REGISTRATION

Camellia City Acupuncture
3400 Cottage Way, Suite N, Sacramento CA, 95825 (916) 486-1402 www.camelliacityacupuncture.com

Patient Information (CONFIDENTIAL)

Name: _____ *Age:* _____ *Birth date:* _____

Biological sex: Female ☐ Male ☐

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Email Address: _____

Home Phone: _____ *Work Phone:* _____ *Cellular Phone:* _____

*Driver's License N°:*_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed

Patient's Employer: _____ *Work Phone:* _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Spouse or Parent's Name: _____

Spouse or Parent's Employer: _____ *Work Phone:* _____

Person to Contact in Case of emergency: _____

Relationship to Patient: _____ *Phone:* _____

Who May We Thank for Referring You?_____

Financial Policy

Our Staff is dedicated to making your visits to our office as pleasant as possible; this includes your peace of mind regarding payment for the services we provide. We request that payment be made at the time of service. A 1.5% monthly finance charge (18%APR) will be added to balances over 30 days late. We accept cash/checks American Express, Visa and Master Card payments for your convenience.

Health Insurance Patients will receive a detailed statement that may be submitted directly to insurance companies for reimbursement. We will bill directly Personal Injury claims that have been pre-authorized. If you have any questions please feel free to ask.

Cancellation Policy

Less than 24 hours cancellation notice and/or missed appointments will be billed at $90.00. If any emergency prevents you from keeping your appointment, arrangements can be made. PLEASE BE ON TIME. If you know you will be late, please call. Every effort will be made to reschedule you for a later time.

**Acknowledgement of Receipt of Notice of Privacy Practice*

I have read or have been informed of this office's Notice of Privacy Practices.

Patient's Signature: _____Date: _____

(or Parent or personal representative)

*You are entitled to a copy of this Consent Form and our office's Notice of Privacy Practices

Informed Consent for Acupuncture Treatment and Care

I hereby consent to the performance of acupuncture treatments and other Asian Medicine procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Gena L. Spencer a licensed acupuncturist.

I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needle sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping and spooning.

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 Asian Medicine. I understand that some herbs may be inappropriate during pregnancy. I will notify my acupuncturist should I become pregnant or if I am trying to become pregnant (for which Asian Medicine can be very helpful). If I experience any gastro-intestinal upset or allergic reactions to the herbs I will stop taking the herbs and immediately inform the acupuncturist.

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, based on the facts they know, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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's Signature_____Date:_____
(or Parent or personal representative)

I certify that the above information has been accurately provided. I have read and understand the above policies to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature_____ Date: _____
(or Parent or personal representative)