Welcome!

In an effort to better serve you, below is a reminder checklist of things to prepare before your first visit:

* Fill out and sign all downloadable forms before your appointment.

* We want to remind you that we do not bill any business managers, insurance companies, etc.

* Payments, in the form of **cash, check, or credit card (MC/V)**, are expected at the time services are rendered.

* There is paid parking in the building (sorry, we do not validate) and metered and restricted parking on surrounding streets. (Please be aware of street cleaning and other parking restrictions).

* Please allow approximately an hour for your child's first visit and 30 minutes for subsequent visits.

* Bring your child's new patient forms with you when you come in for the first visit: all new patient forms need to be complete before your first visit. Do not hesitate to discuss any questions you might have with us.

* **Have your child wear something very comfortable and loose fitting with a separate top and bottom, not a one piece**.

* Please do not have your child come on an empty stomach. If they are hungry, please have them finish all full meals at least an hour before their treatment.

We look forward to serving you!

Our Playa Vista address:

If you are visiting the Playa Vista Adjacent Office,

please contact the office for the address if we have not provided it already.

Preparing For Your Child's First Acupuncture Visit

A reminder, here are the most Frequently Asked Questions to prepare you and your child for his/her first visit to Iyashi Wellness.

What can I and my child expect for a pediatric visit at Iyashi Wellness? Fun times and learning new ways to take care of your bodies! **Acupuncture and Oriental Medicine help to heal the body,** so everything I will do to your child and prescribe and teach the parents will be to help facilitate or jump start your child's innate healing ability.

Will my child be nervous about coming to see an acupuncturist? Most children (and adults) are weary of coming to a healthcare practitioner's office because of their experiences getting poked, prodded, palpated, drilled (at the dentist!) and the dreaded ouchy vaccine shots. For children with chronic conditions, they may also experience not getting better as soon as they and their parents would like visiting conventional doctor's offices, so they may already be apprehensive. So if this is your family's case, please be aware of your own apprehension as well as your child's apprehension.

So what can I as a parent do to ease my child's possible apprehension for their first visit? *Be relaxed yourself*. Your child will read your energy and respond to that. Please know that your child will not be administered acupuncture in their first visit. Or second, or third. I will gain your child's trust first, and only if I feel they are ready and will benefit from acupuncture, will I give them an acupuncture treatment. To acquaint them to acupuncture, I will casually show them what acupuncture needles are like and even demonstrate on myself or you of the virtually painless experience of acupuncture. This will start getting your child used to the idea of acupuncture and that it is something very special done only at my office. ***Please do not mention the words "needles," "poke," "pokey," or "pins" to your child for our visit, or ask them if they are afraid.*** Instead, if you want to bring up the notion of acupuncture, tell them they'll get to learn about "taps." I call acupuncture needles "taps" with children so that I can get rid of the fear factor and also because I literally "tap" the needles into a child. If you want to bypass this part of the conversation all together, you can inform your child that s/he will be asked questions about their health, have their pulses felt on their wrists, and they can even stick their tongues out at me! How fun is that?! I will also show them different tools that they can use together with me that will make them feel better and teach them about eating well so that they'll get better soon.

Should I bring toys and goodies, like to an airplane ride, for our visit? Yes! I will spend a considerable time going over your child's forms and current complaint that brought you two in for the initial visit. Although I will have some toys to keep your child entertained, please bring something special for your child to keep him/her busy during this portion of the appointment. This is especially the case for children under age 6.

For children who have been dealing with a chronic condition and are extra apprehensive to visit a doctor's office, please bring their lovey, stuffed animal or blanket to give them comfort. You can even encourage them to play dress up and come in their favorite pretend-play outfit to help them feel more confident - and fun - about visiting my office.

If you're not doing acupuncture on my child, what will my child get as a treatment? Pediatric Oriental Medicine is ancient, so several non-invasive methods were developed over time to facilitate healing in a child. In my goody bag of treatment options, we have multiple non-invasive methods available, like acupressure, pellets and magnets, therapeutic massage, *guasha*, cupping, dietary prescriptions and herbal prescriptions. I will show your child all these tools during the course of our treatments.

How long are pediatric wellness visit? The first visit will last approximately an hour. Follow up visits will be approximately 15-30 minutes long.

What happens after a treatment? Depending on the complexity of your child's case and his/her sensitivity, you may see your child more energized after the treatment, sleep very well through the night, have a more stable emotional equilibrium, reduction of inflammatory conditions, more regular bowel movements, improvement in appetite -- or experience a *healing crisis* where your child may experience, say the eczema they're battling with, flare up and then significantly subside, or their cold symptom get worse, but see significant improvements the following day. This is called a healing crisis.

How often should we come and see you? Please consider coming for a minimum of 3 months initially for chronic conditions. At that point, we will reevaluate the progress of your child's condition and referrals may be provided if other adjunct care will improve your child's condition. For acute conditions, your child may only need one or couple visits. For wellness visits, I recommend parents bring their children in the beginning of cold/flu season, when they start school after holiday breaks, and if they are going through environmental changes or emotional upheavals at home. Holistic pediatric care will help your child transition through the seasonal, environmental, and emotional changes that occur in a child's life.

GENERAL PEDIATRIC INTAKE FORM

Patient's Name: _____ DOB:_____

Street Address: _____

City: _____ State:_____ Zip Code:_____ Sex: M / F

Mother's Name and Occupation: _____

Contact Email: _____ Cell Phone: _____

Evening Phone: _____ Work Phone: _____

Father's Name and Occupation: _____

Emergency Contact **separate** from the mother – Name & ph.#:

_____

Emergency Contact's relationship to patient: _____

Parents are (circle): Married Separated Divorce Other: _____

Would you like to receive periodic newsletters on pediatric health and wellness: Y / N

Insurance Company: _____ Insured Name:_____

Relationship to Patient: _____Employer:_____

Insurance ID #: _____ Group #:____ _____ CoPay:_____

Insured's Date of Birth:_____

REFERRED BY: _____

Payment Information

Credit Card Number _____ (circle one) MC or Visa

Exp Date _____CCV code_____ Authorizing Signature _____ Date _____

Wellness Commitment

At our clinic, we are dedicated toward achieving the goal of total lasting health for our members. To better help your child achieve this we need to understand your commitment toward the whole family being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% ---------20%---------30%---------40%---------50%---------60%---------70%---------80%---------90%---------100%

_____ _____

Signature Date

Name: _____ **Today's Date**: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: M / F
(month) (day) (year)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Reason for Office Visit: _____

_____

- When did it first occur? Or diagnosed_____
- How long has your child had this problem?_____
- Has your child had this in the past? Y / N When?_____
- Related to: □ trauma □ vaccine □ other_____
- What makes the condition worse? _____
- What makes the condition better? _____

Please describe past care for this complaint:_____

_____

_____

Has your child been seen by any other doctor(s) for this complaint? Yes No Past

Current or Previous Pediatrician's Name and Phone:_____

_____

What health goals for your child would you like met under Luriko's care? _____

_____

_____

Last time child had blood work done and what labs:_____

_____

_____

Any known allergies to food, drugs, environment, animals, etc: _____

_____

_____

PREVIOUS MEDICAL HISTORY

YES (Y) indicates the child gets the problem regularly

NO (N) indicates the child never had the problem

PAST (P) indicates the child had the problem in the past, but not recently

Please circle the correct one for your child

Ear infections: Y N P If has had, how frequent per year: _____

Colds: Y N P If has had, how frequent per year: _____

Strep Throat: Y N P If has had, how frequent per year: _____

How many times has your child taken antibiotics: _____

Has your child had any of the following:

Chicken Pox: Y N Rubella: Y N Mumps: Y N

Age: _____ Age: _____ Age: _____

Whooping Cough: Y N Rubeola: Y N

Age: _____ Age: _____

What medications has the child taken in the past and how often:

1) _____ 3) _____

2) _____ 4) _____

Hearing test normal: Y N Not Tested **Speech Impediments:** Y N Past

Vision test normal: Y N Not Tested **Learning Impediments**: Y N Past

VACCINATION HISTORY

Yes, has had; **No**, has not; **Some**, did not finish all shots:

MMR: Yes No Some **DPT:** Yes No Some **Hep B:** Yes No Some

Hib: Yes No Some **Chicken Pox:** Yes No Some **Polio:** Yes No Some

Others: _____

Any reactions to vaccinations? If so, please explain: _____

_____

FAMILY HISTORY

Food Allergies/Sensitivities: Y N P **Environmental Allergies:** Y N P

Obesity: Y N P **Cancer:** Y N P **Tuberculosis:** Y N P

Mental Illness: Y N P **Heart Disease:** Y N P **Autoimmune Disorder:** Y N P

Thyroid Disorder: Y N P **Digestive Disorders:** Y N P

Eczema/Skin Disorders: Y N P

Other diseases in your family: _____

If answers yes to any of the above, please write relationship of family member to child and severity of the disease: _____

_____

_____

MOTHER'S PREGNANCY HISTORY

Child was adopted: Y N

Ease of conception: Easy/Relatively Easy Difficult -- Please explain: _____

_____

Age at conception: _____ **Length of Labor:** _____ **Vaginal Birth:** Y N

Traumatic Birth: Y N **If yes please explain:** _____

_____

_____

Stressors during pregnancy: _____

Medications during pregnancy: _____

How many ultrasounds during pregnancy: _____

Birth interventions (circle one): Forceps Vacuum Extraction C-Section Induction Use of Epidural Use of Antibiotics None

During pregnancy did any of the following occur?

Smoking: Y N Diabetes: Y N Nausea/Vomiting: Y N

Recreational Drugs: Y N Emotional Stress: Y N Alcohol: Y N

Preeclampsia: Y N Coffee: Y N

Dietary Restrictions during pregnancy: Y N **If yes, please explain:** _____

_____

HEALTH HISTORY OF CHILD

How was the child conceived? (Circle one and answer): Natural Medical Intervention - what kind? (eg. IVF, Surrogacy, Donor eggs, etc.): _____

Gestational age at birth (weeks at birth): _____ **Apgar scores:** _____

Birth Weight: _____ **Birth Length:** _____

Complications after delivery: Y N **If yes, please explain:** _____

_____

Location of Birth (circle one): Hospital Birthing Center Home

Child Breastfed: Y N **For how long:** _____ **When put on formula:**_____

What formula was used: _____ **When was solid food introduced:**_____

When was whole milk introduced:_____

Any food cravings: _____

First foods: _____

When did child walk: _____ **Talk:** _____ **Develop teeth:** _____

Jaundice as a baby	Y	N	Colic	Y	N
Cradle Cap	Y	N	Anemia	Y	N
Eczema or Psoriases	Y	N	Stomach Aches	Y	N
Diarrhea	Y	N	Asthma	Y	N
Constipation	Y	N	Warts	Y	N
Finicky eating	Y	N	Nightmares	Y	N
Poor teeth	Y	N	Bed-Wetting	Y	N
Chronic sniffles	Y	N	Excessive Tantrums	Y	N
Bad foot odor	Y	N	Defiant	Y	N
Very sweaty	Y	N	Fears/Phobias	Y	N
Hyperactivity	Y	N	Diaper rash	Y	N
Growing pains	Y	N	Early Puberty	Y	N

<u>Circle all that apply:</u>

Your child's skin is:

dry itchy moist/clammy burning changing moles or lumps (cysts/tumors) acne dry scalp/dandruff

Child's Bowels:

Child has: constipation diarrhea/loose stools bloody stools black stools white/light color stools mucus in stools hemorrhoids unusually foul smelling stools colon problems

other:_____

Number of movements a day:_____ **If less than one a day, how many per week?** _____

Urination:

normal color (pale yellow) clear dark yellow reddish cloudy has odor burning painful difficult/weak urgent

How many times does your child urinate a day? _____

Sleep schedule:

1) Wake up time:_____ 2) Nap time(s) :_____ 3) Bed Time:_____

Does the child sweat during naps or sleeping? Y N If yes, where on the body?:_____

List all surgeries and hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all medications (from drugstore or prescription) child is on now and dosages if known:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all supplements child is now taking, and dosages if known:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Any particular household stressor child has witnessed or gone through:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

TYPICAL DAY'S DIET TYPICAL TIME THEY EAT THIS:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

ENVIRONMENTAL EXPOSURE

Has the child ever lived near a refinery, polluted area or in a home with lead paint? If so, what sort of pollution were they exposed to: _____

_____

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? _____

_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

_____

Do you spray pesticides, herbicides or other chemicals around your home? _____

_____

What year was your home/apartment built? _____

YOUR CHILD'S TEMPERAMENT

Please describe your child's temperament and personality: _____

_____

_____

OTHER QUESTIONS:

Please list any questions you would like the acupuncturist to address during this appointment:

_____

_____

_____

_____

_____

_____

_____

Iyashi Wellness
2001 S. Barrington Avenue, Ste 219
Los Angeles, CA 90025

TEL: 424-248-5576
FAX: 310-914-9031
www.iyashiwellness.com
e-mail: info@iyashiwellness.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ authorize Luriko Ozeki, L.Ac. of Iyashi Wellness to release the information or records specified regarding patient, _____to the health care provider(s) listed below. We do this in order to facilitate proper and effective communication with the team of health care providers the patient may have. Specified at the time of the request, these are:

- Patient Care Reports, including:
  - Findings of present illness or chief complaint
  - Details of signs and symptoms
  - Diagnosis and differential medical diagnostic information
  - Detailed treatment protocol
  - Progress reports with treatment progressions and outcomes, expected number of visits.

Please list below the health care provider(s) you authorize release of medical records by Luriko Ozeki, L.Ac.:

1) _____
2) _____
3) _____
4) _____

Initial: _____ I do NOT authorize Luriko Ozeki L.Ac. to release medical records.

_____
(Patient Name)

_____
(Parent/Guardian Name)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Patient SS#) (Patient DOB)

Your Child's Primary Care Physician (Current or Past)

Name/Office_____

Phone Number_____

Address_____

_____

Your Child's Specialists

(OB, Gastroenterologist, Psychiatrist, Counselor, etc)

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____

_____

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____

_____

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

1. Sometimes after receiving an acupuncture treatment the child may feel a little bit light-headed. If that is the case, please have him/her sit down for a while in the waiting room. In a few minutes child will feel relaxed and clear-headed.
2. Occasionally your child may get a small hematoma (a small dime sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away in a few days. Gentle pressure applied to the site will stop any bleeding that is occurring under the skin.
3. We use only sterile disposable needles that are used once on each patient.
4. Occasionally after the cupping procedure is performed there may be bruising at the site of the cups. This is will fade after a few days and is purely cosmetic in nature.

Initial_____

APPOINTMENT CANCELLATION POLICY

We will set a specific course of treatment for you (or your child). A certain number of visits in a set amount of time are required to get results. If you need to change or cancel an appointment, be sure to make up the appointment within a week. If, for some reason, you need to cancel an appointment, please call ahead and let us know so that we can may accommodate another patient at that time.
No shows and late cancellations less than 24 hours before appointment time will be charged at the full rate of the missed appointment.

Initial _____

OUR SICK POLICY

For the health and safety of our staff, patients and their families, we ask that you reschedule appointments when active infections are present (i.e. sore throat, fever, chills, vomiting, diarrhea). This will allow you to rest at home, and if a parent of a sick child, to help focus your energies in helping your child be comforted and cared for by you.

We will however, provide herbal remedies to mitigate/lessen the severity of symptoms (both internal – and topical, if necessary) and speed up recovery via quick herbal consultation. **In lieu of a missed visit, we will do a phone consult** to support the immune response of the patient as well as to prevent latency that can often occur with infections (to learn more about latency, go to http://bit.ly/latentpathogen), which can lead to other chronic complications. **Please contact the office as soon as you know that you or your child is sick and unable to attend the visit, and we will convert the office visit to a phone herbal consultation.** (Herbs will be dispensed either through an online herbal pharmacy or made available for pick up at Iyashi Wellness.)

Initial _____

PAYMENT DUE AT TIME OF SERVICE

Payment is due at the time services are rendered. If you have insurance coverage, we will provide you with a superbill for you to mail to your insurance company with their appropriate claim form. Your insurance company will reimburse you directly. We will be glad to provide you with whatever paperwork your insurance company needs to reimburse you. However, it is your responsibility to follow-up with your insurance company should there be any delay in payment to you.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Iyashi Wellness to release my personal medical information to me.

There is a service charge of $35.00 for every returned check from the bank.

Initial _____

PRODUCT RETURNS

In order to safe guard the quality of any herbs or supplements sold at Iyashi Wellness, no product returns will be granted, whether opened or not, custom or ready-made.

Initial _____

AUTHORIZATION FOR CARE OF A MINOR

My signature authorizes Luriko P. Ozeki, L.Ac. of Iyashi Wellness to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine within the licensure granted by the California Acupuncture Board. 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 on the facts known, is in my best interests. I intend for 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. I clearly understand that I have the right to refuse care and that I am personally responsible for payment of all costs associated with the treatment of care:

Name of Patient_____

Signature_____ Date _____
(of patient or legal guardian of patient)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
At Iyashi Wellness we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective 1/01/08, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Information
Our office is permitted by federal privacy laws to make uses and disclosure of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Disclosures for Treatment, Payment, and Health Operations
Iyashi Wellness collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of our medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you, or who will provide services which we do not provide. We may also share information with a laboratory that performs a test.
2. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. Healthcare operations: We may obtain services from business associates, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.
4. Notification and communication with family: We may disclose health information to a family member, or your personal representative or another person responsible for your care about your care, location, and general condition. Using our best judgment, we will only disclose health information that is directly relevant to the person's involvement in your care.
5. Required by law: We may also use or disclose your health information when we are required to do so by law. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reactions to medications.

When Iyashi Wellness May Not Use or Disclose Your Health Information
Most uses and disclosures that do not fall under treatment, payment, and healthcare operations will require your written authorization.
Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Your Health Information Rights
You have the right to:

- Restrict the disclosure of your protected health information by written request. The request for restriction may be denied if the information is required for treatment, payment of healthcare operations;
- Received confidential communications regarding your protected health information;
- Inspect and copy your protected health information with written request to our office using the form we provide upon request;
- Request that your protected health information be amended to correct incomplete or incorrect information (in writing);
- Receive an account of disclosures of your protected health information upon written request; and
- Obtain a paper copy of this Notice of Privacy Practices upon request.

Our Responsibilities
Our office is required to:

- Maintain the privacy of your protected health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to make the new provisions effective for all protected health information we maintain. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

For More Information or to Report a Problem
If you have questions and would like additional information, please contact us at the following address or phone number:

2001 S. Barrington Avenue
Ste. 111
Los Angeles, CA 90024
(424) 248-5576

If you believe your privacy rights have been violated, you may file a written complaint with our office. You may also file a complaint by mailing it to the Secretary of Health and Human Services at the following address:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Print Name_____ Date_____

Signature_____