youngQi 2905 Stender Way #82, Santa Clara, CA 95054 | (650) 917-2355 | www.youngQi.com

Patient Registration Form

Last Name 姓：	Gender： ☐ Male 男 ☐ Female 女
First Name 名：	Status： ☐ Single ☐ Married
Date of Birth (mm/dd/yyyy) 生日：	
Phone # 電話：( )	Cell # 手機：( )
Email 電郵：	
Address 地址：	
City 城市： State 州：	Zip 區域號：

Emergency Contact	Name 姓名：	Phone # 電話：( )

How did you hear about us? 您從哪知道陽氣診所？
What is the reason for your visit? 就診原因？
Are you currently under the care of a physician or under other treatment? ☐No ☐Yes 您是否正在看其他醫生或用其他療法？ If yes, please explain:
Are you using prescription or herbal medicines? 現在是否正在服用任何中西藥？ ☐No ☐Yes If yes, please list:
Have you ever had surgery? 是否有接受過手術？ ☐No ☐Yes If yes, please explain:
Medical devices (e.g. pacemaker, medical implants) 體內器材（起搏器、支架）？ ☐No ☐Yes If yes, please list:
Allergies 過敏？ ☐No ☐Yes If yes, please list:
Medical history 繼往病史：

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this provider immediately whenever there are changes in my health condition.

Patient Signature: _____ Date: _____
Or Patient Representative Indicate relationship if signing for Patient

PATIENT NAME (please print): _____

ARBITRATION AGREEMENT, INFORMED CONSENT, AND PATIENT FINANCIAL RESPONSIBILTY FORM

ARBITRATION AGREEMENT

Responsibility: It is understood that all medical services are rendered by individual health care providers. youngQi, Inc., youngQi Integrative Medicine and Acupuncture Group, Inc., and their affiliates and partners provide supporting services to the individual health care providers and do not render any medical services. It is also understood that youngQi, Inc., youngQi Integrative Medicine and Acupuncture Group, Inc., and their officers, board directors, employees, contractors, shareholders, affiliates, and partners should not be held responsible for any medical services rendered under this agreement.

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this agreement 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 provides for judicial review of arbitration proceedings. Both parties to this agreement, 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.

All Claims Must be Arbitrated: It is 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.

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.

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.

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.

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 in this agreement, I acknowledge that I have received a copy.

BY VOLUNTARILY SIGNING THIS AGREEMENT, I AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND I GIVE UP MY RIGHT TO A JURY OR COURT TRIAL.

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 in this agreement 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 in this agreement, 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 youngQi, Inc., youngQi Integrative Medicine and Acupuncture Group, 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 by phone calls, voice messages, emails, short message services, or other forms of communications about my treatments, 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 this agreement, 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

Financial Responsibilities: 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.

Insurance: The health care providers and staff are pleased to assist the patient by filing insurance claims and billing the patient's insurance providers with a reasonable insurance processing fee, if it is determined at the sole discretion of the health care providers and staff that the patient's insurance policy is acceptable. The patient is required to provide 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 copays, 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 does not cover the full amount of the fees, the patient is required to pay the difference within ten (10) business days upon verbal or written notices.

It is understood that the fees for cash-payment patients is significantly discounted from the regular fees. When the patient's insurance provider is billed, the regular fees are applied. It is also understood that the payment from the patient's insurance provider should be payable and sent to the clinic or the entity assigned by youngQi Integrative Medicine and Acupuncture Group, Inc.. From time to time, the insurance providers might mistakenly send the payments to the patient directly. When it happens, it is the patient's responsibility to contact the clinic promptly and return the payments to the clinic within ten (10) business days.

Additional Charges: Patients may incur, and are responsible for the payment of additional charges, including but not limited to:

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

Authorizations: I hereby authorize the health care providers and staff associated with youngQi, Inc., youngQi Integrative Medicine and Acupuncture Group, 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.

I hereby authorize assignment of financial benefits directly to youngQi, Inc., youngQi Integrative Medicine and Acupuncture Group, 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 VOLUNTARILY SIGNING THIS AGREEMENT, I SHOW THAT I HAVE READ, OR HAVE HAD READ TO ME, UNDERSTAND, AND AGREE TO ALL THE PROVISIONS OF THIS ARBITRATION AGREEMENT, INFORMED CONSENT, AND PATIENT FINANCIAL RESPONSIBILITY FORM.

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

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____

Office Signature:_____ Date: _____