
New Patient Registration

Patient Full Name:

Date of Birth:

Address, city, state, ZIP:

Phone number:

Email:

Emergency contact name, relationship, and phone:

Primary care provider and phone:

Insurance company, member ID, and group number (if requesting a superbill):

New Patient Health Questionnaire

Patient Full Name:

Date of Birth:

What is your main concern, and when did it begin?

What medical conditions have you been diagnosed with?

What medications, supplements, and herbs are you currently taking? Include doses if known.

Do you have any allergies? List the substance and reaction, or write "None" or "Unknown."

Have you had any surgeries or hospitalizations? Please describe.

New Patient Health Questionnaire - Continued

Patient Full Name:

Date of Birth:

Are you pregnant, possibly pregnant, or breastfeeding?

Do you take blood thinners, have bleeding problems, or have a pacemaker or implanted electrical device?

Have you had any reactions to acupuncture, herbs, or injections? Please describe.

Is there anything else we should know about your health?

Payment Policy Acknowledgment

Patient Full Name:

Date of Birth:

Payment is due at the time of service unless otherwise agreed in writing. Fees will be explained before treatment or purchase.

Insurance reimbursement is not guaranteed. A superbill is available upon request.

Any applicable cancellation fees or package terms will be provided separately before booking or purchase.

I acknowledge the payment terms above.

PATIENT SIGNATURE:

Date Signed:

Privacy Notice Acknowledgment

Patient Full Name:

Date of Birth:

I acknowledge that I have received Ling Chen Clinic's Notice of Privacy Practices. I understand that I may request a paper copy at any time.

My signature confirms receipt of the notice and does not waive my privacy rights.

PATIENT SIGNATURE:

Date Signed:

Cancellation and No-Show Policy Acknowledgment

Patient Full Name:

Date of Birth:

Cancellation and No-Show Policy

Please cancel or reschedule at least 24 hours before your scheduled appointment.

A \$25 fee applies to cancellations or rescheduling less than 24 hours before the appointment, or missed appointments without notice.

This policy applies to scheduled appointments only.

I have read and understand this policy and agree to the fees stated above.

PATIENT SIGNATURE:

Date Signed:

Treatment Consent

Patient Full Name:

Date of Birth:

I voluntarily consent to the treatments discussed and agreed upon with my clinician at Ling Chen Clinic. Services may include acupuncture, Chinese herbal medicine, community acupuncture, facial rejuvenation acupuncture, nappage facial injections, Vitamin B12 injections, and homeopathic injections.

Before treatment, my clinician will explain the proposed procedure, its purpose, expected benefits, relevant risks, and alternatives, including no treatment. I understand that results vary and are not guaranteed. I may ask questions, decline any procedure, or withdraw consent at any time.

Acupuncture involves inserting thin, sterile, single-use needles at selected points. Possible risks include soreness, bleeding, bruising, dizziness, fainting, and temporary worsening of symptoms. Rare complications include infection, nerve or organ injury, and pneumothorax. Additional procedures may include cupping, scraping (gua sha), far-infrared light therapy, electrical stimulation, or bloodletting. These procedures will be discussed before use. Depending on the procedure, risks may include skin irritation, bruising, bleeding, burns, or infection.

Chinese herbal medicine may be recommended following an individualized assessment. Possible risks include digestive upset, allergic reactions, interactions with medications or supplements, and, with some products, liver or kidney injury. I will follow the prescribed instructions and report unexpected symptoms. I will not discontinue or change prescribed medication without consulting the prescribing clinician. Herbal medicine is purchased separately.

Community acupuncture takes place in a shared treatment area. Other patients may see me receiving treatment or overhear conversations. I may request to discuss sensitive information privately. The acupuncture risks described above also apply to treatment in this setting.

Facial rejuvenation acupuncture involves needles placed at selected facial and, when appropriate, body points. Possible risks include discomfort, bruising, bleeding, swelling, infection, and the acupuncture risks described above. Cosmetic results vary and are not guaranteed.

Treatment Consent - Continued

Patient Full Name:

Date of Birth:

Nappage facial injections involve superficial microinjections in selected facial areas. Possible risks include pain, redness, swelling, bruising, bleeding, infection, temporary bumps, uneven appearance, pigment changes, scarring, and allergic reactions. The clinician will explain the specific product, dose, injection sites, expected benefits, and product-specific risks before treatment.

Vitamin B12 injections are offered when appropriate based on my health history and individual needs. Possible risks include injection-site discomfort, redness, swelling, bleeding, bruising, infection, fainting, tissue or nerve injury, and allergic reactions, including rare severe reactions. Product-specific risks and contraindications will be reviewed before treatment.

Homeopathic injections involve administering a selected homeopathic product at designated sites or acupuncture points. Possible risks include pain, redness, swelling, bleeding, bruising, infection, fainting, tissue or nerve injury, and allergic reactions, including rare severe reactions. I understand that homeopathic products are not FDA-approved and their safety and effectiveness have not been established through FDA approval. The specific product, purpose, dose, injection sites, and product-specific risks will be explained before treatment.

I agree to provide accurate information about my medical conditions, medications, supplements, allergies, pregnancy status, and previous reactions to treatment. I will notify my clinician of any changes and promptly report unexpected symptoms or treatment reactions.

I have read and understand this form. The treatments I am consenting to have been explained to me, and my questions have been answered to my satisfaction. Any new treatment or material change in the treatment plan will be discussed with me before proceeding.

PATIENT SIGNATURE:

Date Signed: