# Notification Form Regarding Evaluation of Patient by Physician

*In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, CostaCoast Sprinters, LLC is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.*

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

I (patient's name) _____ am notifying CostaCoast Sprinters, LLC of the following:

__Yes __No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

**OR**

__Yes __No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of treatment prior to acupuncture treatment is _____.
After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

**OR**

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

__Chronic Pain
__Smoking addiction
__Weight loss
__Alcoholism
__Substance abuse
Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____ _____
Patient Signature Required Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____ _____
Patient Signature Required Date

_____ _____
Acupuncturist's Signature Date

*CostaCoast Sprinters, LLC is not responsible for untrue statements made by patients.*

# HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the CostaCoast Sprinters, LLC (CCS) "Notice of Privacy Practices". I understand that I have the right to review CCS's "Notice of Privacy Practices" prior to signing this document.
I understand that CCS staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.
I also understand that my clinical information may be used for educational and/or research purposes by CCS or individuals authorized by CCS. All information that can identify me personally will be removed.
By signing this form, I am giving CCS authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at CCS appointments will be held confidential except in the instance where my safety or the safety of others may be at risk

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature CCS Privacy Rep/Date

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# Authorization for Release of Health Information (Optional)

I, _____, hereby authorize CostaCoast Sprinters, LLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

*Persons/Organizations authorized to receive information: (please print)*

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date

# New Patient Information

Welcome to CostaCoast Sprinters, LLC (CCS). Treatments are available from licensed acupuncturists at any location. Please initial next to each paragraph and sign below.

____**Cancellation Policy** – Treatments are by appointment, although walk-ins are often able to be accommodated. If you find you need to cancel an appointment, please call or email CCS as soon as you are aware of the cancellation. We reserve the right to charge a $25.00 fee for an appointment canceled with less than 24 hour notice (Late cancels) or for a "no-show" appointment. If the appointment is rescheduled for an appointment the same day, this fee is waived. In the event of inclement weather or other severe circumstances, CCS will make every attempt to contact the patients, a message will be posted on the website and a message will be left on our phone line at 915-309-1998.

____**Payment for Clinic Services Rendered** – Payment is due at the time of service and may be paid by check or with a credit card. CCS is not a Medicare/Medicaid provider. CCS is not set up through any insurance carriers and is happy to provide a superbill so you may file with your insurance carrier.

____**Herbal Refills** – Please call no less than 24 hours before you wish to pick up an herbal refill from CCS to allow us to process the request. Herbal formulas will not be prepared until you arrive unless they are guaranteed with valid credit card payment. If an herbal formula requires herbs which are not carried by CCS, the patient has the option requesting a drop shipment from a reputable source(via CCS) or to request that the formula be filled via AOMA Herbal Medicine and picked up by the patient during regular business hours.

Patient Signature Required: _____

Date: _____