HEALTHCHOICE MANAGEMENT, Inc.
5567 Reseda Blvd., # 101
Tarzana, CA 91356

DATE: SS#____________________

NAME__________________________________DATE OF BIRTH__________MALE/FEMALE

MARITAL STATUS____________________ DRIVERS LICENSE#______________________________

ADDRESS________________________ CITY:______________ STATE:___ ZIP:________________

TELEPHONE # (DAY)________________EVENING________________ CELL:___________________

EMPLOYER'S NAME AND ADDRESS____

____REFERRED BY:_____________________________

IS YOUR CONDITION DUE TO ACCIDENT OR ILLNESS?_______________________________________

IF DUE TO AN AUTO ACCIDENT OR INJURY AT WORK, PLEASE SPECIFY__________________________

____________________________YOUR DOCTOR'S NAME_________________________________

TELEPHONE #__________________DIAGNOSIS BY YOUR DOCTOR_____________________________

DATE OF FIRST SYMPTOM__________________

ARE YOU PRESENTLY COVERED BY ANY TYPE OF HEALTH INSURANCE? Y / N

YOUR EMAIL ADDRESS IS____________________________

PERMIT FOR TREATMENT

(NO TREATMENT WILL BE GIVEN UNTIL THIS REQUIREMENT HAS BEEN COMPLIED WITH.) I/WE HEREBLY AUTHORIZE THE PAIN MANAGEMENT CENTER STAFF TO RENDER WHATEVER SERVICES DEEMED NECESSARY FOR THE CARE OF ____.

____
PATIENT'S SIGNATURE / PARENT IF A MINOR DATE

PERMISO PARA TRATAMIENTO

(NINGUN TRATAMIENTO SERA DADO HASTA QUE ESTE PERMISO SEA FIRMADO)
YO/NOSOTROS AUTORIZAMOS AL PERSONAL DEL PAIN MANAGEMENT CENTER A DAR LOS SERVICIOS NECESARIO PARA EL CUIDADO Y TRATAMIENTO DE______________________________________

____
FIRMA DEL PACIENTE/ PADRE SI ES MENOR FECHA

C1

INFORMED CONSENT TO TREATMENT:

I hereby request and consent to the performance of acupuncture and related procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Alejandro Katz, L. Ac. and/or other health professionals who now or in the future treat me while employed by, working or associated with, or serving as back up for Alejandro Katz, L. Ac.

I understand that methods or treatment may include, but are not limited to acupuncture, electric-acupuncture, cupping, massage, gua sha, infrared therapy, and nutritional-lifestyle counseling.

I have the opportunity to discuss with Alejandro Katz, and/or with other office personnel the nature and purpose of acupuncture treatments, other modalities (above mentioned) and safe method of treatment.

Acupuncture has the effect of normalizing physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture and other modalities employed in this office is a safe method of treatment, but occasionally there may be bruising, tingling in/or near the treatment site that may last a few days. There have been very rare instances reported in the literature of fainting, infections, scarring, spontaneous abortions, and pneumothorax. Such serious problems have not occurred in this office.

We use pre-sterilized, disposable needles only.

I do not expect Alejandro Katz and/or other health professionals in the office to be able to anticipate and explain all possible risks and complications. I wish to rely on him/them to exercise his/their good judgment to provide treatment, which is in my best interest.

I understand the clinical and administrative staff 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. In the event of a dispute, I agree to use biding arbitration.

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 mention 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.

Esta forma ha sido completamente traducida para mi entendimiento.

Dated______________ Patient's Name_______________________________________

Signature of patient, parent or legal guardian_______________________________

Relationship to Patient____________________________

ICA 122012

HealthChoice Management, Inc.
5567 Reseda Blvd., Suite 101
Tarzana, CA 91356
(213) 387-4710

General acupuncture care recommendations:

1- **Physical therapy, chiropractic or acupuncture: should not be done the same day.**

2- Avoid overeating or fasting before your acupuncture treatment.
3- **Avoid using body/hand lotion the day of the treatment.**
4- Waiting time to be seen is usually less than 15 minutes.
5- Treatment length is about 45 minutes, plan accordingly.
6- **Notify our staff if you are pregnant, have Diabetes, HIV+, Hepatitis, have a pace maker or any other device implanted. Also, let us know if you have skin allergies.**
7- After the acupuncture is performed, you may experience a slight blood pressure drop (dizziness or nausea). Take your time to sit/stand up, until your blood pressure stabilizes. If you need assistance, let us know right away.
8- Bruising is not uncommon with acupuncture and/or cupping: if needed, apply ice to reduce the inflammation.
9- It is not uncommon a temporary increase of pain (24-48 hours) following an acupuncture treatment. Please call our office in case you have questions or concerns.
10- We will schedule all your appointments at the time of your first visit, to reserve the time slot you need.
11- Be compliant with your treatment: if you have an emergency, please call the office to reschedule your visit(s) ASAP.

For patient with needle implants:

Needle implant(s) care:

1- Needle implant(s) could be retained up to 5 days.
2- If you experience any discomfort or pain from the needle/tape, the needle implant(s) should be removed, and the area cleaned thoroughly with alcohol.
3- When you take a shower, the implant area should be padded and not scrubbed.
4- When the needle implant is removed, carefully wrapped it with the same tape used to cover it and bring it to the clinic for proper disposal.
5- **You should always call our office for further questions or additional instructions.**

Chiropractic care recommendations:

1. Following any manipulation of the spine or extremities, relief of pain and increased function could be experienced, sometimes only for a brief period. Remain active and mindful of any restrictions that we may have recommended.
2. Compliance with the active care instructed is recommended. Avoid prolonged sitting or standing unless short periods of exercise are introduced throughout the day. A return of pain during prolonged stand/sitting is a reminder that movement is required.
3. Don't stop taking medications if prescribed by your physician. Often, following a spinal adjustment pain will decrease allowing for a reduction in anti-inflammatories or pain medications. Always check with your physician prior to modifying any prescribed medication.
4. Should your condition adversely change prior to your return visit, please contact this office right away for additional instructions.

________________________ ____________________
Patient Signature Date