MORGAN HILL ACUPUNCTURE

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address		Home Phone No. ( )
City	State	Zip	Mobile Phone No. ( )
Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. ________ ❑ Le Tip ❑ Web

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ________

E-mail Address: ________

INSURANCE INFORMATION - FILL OUT ONLY IF YOUR INSURANCE COVERS ACUPUNCTURE

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No Name of Insurance Co:________

Billing Address:

Insurance Co. Phone #:________

Subscriber's Name	Subscriber's ID #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I understand that payment is due at the time of service and that I will be given a superbill to mail to my insurance company for reimbursement. I also authorize Robin Green, L.Ac. or my insurance company to release any information required to process my claims.

X ________

PATIENT/GUARDIAN SIGNATURE DATE

OFFICE POLICY

A. All fees for medical services are due at the time of each treatment. If you have insurance that covers acupuncture, we will be happy to e-bill your insurance as a courtesy to you. However, it is your responsibility to track your claims and contact your insurance company regarding any delay in payment.
B. If you need to cancel an appointment, please give us a minimum of 24 hours notice.
C. Herbal patent medicines are prescribed for you and you only. Do not give herbal formulas to anyone else.

Initials_____

FOR YOUR INFORMATION

1. Sometimes after receiving an acupuncture treatment you may feel a little bit light-headed. If that is the case, please sit down for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed.
2. Occasionally you 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.

Initials_____

INFORMED CONSENT

My signature authorizes Robin Green, L.Ac. of Morgan Hill Acupuncture to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine within the licensure granted by the Medical Quality Assurance Board of the State of California and 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 authorize the release of any medical or other information necessary for insurance claim processing.

Signature_______________________________________ Date _____________________
(Patient, parent or guardian)

Witness____ Date _____________________