First Name: _____ Last Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____ Gender: _____ Male _____ Female

Cell Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact

Name: _____ Address: _____

Cell Phone: _____ Home Phone: _____

Please list all of your current sleep-related health concerns &/or all pre-existing sleep-related diagnoses.
Should this change during the course of your treatments at AcuSleep, please notify AcuSleep in writing.

_____

_____

_____

_____

Do you have any reason to believe you may be **pregnant**? ___ No ___ Yes If so, how far along are you? _____

Do you have any **infectious diseases**? ___ No ___ Yes If yes, please identify the condition: _____

All Food, Drugs, &/or Medication Allergies (include reaction): _____

All Current Medications, Vitamins, Herbs, & Supplements: _____

All Hospitalizations & Surgeries: _____

_____

Please Fill In Your Medical History:

Head, Eyes, Ears, Nose, Throat: _____

Hair & Skin: _____

Respiratory: _____

Blood/Cardiovascular: _____

Gastrointestinal: _____

Genito-Urinary: _____

Endocrine/Energy: _____

Mental/Emotional: _____

Immune System: _____

Neurological: _____

Musculoskeletal: _____

Menstrual/Birth History: _____

Male / Female Reproductive System: _____

Lifestyle (Include Frequency & Amount) Alcohol Consumption: _____ Caffeinated/Carbonated Beverages: _____

Coffee Or Black Tea: _____ Exercise: _____ Toxins, Chemical Exposure _____

Recreational Drugs: _____ Tobacco Consumption: _____ Water Consumption: _____

Meals Eaten Per Day: _____ Hours Of Sleep Per Night: _____ Wake Feeling Rested: _____ No _____ Yes

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

By signing this form, you consent to our use & disclosure of your protected health information to carry out treatment, payment activities, & healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully & completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time. You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, & we may decline to treat you or to continue treating you if you revoke this consent. I have had full opportunity to read & consider the contents of this consent form & your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use & disclosure of my protected health information to carry out treatment, payment activities, & healthcare operations.

I authorize you to disclose health information to:

____ No person at this time.

____ Name: _____ Phone: _____

I understand that all payments (including all pre-payments) are non-refundable. Additionally, all herbal formulas, supplements, and products cannot be returned. I intend this consent form to cover the entire course of treatment for my present condition, wellness & prevention treatments, & for any future condition(s) for which I seek treatment by AcuSleep's practitioners. I understand that all medical information will be kept private by the practitioners at AcuSleep. Any information you disclose in group settings, however, may be overheard by other patients in the area. We strongly encourage you not to discuss private information you do not intend for others to hear. We will make every effort to uphold your confidentiality agreement but it is partially based on what you say in group settings as well. By signing below, I give consent for AcuSleep to video monitor me in the patient treatment areas during any & all treatment sessions at all AcuSleep locations. I understand that the video cameras are not used for recording purposes in any way & are only used for monitoring patient safety during treatment sessions. For purpose of confidentiality, I give permission for AcuSleep to leave a phone message, text message, email, or information mailed to my address at both the address listed on my driver's license or other form of identification as well as the phone numbers & email addresses & mailing addresses I filled out above. This document is filled out to the best of my knowledge with the most current & accurate information I am aware of. By signing below, I agree to the entirely of the two pages of this document.

Patient Signature: _____ Date: _____

(Or parent/guardian) Relationship if signing for patient: _____

ARBITRATION AGREEMENT AND INFORMED CONSENT

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 state 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. 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 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 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. ARTICLE 3: PROCEDURES AND APPLICABLE LAW: A demand for arbitration must be communicated in writing to all parties. 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 state and federal law, where applicable establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extend permitted by the law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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 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.

PATIENT'S PRINTED NAME: _____ Date: _____

PATIENT'S SIGNATURE (Or Patient Representative): _____

(Indicate relationship if signing for patient): _____

INFORMED CONSENT FOR 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 on 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 treats 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 or treatment may include, but are not limited to, acupuncture, 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/or 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 these 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. 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 and if I choose to take them, I do so at my own risk. Some possible side effects of taking herbs are nausea, gas, stomach ache, 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 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 are 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 has 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 for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S PRINTED NAME: _____ Date: _____

PATIENT'S SIGNATURE (Or Patient Representative): _____

(Indicate relationship if signing for patient): _____