



PATIENT CONFIDENTIAL INFORMATION

Name: First Middle Last
Mailing Address: Street City State Zip
Home Phone: Business Phone:
Cellular Phone: Email:
Can we leave a message? Y/N At what number? Home Phone/Cell Phone
In case of emergency, call: Name: Phone:

Date of Birth: Age: Gender: M/F

- Are you 18 years or older? Y N
o If 'NO' parent must sign for consent here:
I understand that bleeding or bruising is a possible side effect of acupuncture. Y N
Do you have any bleeding disorder? Y N
Are you taking any blood thinners? (Coumadin, Heparin, Aspirin, or other) Y N
Is your immune system compromised by cold, flu, diabetes or autoimmune disease? Y N

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?

Do you have any infectious diseases? Y N If yes, please identify:

I understand that the "Trying Out Acupuncture" treatment is designed solely for the purpose of relaxation and is not meant to treat any medical symptoms. Y N

How did you find out about New Leaf ?



FINANCIAL POLICIES

Oriental Medicine Evaluation & Acupuncture Treatment (45-75 min)	\$60
Extended OM Evaluation & Acupuncture Treatment (75-90)	\$80
New Patient Comprehensive Health History	\$60
Herbal Prescription with Herb/Drub Database Check	\$15
Missed Appointment / Cancellation of 24 hours or less	\$25
Clerical Requests (per 15 minutes)	\$15
Cosmetic Acupuncture Treatment	\$135
“Trying Out Acupuncture” Treatment	\$75

Please initial the following:

_____ All payments are due in full at the time of service.

_____ Insurance is not accepted, however if your policy covers acupuncture, we can provide paperwork for you to submit to you insurance company yourself.

_____ In the event of a missed appointment, or an appointment cancelled with notice of 24 hours or less, a \$25 fee will be charged.

Please indicate your understanding and acceptance of these policies by signing below.

Signature

Printed Name

Date

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

X

Patient Signature

Date