Confidential Patient Data

The Restorative Center

If you would like our assistance in completing this form, please let us know!

Today's Date:				
Please share some important information with us:				
Last Name: First Name: Middle Initial: Date of Birth:				
Street Address:		Work Phone	Home/Cell Phone:	Preferred method of contact:
City:	State:	Zip Code:	Email:	
Employer:		Occupation:		

<u>Current Medications:</u>

Drug Name: _____ Date Started: _____ Frequency: _____
Drug Name: _____ Date Started: _____ Frequency: _____
Drug Name: _____ Date Started: _____ Frequency: _____
Drug Name: _____ Date Started: _____ Frequency: _____

<u>Drug Allergies:</u>

Drug Name: _____ Reaction: _____
Drug Name: _____ Reaction: _____
Other Allergies:

Insurance Information	
Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient Relationship to Insured:	Insured Date of Birth
Secondary Insurance	Insured ID

Please share with us the reason for your visit and how we can help you:

_____

_____

_____

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Seven Star Acupuncture all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that my health care information may be disclosed to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Signature_____ Date_____ Please Print Name _____

Our Privacy Promise:

We take the privacy of your information very seriously. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

If we have to make a change to our privacy practices for any reason, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time to discuss our privacy promise.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction binds us to honor your privacy request.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. Before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Representative

_____ _____

Signature Date

Seven Star Acupuncture Consent for Treatment

Thank you for choosing Seven Star Acupuncture for your acupuncture therapy. During your visit, you will be treated with sterile, disposable needles. It is best to have eaten before your treatment, up to an hour before your appointment. Please wear or bring loose or comfortable clothing.

During your treatment, please communicate freely with your acupuncturist regarding any sensations you may feel with needle placement, as needles can be adjusted to accommodate any uncomfortable sensations. Although rare, needles may cause temporary bruising, swelling, bleeding, numbness, tingling or soreness at the needle site.

Please notify your acupuncturist if you are pregnant, or planning on becoming pregnant. Please feel free to discuss risks and benefits of acupuncture therapy with your acupuncturist before signing this form. Your acupuncturist will exercise his or her judgment in your best interest during the course of treatment, based on the facts provided.

It is recommended that your physician be consulted for any medical problems before receiving acupuncture and at any time during the course of treatment if your symptoms change significantly for the worse. Your signature indicates that you have read and understand this consent carefully, have asked any questions, and received satisfactory answers.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care, but this office cannot make the assurance that yours does. Insurance policies vary 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 for your treatments. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Assignment of Benefits
By signing this form, you are authorizing that payment of medical benefits may be made directly to this office. If your insurance carrier sends payment to you for services provided in this office, you agree to send or bring those payments to this office upon receipt.

_____ _____

Print Name Date

_____

Signature