

Unique *Remedy*

NEW PATIENT PACKET

NOTICE OF PRIVACY PRACTICES (HIPAA)

Effective Date: January 2026. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Unique Remedy is committed to protecting the privacy and security of your Protected Health Information (PHI). We are required by law to maintain the privacy of your PHI, provide you with this Notice, notify you of any breach affecting your information, and follow the privacy practices described herein. We reserve the right to modify this Notice at any time and make revisions effective for all PHI maintained by our practice.

Uses and Disclosures of Your Health Information: We may use and disclose your PHI for treatment, payment, and healthcare operations. This may include coordinating care with other healthcare providers, obtaining payment from insurance carriers, verifying benefits, processing claims, quality improvement activities, staff training, business management, licensing, and compliance activities. We may contact you regarding appointments, follow-up care, treatment recommendations, or healthcare-related services using phone calls, voicemail, email, or text messages. Unless you object, we may share relevant information with family members, caregivers, or others involved in your care or payment for your care. We may disclose PHI when required by federal, state, or local law, including public health reporting, law enforcement requests, court orders, audits, investigations, and workers' compensation claims. We may also disclose information to business associates who perform services on our behalf and are contractually required to protect your information.

Uses Requiring Authorization: Uses and disclosures not otherwise permitted by law, including most marketing activities and any sale of PHI, require your written authorization. You may revoke an authorization at any time in writing, except to the extent action has already been taken in reliance on it.

Your Rights: You have the right to inspect and obtain copies of your health records, request amendments to your records, request confidential communications, request restrictions on certain uses and disclosures, request an accounting of certain disclosures, obtain a paper copy of this Notice, and, if you pay for services entirely out-of-pocket, request that information related to those services not be disclosed to your health plan unless otherwise required by law.

Electronic Communications: Email and text communications may not be fully secure. By providing your contact information and communicating electronically, you acknowledge and accept the potential risks associated with electronic communications. Please do not transmit urgent or emergency medical information through email or text.

Questions or Complaints: If you have questions about this Notice or believe your privacy rights have been violated, contact Dr. Nirali Patel, DACM, L.Ac., Unique Remedy, 969-G Edgewater Blvd., Foster City, CA 94404, (650) 539-2434, www.uniqueremedy.com. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

I acknowledge that I have received a copy (if I request) of the Notice of Privacy Practices from Unique Remedy.

Patient Name: _____ Signature: _____ Date: _____

Personal Representative: _____ Relationship to Patient: _____

FINANCIAL & CANCELLATION POLICY

FINANCIAL POLICY

Payment is due in full at the time services are rendered. Insurance benefits may be verified and claims submitted as a courtesy; however, verification is not a guarantee of coverage or payment. Patients remain responsible for all deductibles, copayments, coinsurance, non-covered services, denied claims, and any remaining balance. Full payment for the scheduled service is due at the time of treatment. If insurance subsequently pays toward the claim, any applicable reimbursement or account credit will be issued accordingly.

CURRENT FEES

Acupuncture New Patient \$310 • Acupuncture Follow-Up \$195 • Cosmetic Acupuncture New Patient \$310 • Cosmetic Acupuncture Follow-Up \$250 • Cupping Therapy \$95. Current pricing is always available at www.uniqueremedy.com.

PAYMENT PROCESSING FEE

A 3% processing fee applies to payments made by credit card, debit card, HSA card, FSA card, or other electronic card payments. Processing fees are non-refundable.

CANCELLATION POLICY

Appointments canceled with less than 24 hours' notice, missed appointments, or appointments where the patient arrives 15 minutes or more late will be charged 100% of the scheduled service fee. Appointment reminders are provided as a courtesy and failure to receive a reminder does not waive this policy. If you are ill, please notify the office at least 24 hours before your appointment. Patients arriving with signs of illness will be asked to reschedule and the cancellation policy will be enforced.

INSURANCE PATIENTS

Cancellation and no-show fees are not billable to insurance. Patients who cancel within 24 hours, fail to attend their appointment, or are considered a no-show are personally responsible for the full cost of the scheduled service regardless of insurance coverage.

PATIENT ACKNOWLEDGMENT

I have read, understand, and agree to the Financial Policy and Cancellation Policy of Unique Remedy.

Patient Name: _____

Signature: _____ Date: _____

ARBITRATION AGREEMENT

PATIENT NAME: _____

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, 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 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 extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment 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 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. ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Patient Signature: _____ Date: _____

Office Signature: _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as 'informed consent' and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Patient Name: _____ Signature: _____ Date: _____

Acupuncturist Name: Dr. Nirali Patel, DAOM, L.Ac

PATIENT INFORMATION & HEALTH HISTORY

PATIENT INFORMATION

Date: _____ Name: _____

Age: _____ DOB: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact (Name / Relationship / Phone): _____

Occupation: _____ Referral Source: _____

INSURANCE VERIFICATION

Primary Insurance Carrier: _____ Phone Number on Card: _____

Patient ID #: _____ BIN #: _____

HEALTH CONCERNS

Primary Concern: _____

Duration: _____ Previous Treatment: _____

Secondary Concern: _____

Duration: _____ Previous Treatment: _____

First Acupuncture Treatment? Yes No

MEDICAL HISTORY

Major Illnesses: _____

Surgeries / Hospitalizations: _____

Medications / Supplements: _____

Allergies / Sensitivities: _____

CURRENT SYMPTOMS (CHECK ALL THAT APPLY)

GENERAL: Fatigue Appetite Changes Weight Changes Night Sweats Strong Thirst

SKIN & HAIR: Acne Eczema Rashes Hives Hair Loss Moles/Warts

HEAD: Headaches/Migraines Dizziness TMJ Blurry Vision Ear Pain Throat Pain

CARDIOVASCULAR: High Blood Pressure Low Blood Pressure Irregular Heartbeat Chest Pain Palpitations

RESPIRATORY: Difficulty Breathing Asthma Cough Easily Winded

GASTROINTESTINAL: IBS/Crohn's Nausea/Vomiting Constipation Diarrhea Gas/Bloating

URINARY: Painful Urination Frequency Urgency Kidney Stones UTI

NEUROLOGICAL: Numbness Tremors/Twitching Poor Balance Seizures

MENTAL / EMOTIONAL: Stress Anxiety Depression Mood Swings Irritability

GYNECOLOGY: Irregular Periods PMS Menopause Fertility Concerns Painful Periods Heavy Periods

Clots Spotting Between Periods // Date of Last Menses: _____ Duration: _____ Cycle Length: _____

MUSCULOSKELETAL: Arthritis Scoliosis Joint Weakness Muscle Pain Muscle Spasms

1. Location _____ Pain Level (1-10): _____

When Did It Start?: _____ What Helps?: _____ What Makes It Worse? _____

Pain Description (Dull, Sharp, Aching, Etc.): _____

2. Location _____ Pain Level (1-10): _____

When Did It Start?: _____ What Helps?: _____ What Makes It Worse? _____

Pain Description (Dull, Sharp, Aching, Etc.): _____

3. Location _____ Pain Level (1-10): _____

When Did It Start?: _____ What Helps?: _____ What Makes It Worse? _____

Pain Description (Dull, Sharp, Aching, Etc.): _____