INTEGRATED HEALTH CARE

Today's Date: _____ File I.D.: _____

Patient's Name: (Last) _____ (First) _____ M.I.: ____ Gender: M ____ F ____

Home Address: (Please Print Street) _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: ( ) _____ - _____ Social Security #: _____ _____ _____

Date of Birth: _____ / _____ / _____ Marital Status: S M D W Spouse's Name: _____

Business or Employer Address: _____

Business Phone: ( ) _____ - _____ Emergency Contact: _____ Tel.: ( ) _____ - _____

Major Complaint: _____

Have you been treated by a doctor for this conditions? Yes _____ No _____

If yes, Doctor's Name and Phone #: _____

Primary Health Insurance: _____ Policy #: _____ Group #: _____

Claim Office Address: _____

Relation to Insured: Self _____ Spouse _____ Child _____ Other _____

Secondary Health Insurance: _____ Policy #: _____ Group #: _____

Claim Office Address: _____

Do you have Medicare: Yes _____ No _____ If yes, relation to patient: Self _____ Spouse _____

Do you have third Insurance? Yes _____ No _____ If yes, Company Name: _____

You have been referred to this clinic by: _____

I hearby give my permission to Dr. Hua Gu's office to administer treatment and to perform such procedures as may be deemed necessary in diagnosis and/or treatment of the condition. I, the undersigned certify that I (or my dependent) have Insurance coverage with _____ (Insurance Company), and assign directly to Dr. Hua Gu's office all medical benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submission.

_____ _____

Patient Signature: Today's Date:

Hua Gu, Ph.D., L.Ac.
Hoang Vu, L.Ac.
Nancy Gu, L.Ac.
20121 Ventura Blvd. Suite 205, Woodland Hills, CA 91364
30200 Agoura Rd., Suite 140, Agoura Hills, CA 91301
Tel.: (818) 592-0355; Fax: (818) 592-0378

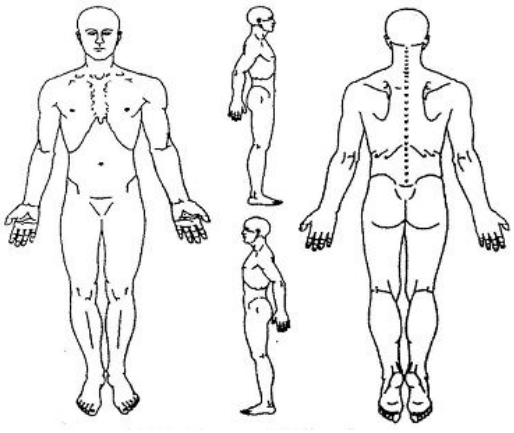
CONFIDENTIAL HEALTH REPORT:

MAJOR COMPLAINTS: Describe the nature of your current illness.

_____

_____

POINT OUT THE PAINFUL OR DISTRESSED AREA:



PAST HISTORY:

Please check the following conditions which you have had:

( ) Addiction	( ) Alcoholism	( ) Anemia
( ) Arteriolosclerosis	( ) Arthritis	( ) Cancer
( ) Diabetes	( ) Emphysema	( ) Epilepsy
( ) Gout	( ) Heart Disease	( ) Hypertension
( ) Hypoglycemia	( ) Kidney Stone	( ) Miscarriage
( ) Multiple Sclerosis	( ) Nephritis	( ) Pacemaker
( ) Pneumonia	( ) Rheumatic Fever	( ) Stroke
( ) Thyroid	( ) Tuberculosis	( ) Ulcers
( ) Venereal Disease		

MEDICATIONS: Please list all prescription drugs you now take.

_____

_____

_____ _____

Patient's Signature: Date:

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. **I understand that this Consent is valid for seven years.** I further understand that I have the right to revoke this Consent, **in writing**, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. **I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.**

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)	Signature of Individual
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):	Relationship

Date Signed: _____ / _____ / _____ Witness: _____

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

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 one of the patient named below, for whom I am legally responsible) by the acupuncturist named 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 have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine in the practice of acupuncture, there are some risks to treatment, including, but not limited to, nausea, a punctured lung, and infection. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by patient:

Print Patient's Name

Signature of Patient

Date Signed

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

Print Name of Patient

Print Name of Patient's Representative

Signature of Patient's Representative

As: Relationship or authority of Patient's Representative

Date Signed

To be completed by acupuncturist or staff:

Name and address of clinic/office:

Integrated Health Care
20121 Ventura Blvd., Suite 205
Woodland Hills, CA 91364

Print name(s) of acupuncturist(s) treating this patient:

Hua Gu, Ph.D., L.Ac.
Hoang Vu, DAOM, L.Ac.
Nancy Gu,DAOM, L.Ac.

Witness to Patient's Signature: _____ Date: _____

Translated by: _____ Date: _____