PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____/_____/_____

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____ EMAIL _____

MARITAL STATUS M S D W GENDER M F

FEMALE PATIENTS: FIRST DAY OF LAST MENSTRUAL PERIOD _____/_____/_____
ARE YOU CURRENTLY PREGNANT? *Y N*

EMERGENCY CONTACT (PARENT/GUARDIAN INFO FOR MINORS)

NAME _____ PHONE _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION:

INSURANCE NAME _____ MEMBER ID _____

PRIMARY CARRIER OF THE INSURANCE POLICY: SELF OR FILL IN BELOW

POLICY HOLDER NAME _____ DATE OF BIRTH _____

COPAY _____

PRIMARY REASON FOR VISIT _____

SECONDARY REASON(S) _____

HAVE YOU SEEN A MEDICAL DOCTOR ABOUT THIS CONDITION? Y N

IF SO, WHO & WHEN? _____

REFERRED BY _____

HIPAA GUIDELINES:

PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM/DISCUSS ABOUT YOUR HEALTH CONDITION OR TREATMENT.

_____

PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE ANY CORRESPONDENCE FROM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME ADDRESS.

_____

PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL." Y N

PLEASE PRINT THE TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT APPOINTMENTS OF OTHER HEALTH CARE INFORMATION OTHER THATN YOUR HOME PHONE NUMBER. _____

CAN WE LEAVE CONFIDENTIAL MESSAGES (I.E. APPOINTMENT REMINDERS) ON YOUR TELEPHONE ANSWERING MACHINE OR VOICEMAIL? Y N

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I ACKNOWLEDGE THAT I HAVE RECEIVED AND/OR DECLINED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT IT. ANY QUESTIONS I HAVE ASKED HAVE BEEN FULLY ANSWERED.

SIGNATURE _____ DATE _____

PRINT NAME _____

CLINIC POLICIES AND GUIDELINES:

PAYMENT OF SERVICES

Payment for treatments, herbs and other products are due at the time rendered. Cash, personal checks and credit cards (all except AMEX and Discover) are accepted. Please note there is a $50 fee for each bounced check.

MEDICAL INSURANCE PAYMENT

Any balances accrued in the form of copays, coinsurance, deductibles and/or rejected claim fees are the full responsibility of the patient. If payment has not been received on billed claims from the insurance company by 90 days from the visit, the patient assumes full responsibility of the balance

CANCELLATION OF APPOINTMENTS / NO SHOWS

Cancellation of appointment(s) less than 24 hours prior to scheduled visit will be charged at the full rate. Payment is due before the next scheduled visit. Scheduled appointments missed by the patient (no shows) will also be charged at full rate

APPOINTMENT TIMES

Please be punctual for your appointment so that maximum time can be dedicated to you and your treatment. Late arrival will not extend your appointment time beyond its scheduled hour.

PRIOR TO YOUR APPOINTMENT

Please avoid coffee, caffeine, and other stimulants prior to your appointment time as they can interfere in the clear diagnosis of pulses as well as decrease the effectiveness of treatment.

I HAVE READ AND REVIEWD THE CLINIC POLICIES. I UNDERSTAND AND ACCEPT THE TERMS OF THE TREATMENT GUIDELINES AS STATED ABOVE.

SIGNATURE _____ DATE _____