WELL BEING ACUPUNCTURE CENTER LLC.

WELL MIND. WELL BEING. WELL SOUL. WELL-BEING.

DATE: _____ HOW DID YOU HEAR ABOUT US? _____

LAST NAME: _____ FIRST NAME: _____ DOB: ___ /___ /___

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME TELE: ____-____-_____ CELL: ____-____-_____ WORK: ____-____-_____

EMAIL: _____ HAVE YOU HAD ACUPUNCTURE BEFORE? YES ____ NO ____

When? _____ Where? _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: ____-____-_____

PRIMARY CARE PHYSICIAN: _____ PHONE: ____-____-_____

WHAT IS YOUR MAIN COMPLAINT: _____

_____

WOULD YOU LIKE TO RECEIVE OUR FREE MONTHLY NEWSLETTER?

YES ____ NO ____

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HIPPA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), that I have certain rights to privacy regarding my protection of health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Your office and its staff have informed me of the Notice of Privacy Practices that contain a more complete description of the uses and disclosures regarding my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that I may restrict how my private information is used or disclosed to carry out treatment, payment, or health care options. I understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action replying on this consent.

Patient Name: _____ (Please Print)

Signature: _____ ___ Date: _____

Guardian Signature: _____

Relationship to Patient: _____

CLIENT RESPONSIBILITY

I understand that Acupuncture is a system of medicine based on Traditional Oriental principles and is not meant to replace western medicinal treatment should the case warrant it. I further understand that any western medical diagnosis of my condition must be performed by a licensed physician, and that I shall be advised to seek more appropriate treatment when indicated. I assume full responsibility for consulting with the appropriate physician, if this is necessary. I understand that no claims are being made about my condition.

I hereby certify that the information I have provided is true and complete to the best of my knowledge. In addition, I will advise my Acupuncturist of any changes in my medical condition, address and work status

I also realize that it is my responsibility to pay for all services rendered, and that I will be charge for my visit if I fail to comply with the 24-hour cancellation policy.

_____ _____

Patient Initial Practitioner Initial

_____ _____

Date Date