes ☐ No **Concerns about your child's attention span?**
☐ Yes ☐ No **Concerns about how your child is doing academically?**
☐ Yes ☐ No **Concerns about your child's behavior in school?**