Harmony Acupuncture

Agatha Suk L Ac.
917 C st. Hayward, CA 94541
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Patient Information

Patient Name _____DOB ___/___/_____ Primary Language_____-___

Sex: M F Home: (_____) _____ - _____ Mobile: (_____) _____ - _____

Email: _____ preferred method of contact (circle one): Call / Text / Email

Address: _____ Suite/Apt # _____

City_____ State _____ Zipcode_____

Insurance Information

Primary Health Plan:_____

Subscriber Name: _____ SSN: _____

Subscriber ID#_____ Group # _____

Primary Care Physician:_____ PCP Phone # : (_____) ____ - _____

Protecting your privacy and healthcare information is fundamental in the course of our relationship. Our staff at Harmony Acupuncture may need to use your name , address and phone number to contact you with appointment reminders, to follow-up after an appointment, to provide information about your treatment alternative, or other health -related information that may be of interest to you. If this contact is made by phone if you are not available, a message will be left on your answering device or with whomever answers the phone. Appointment reminders, cards and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information. Please let us know in person if you would like to change your preferences.

Further, in order to provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive at this clinic. We are committed to protecting, securing and keeping confidential your personal and medical information unless we have your written consent for its disclosure. There are instances, however, in which your personal health information may be disclosed without your expressed written consent according to the Health Insurance Portability & Accountability Act (HIPAA); these include 1) at your verbal request, 2) for default of payment, 3) as required by an agency of the government.

Financial Agreement Health Insurance : Most insurance policies cover Acupuncture care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

Most insurance policies do not cover cupping treatment, so if you receive cupping treatment, there will be $30 added to your Co-payment.

Appointment Cancellations : When you are booking your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of our time and your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If a cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand and your advanced notice will allow another patient to access that time.

Late Cancellations / No Shows: A cancellation is considered late when the appointment is cancelled less than 6 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $50 missed appointment fee.

_____	_____	___/___/_____
Patient's Name (printed)	**Signature**	**Date**

Informed Consent to Acupuncture and Oriental Medicine

I hereby request and consent to the performance of acupuncture, and other procedures within the scope of the practice of Oriental Medicine, on me (or the patient named below for whom I am legally responsible) by Agatha Suk, L.Ac.

I understand that methods of treatment may include, but are not limited to: acupuncture; moxibustion; cupping; gua'sha (scraping therapy); needle retention; tuina (Chinese manipulation); electrical, laser, and/or magnetic stimulation; micropuncture (mild bleeding therapy); diagnostic palpation on various areas of my body; herbal medicine; and nutritional and/or lifestyle counseling.

I understand and am informed that in the practice of Oriental Medicine, as in the practice of allopathic medicine, there are some side effects and/or risks of treatment; I understand that although these are unlikely to occur, they are possible. Some of these effects include, but are not limited to: bleeding; bruising, numbness, tingling, pain or other strong sensation at the location where a needle is inserted or radiating from that location; aggravation of current symptoms; appearance of new symptoms; general aches or dizziness. Bruising is a common side effect of gua'sha and cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include infection or nerve pain, although the acupuncturist uses sterile, single-use, disposable needles and maintains a clean and safe environment. Highly unusual risks include organ puncture, including pneumothorax (punctured lung), and spontaneous miscarriage. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, at any time before or during the diagnosis or treatment.

The Chinese and Western herbs (which are derived from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of herbal medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, headache, rashes and tingling of the tongue; some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I understand that some herbs may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. Further, I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of any Chinese herbs. I do not expect the acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist(s) to exercise such judgment based on the known facts, during the course of my treatment, to be in my best interest. I understand that results are not guaranteed. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of acupuncture treatments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any furniture condition(s) for which I seek treatment from this clinic.

_____ _____

Patient's Name (printed) **Representative/Legal Guardian**

_____ _____/_____/_____

Patient Signature/ or Legal Guardian **Date**

Authorization and Assignment

It is my understanding that if I become a patient in this office, I agree to the following:

Authorization to Release Information

I am authorizing you to release any information you feel appropriating my condition to any insurance, attorney, or adjuster in order to receive reimbursement on any charges incurred by me as a result of services rendered by you professionally.

Authorization to Pay Directly to Practitioner

I authorize direct payment to the practitioner of any sum that I owe or in the future from any insurance company that is obligated to reimburse me charges incurred in the practitioners office in part or full/or my attorney of the proceeds out of my settlement. A photocopy of this form is acceptable for payment.

Assignment of Cause Action

I hereby assign and give to the practitioner the right to take against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name to resolve this claim. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be responsible for this bill. I do understand that whatever amounts are not collected from the insurance company do become my responsibility and I am to pay these as soon as possible.

_____ _____

Patient's Name (printed) **Representative/Legal Guardian**

_____ _____/_____/_____

Patient Signature/ or Legal Guardian **Date**