359 SAN MIGUEL DR. SUITE 303, NEWPORT BEACH, CA 92660
PHONE: (949) 424-8956 | EMAIL: drkelly@acupunctureoc.com WEBSITE: http://acupunctureoc.com/

WOMEN FERTILITY NEW PATIENT INTAKE FORM

Today's Date______/____/_____

General Patient Information: all information provided is strictly confidential.

Last Name:___________________________________First Name:___________________________________

Street address:____

City:____State:_________Zip Code:____________________

Home Phone:____________________Cell:__________________Email:_____________________________

Date of Birth:______/___/______Age_________Sex: F/M Marital Status M S D W P _________________

Occupation/Employer________________________________Social Security #_______________________

HISTORY

Reason for your visit
today:____

Complaint is result of: Auto accident Injury Job Related Other Date

of the accident/injury/other_____________/______/_______

How long have had this condition?___________________________________ Is it getting worse? Y N

Does it affect your: Sleep___________Work__________ Other___________________________________

What seemed to be the initial cause?____

What makes it better?____

What makes it worse?____

Are you under physician's care? Y/N

Dr. Name____Phone:______________________________

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Reason you decided to try Acupuncture ____

Allergies____

Surgeries____

Please list ALL medications and supplements you are currently taking:

Medications/Supplements/ Dosage	Reason/Objective	Date Started
______________________	____________	__________
______________________	____________	__________
______________________	____________	__________
______________________	____________	__________
______________________	____________	__________

FINANCIAL ARRANGEMENTS

CASH CHECK CREDIT DEBIT

INSURANCE INFO: ADDRESS:____

COMPANY NAME_________________________SUBSCRIBER ID ____________________

Group Number___________________________

Referred By: Name_______________________Address_____________________________

CONSENT

I have read the above information and verify it to be true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary, in accordance with the state statutes, for the care and management of this complaint to be treated by Dr. Ata Kelly, L.Ac
I accept full financial responsibility for all medical services performed on my behalf.

Date____/____/____ **Patient Signature________________________________**

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Family Medical History: *(Please check any and all condition(s) members of your family have had)*

Illness:	Father	Mother	Sibling(s)	Grandparents	Aunt/Uncle
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Drug Abuse	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Strokes	_____	_____	_____	_____	_____
Other: __________________	_____	_____	_____	_____	_____

General Health Information:

Major Health Complaints and/or Symptoms:

1. ____
2. ____
3. ____

Please explain how these conditions affect or impair your daily activities:

____
____

Describe your symptoms when they are at their worst:

____
____

What makes your symptoms better?

____
____

Are there any other complaints or conditions that you would like us to know about?

____
____

Please list any non-prescription drugs or recreational drugs you currently take:

____
____

Medical Conditions/History: *(Circle any conditions you have had, or are currently experiencing)*

Aids/HIV	Cancer	Hepatitis	Osteoporosis	Stroke
Alcoholism	Diabetes	Herpes	Pacemaker	Thyroid Disorder
Allergies	Emphysema	Lyme Disease	Pnuemonia	Tuberculosis
Appendicitis	Epilepsy	High Blood Pressure	Polio	Typhoid Fever
Arteriosclerosis	Goiter	Measles	Rheumatic Fever	Ulcers
Arthritis	Gout	Menopause	Scarlet Fever	Venereal Disease
Asthma	Heart Disease	Multiple Sclerosis	Seizures	

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GLOBAL WELLNESS

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Gynecological History:

Age at your first period: ________________
The first day of your last period? ___________________________
Are your periods regular? YES NO _________________
Number of days between periods: ________________
Number of days of bleeding: ____________________
Amount of bleeding? (*circle one*) LIGHT - - - - MEDIUM - - - - HEAVY
What color is the blood? PURPLE BROWN BLACK BRIGHT RED PINK
Is there clotting? YES NO
Do you bleed or spot between periods? YES NO
Have you ever taken medication to bring on your period? YES NO
Do your breasts become tender pre-menstrually? YES NO
Do you have pre-menstrual low back pain? YES NO
Do you have pain with menstruation? YES NO
Degree of pain: MILD - - - - MODERATE - - - - SEVERE
Pain relieved by over-the-counter medications? YES NO
Does the pain start with the onset of bleeding? YES NO
Begin before the onset of bleeding? YES NO
Persist more than 48 hours? YES NO

Do you ovulate on your own? YES NO
Do you experience pain during ovulation? YES NO
On which day of your cycle do you ovulate? __________________
Do you have vaginal discharge? YES NO
Associated with itching or burning? YES NO
Associated with unusual odor? YES NO
Do you get yeast infections? YES NO
Do you experience pain during intercourse? YES NO
Is the pain mostly external or internal ? ______________________________

Do you have a gynecologist? YES NO
When was your last pap smear? ______________________ Result? _________________
Have you ever had an abnormal pap? YES NO
If yes, what follow up was necessary____
Have you ever had a mammogram? YES NO

Have you ever had a sexually transmitted disease?
Chlamydia, Gonorrhea, Herpes, Other: ____
When? ______________________ Was it treated? _______________________________

Do you experience milk or other discharge from your nipples? YES NO
Have you ever used an IUD? YES NO
Have you ever used the Oral Contraceptive Pill YES NO
If yes, for how long? ________________ When did you last use it? __________________
How long did it take for your menses to regulate? __________________________________

Please indicate number of:

____Pregnancies
____Children
____Miscarriages
____Abortions

____Premature Births
____Ectopic Pregnancies
____IVF's
____IUI's

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Fill out this section if applicable

Previous Gynecological Surgeries: **Date of Procedure**

C-Section Births ____
Dilation & Curettage (D&C) ____
Hysterosalpingogram (HSG) ____
Hysteroscopy ____
Laparoscopy ____
Other: ____

Previous Diagnostic Assessments: *(please check all that apply)*

__ Advanced Maternal Age
__ Amenorrhea
__ Anovulation
__ Cervical Stenosis
__ Elevated FSH
__ Endometriosis (mild, moderate, severe)
__ Fallopian Tube Blockage
__ Habitual Miscarriage
__ Hostile Cervical Mucus
__ Hyperprolactinemia
__ Luteal Phase Defect
__ Menorrhagia
__ Ovarian Cyst
__ Ovarian Hyperstimulation Syndrome (OHSS)
__ Pelvic Adhesions
__ Pelvic Inflammatory Disease (PID)
__ Phospholipid Antibodies
__ Polycystic Ovarian Syndrome (PCOS)
__ Premature Ovarian Failure
__ Unexplained Infertility
__ Uterine Fibroids or Polyps
__ Other: ____

List any fertility drugs you have taken:

____
____

Medications you use currently: ____

How long have you been trying to get pregnant? ____________________________________

Have you had a fertility workup? YES NO
What were the results? ____

How is your sexual energy? Low Normal High
Do you use vaginal lubricants? YES NO

Do you have a stressful occupation? YES NO
Do you exercise regularly? YES NO
How often? ______________________

Do you have excessive facial hair? YES NO
Do you have excessively oily skin? YES NO
Have you experienced excessive loss of head hair? YES NO

Was your mother exposed to diethylstilbestrol (DES)
when she was pregnant with you? YES NO

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Overall Symptoms: *(Please circle any of the following symptoms that currently pertain to you)*

Body Temperature (Kidney & Organ System)

Cold hands	Hot body temperature	Profuse perspiration	Perspire easily
Cold feet	Cold body temperature	Lack of perspiration	Cold hips/buttocks
Sweaty palms	Afternoon Flushing	Night sweating	Incontinence
Sweaty feet	Hot Flashes	Strong thirst	Night time urination

Low back weakness or pain
Fertile cervical mucus
Dark circles around your eyes
back pain before your period
Feet cold, especially at night
Cold sensation w/menstrual cramps
Colder than those around you

Vaginal dryness
Dizziness
Ringing in your ears Low
Low libido
Early morning loose stools
Premature gray hair

Spleen Function

Energy level: High Normal Low

Poor appetite	Feel heavy/sluggish	Energy lower after a meal
Heaviness in the head	Feel bloated after eating	Poor circulation
Crave sweets	Varicose veins	Bruise easily
Loose stools	Tired around ovulation	Spot before your period comes
Abdominal pain	Tired around menstruation	Nose cold
Indigestion	Nausea	Gas
Often sick	Hypoglycemia	

Stomach Function

Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting

Blood Function (liver, spleen, and heart system)

Menses scanty or late	Difficulty concentrating
Dry skin	Fainting
Chapped lips	Blurry vision
Weak or brittle nails	Poor night vision
Losing head hair	Hair dry/brittle

Heart Function

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High blood pressure	Rapid heartbeat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe shyness	Low blood pressure	Wake up in the early am

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Lung Function

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies

If you are a smoker, how many cigarettes per day? _________________________
How long have you been smoking? _____________________________________
If you are a smoker, do you want to quit? YES NO
Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

Bowel Function and Elimination

Loose stools	Constipation	Difficulty moving bowels
I.B.S or colitis	Diarrhea	Blood in stools
Small, hard, dry stools	Crohn's disease	Incomplete stools
Mucus in stools	Less than 1 BM/Day	Eating disorder

Accumulated Dampness

Mental fogginess	Swollen hands	Edema in the legs
Mental sluggishness	Swollen feet	Edema in the abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion

Heaviness of the head, the limbs or of the whole body

Liver and Gallbladder Function

Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in the ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ringing in the ears	PMS
Breast tenderness	Nipple pain	Painful periods	

Wake with bitter taste in mouth
Difficulty falling asleep at night
Alternating diarrhea and constipation
Easily overwhelmed by stressful circumstances

Urinary Function

Normal color	Reddish color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination

Frequency:____________times at night
_______during the day

Urgency:____________

Libido Function

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	

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Acetylcholine Receptor Antagonist – Antimuscarinic Agents
Atropine, Ipratopium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators
Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)

Dopamine Receptor Agonists
Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder
Flumazenil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Sertonergic Antidepressants (NaSSaa)
Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

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Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___
Consistency of blood: Watery ___ Thick ___ Average ___
Does your blood contain clots? Yes ___ No ___ ...and...
At which point during the cycle? Start ___ Mid ___ End ___
Describe the color of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During ____________ (please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness ___ Cramps ___ Acne ___ Change in bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___
Fatigue ___ Night sweats ___ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? ______	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes ___ No ___	

How many times have you been pregnant? _______________ How many times have you given birth? ______________
Ages of children _______________ Sex of children __________________ Given names ___________________________
Have you had any miscarriages? Yes ___ No ___
If yes, how many, at how many weeks pregnant, and in what year(s)?
____

How many times have you had a D&C preformed? ____________
How many abortions have you had? ____________ In what year(s)? ________________________________
Were there any problems that occurred during these pregnancies? ______________________________________

Have you ever been diagnosed with:

Condition	
STD?	Yes__ No__
Pelvic inflammatory disease?	Yes__ No__
Uterine fibroids?	Yes__ No__
Polyps?	Yes__ No__
Pelvic adhesions?	Yes__ No__
Prolapsed uterus?	Yes__ No__
Unique shape of uterus?	Yes__ No__
Endometriosis?	Yes__ No__
PCOS (polycystic ovarian syndrome)?	Yes__ No__

Date of last pap smear: _________/__________/____________ (dd/mm/yyyy)
Have you ever had an abnormal pap smear? Yes ___ No ___
Have you ever had a cervical biopsy or operation? Yes ___ No ___
Do you get yeast infections regularly? Yes ___ No ___
Do you get bladder infections regularly? Yes ___ No ___
If answered yes, list STDs: ___________________________________

Do you experience vaginal discharge? Yes ___ No ___
If yes, what colour?
White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odour? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ___
If yes, for how long? _______________
When did you stop? _______________
Have you ever had an IUD? Yes ___ No ___
Have you ever taken Depo-Provera? Yes ___ No ___

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Have you had any hormone testing done? (e.g., Day 3, Day 21)			
FSH ………………………………..	___ Low	___ Normal	___ High
Estrogen (E2) ……………………..	___ Low	___ Normal	___ High
Progesterone ………….…………..	___ Low	___ Normal	___ High
Prolactin …………………………..	___ Low	___ Normal	___ High
Thyroid (TSH) ……………….…..	___ Low	___ Normal	___ High
Testosterone ……………………..	___ Low	___ Normal	___ High
Other: ______________________	___ Low	___ Normal	___ High

Do you currently have a partner? __ Yes __ No
If yes, what is your partner's name? ____________________________ Age? _______________
Are you married or living together? _____________________________ For how long? ____________________
Is your partner supportive of your wishes to conceive?_____________

How long have you been trying to conceive? ____________________

Do you have a family history of infertility (mother, father, grandparents, aunt, uncle, siblings)? ______________________
If yes, which family members?__________________________ Diagnosis?_____________________________

Have you had a Western medical diagnosis relating for fertility? __ Yes __ No
If yes, what was the diagnosis? ________________________ Who made the diagnosis? ________________

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? __ Yes __ No
If yes, what was the diagnosis? ________________________ Who made the diagnosis? ________________

Have you taken medication to help you ovulate? __ Yes __ No
If yes, what kind? ____ For how many cycles? _________

Have you had your uterine/fallopian tubes evaluated medically (HSG)? __ Yes __ No
What were the results? ____

Have you had any tubal operations? __ Yes __ No

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc) __ Yes __ No

Month/Year	Type of treatment	Clinic	Results
_________________	________________________	__________________	_________________________
_________________	________________________	__________________	_________________________
_________________	________________________	__________________	_________________________
_________________	________________________	__________________	_________________________
_________________	________________________	__________________	_________________________

What was your medical response to the fertility treatments? ___ Poor ___ Average ___ Good

Are you using donor sperm? __ Yes __ No
If yes, why? (no partner, female partner, male partner has semen issues, etc.) __________________________

Are you using donor eggs or embryos? __ Yes __ No

How is your sexual desire (mental interest)?.......................................	___ Low	___ Normal	___ High
How is your sexual arousal (physical/orgasm)?....................................	___ Low	___ Normal	___ High
Do you use vaginal lubricants?...	__ Yes	__ No	
Have you been exposed to or received chemotherapy or radiation? …	__ Yes	__ No	
Do you have excessive facial or body hair? ……………………………..	__ Yes	__ No	
Do you have excessively oily skin? ………………………………………	__ Yes	__ No	

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On your journey toward parenthood, what expectations do you have of AK-U-Puncture Global Wellness Inc.? Please list the wellness goals you wish to obtain here:

Please consider letting us know what you need most from us during our time together (check as many as you wish):

____ **Perspective** (provide a fresh or different way of looking at a situation)

____ **Validation** (provide encouragement and acknowledgement)

____ **Message** (share fitting knowledge, opinions, or wisdom)

____ **Energy** (provide positive energy and support)

____ **Advice** (provide recommendations and suggestions)

____ **Feedback** (offer observations, insight, ideas, and opinions)

____ **Solutions** (share solutions to problems or issues)

____ **Plan** (co-develop a plan of action with you)

____ **Structure** (provide support and a check-in structure for you)

____ **Challenge** (provide a challenge to you to stretch or make a change)

____ **Tough love** (when necessary, have the conversations you may least want to have)

____ **Resource** (suggest/refer you to experts, books, tools, assessments)

____ **Caring** (provide listening, patience, safety, and love)

____ **Removed** (you may just want to come and relax, nothing more)

If there is anything else you would like us to know about you in order to make your experience here better, please share it here:

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Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements 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 or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Rare Complications

When administered by a properly trained and registered practitioner, acupuncture is considered a very safe procedure. At this clinic we use single-use, sterile, disposable needles. However, although rare, significant complications have been reported in the literature and we need to make you aware. These include pneumothorax, perforation of an internal organ, infection, and nerve damage. We are rigorously trained in safe needle techniques, thus these complications have never been a case in our practice. If you have any questions or concerns in this regard, do not hesitate to speak with your practitioner about it.

I have read and agreed to the terms outline above _________ (initial) Date____________________

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Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical 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 this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, 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 further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to AK-U-Puncture Global Wellness Inc. is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by AK-U-Puncture Global Wellness Inc., unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of AK-U-Puncture Global Wellness Inc. (also, AK-U-Puncture Global Wellness Inc. will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on AK-U-Puncture Global Wellness Inc. premises. On occasion, AK-U-Puncture Global Wellness Inc. may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to AK-U-Puncture Global Wellness Inc. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A minimum of 24 hours notice is required to reschedule or cancel appointments. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand most insurance companies do not reimburse for missed sessions. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

______________________________	______________________________
Print name in full	(Print name of representative if represented by another)
______________________________	______________________________
Signature	(Signature of Representative)
______________________________	
Date	

359 SAN MIGUEL DR. SUITE 303, NEWPORT BEACH, CA 92660
PHONE: (949) 424-8956 | EMAIL: drkelly@acupunctureoc.com WEBSITE: http://acupunctureoc.com/

Patient Information Release Request Form

I, ____ (please print name) understand that as part of AK-U-Puncture Global Wellness Inc.'s effort to provide me with the highest standard of integrated care, they may consult freely with other physicians and healthcare professionals, whose care I am under, regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

I give full consent so that AK-U-Puncture Global Wellness Inc. may share personal information and my confidential treatment plan with my other healthcare providers to better my care. __________
(Initial)

(*to be filled out by your AK-U-Puncture Global Wellness Inc. practitioner*)

The following is an authorization to provide AK-U-Puncture Global Wellness Inc. with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: ____

Medical Services Plan (MSP) #: ____________________________________

Doctor's Name: _______________________________ Clinic Name: _______________________________

Clinic Phone #: _______________________________ Clinic Fax #: _______________________________

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: ____ Date: _______________

Signature of parent or guardian (if applicable): ____

Thank-you for your prompt attention to this request. If you have any questions, please feel free to call us at (949) 424-8956 or email drkelly@acupunctureoc.com

AK-U-Puncture Global Wellness Inc.