

**Jyoti Elias L.Ac. Dip. Ac. M.S.**  
*Acupuncture and Chinese Herbal Medicine*  
45 San Clemente Dr. Suite C-100  
Corte Madera, Ca. 94925  
415-924-2481

## WELCOME!

### Office Hours, Appointments, and Cancellation Policy

Office hours are by appointment

I provide my patients with a high standard of comprehensive and personalized care. Please allow 1 and 1/2 to 1 and 3/4 hours for the initial visit. This gives me time to take a complete history, do a thorough exam, and give you an acupuncture treatment. Follow up visits last 1-1 1/4 hours.

Kindly give at least 24 hours notice when you need to reschedule or cancel an appointment, as this allows me time to schedule someone else who might be waiting for that appointment slot. You will be charged the cost of the office visit for missed appointments without 24 hours notice.

### Fees, Insurance and Payment Policies

Payment is due at the time service is rendered, unless other arrangements have been made in advance.

If you have health insurance coverage, I will provide you with a "super bill" receipt that you can submit to your insurance company. Based on the terms of your policy, you will be reimbursed directly by your insurance carrier.

### On The Job Injury

Please let me know immediately if you were involved in a work related injury or suspect that you were. I accept worker's compensation coverage in lieu of payment at the time of service with the proper authorization.

### Your Care Is My Concern

Please do not hesitate to let me know if you have any questions or comments concerning your care.

Your signature below confirms that you have read and agreed to the above.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**JYOTI ELIAS L.AC.**  
**Acupuncture and Chinese Herbal Medicine**

## Missed Appointment Cancellation Policy

Dear Patient,

We would like to take this opportunity to remind you of the importance of keeping your scheduled appointments. Every day people with acute problems call for last minute help and late cancellations or missed appointments disallow us from serving some of those in need. That said, please keep a scheduled reminder of upcoming treatments, as we do not make reminder calls for appointments.

While we appreciate that you also have a busy schedule, there will be a charge for the full office visit for any appointments cancelled less than 24 hours in advance. Please make sure to cancel by phone on 415.924.2481, as email can only be checked sporadically during the workday.

We greatly appreciate your cooperation.

I acknowledge this cancellation policy.

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Signature

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Date

Tel. 415-924-2481 45 San Clemente Dr Ste.C-100 Corte Madera Ca. 94925

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Jyoti Elias, L. Ac., and / or other licensed acupuncturist who now or in the future may treat me while employed by, working or associated with Jyoti Elias, L. Ac.

I understand the methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I realize that acupuncture may be considered as an investigative procedure in the United States and understand the possible benefits and risks (stated below) of acupuncture care. I fully understand that there is no implied or stated guarantee of success or effectiveness of specific treatment or series of treatments.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that acupuncture, moxibustion, electro-stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Infection is possible, although the practitioner uses alcohol and disposal needles, and maintains a safe and clean environment. Potential risks of moxibustion heat therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping.

I will notify my practitioner immediately should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that can induce miscarriage. Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been prescribed for me are traditionally considered safe in the practice of Chinese Medicine in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate for pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand if I experience any gastro-intestinal upset or allergic reactions to herbs I will stop taking the herbs or supplements, and inform the acupuncturist as soon as I experience discomfort.

I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect the practitioner to be able to anticipate and explain all risky and complications, and I wish to rely on the practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known, is in my best interests.

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.

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 conditions for which I seek treatment.

Patient's Name \_\_\_\_\_, Date \_\_\_\_\_

**Jyoti Elias, L. Ac.**  
License # AC4826

*Jyoti Elias L.Ac.*  
45 San Clemente Dr., Ste. C-100  
Corte Madera, CA 94925

PATIENT NAME:

### ARBITRATION AGREEMENT

**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 California 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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, as to whether this agreement is unconscionable, and any 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

**Article 3: 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.

**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 of 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.**

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

(Date)  
OFFICE SIGNATURE X

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

## ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), 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 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 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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. 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 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 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**