

## Acupuncture Patient Information

Name:					Gender	M ____ F ____	
Home Phone:	(    )    -	Cell:	(    )    -	Work:	(    )    -		
Date of Birth:		Add:					
Soc. Sec. #	-    -	City:		State:		Zip:	

1. Chief Complaint?

Pain on

- a. Neck
- b. Shoulder
- c. Knee
- d. Ankle
- e. Elbow
- f. Other: \_\_\_\_\_

- Lower Back Pain
- Digestion Problem
- Edema
- Chronic Fatigue
- Dizziness
- Vomiting
- Sprain
- Headache
- Other: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Informed Consent and Disclosure Form

I hereby request and consent to the performance of acupuncture treatment and other procedure within the acupuncture scope of practice on me (or, on the patient name below, for whom I am legally responsible) by the acupuncturist 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 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(or Oriental Massage), oriental herbal medicine, nutritional counseling. I understand that the herbs maybe an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method or treatment, but that it may have some effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burn and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risk may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Oriental medicine, although some may be toxin in large possible side effects of taking herbs are nausea, gas, stomachaches, vomiting, headache, 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.

I understand that the provider will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment.

By voluntary 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 acupuncturist and other procedure, and have had an opportunity to ask questions.

I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

\_\_\_\_\_  
Patient Signature (or Patient representative)

Date: \_\_\_\_\_

Chong Ho Cho L.A.c.  
Acupuncturist's Name

## **OFFICE FINANCIAL POLICY**

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out-of-pocket expense and allows you to place your family under care.

**1. If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

**2. If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

Insurance figures are ESTIMATES ONLY! It is not easy for an office to become familiar with the exact details of every Insurance Plan it encounters. It is the responsibility of the patient, NOT the doctors' office to know what is covered and what is excluded from their particular Insurance Plan.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your carrier has not been paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.

If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Finance Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Front Desk: \_\_\_\_\_ Date: \_\_\_\_\_

For your convenience you may retain your credit card number on file with us.

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as appears on card: \_\_\_\_\_