

MELINDA CHOY, L Ac

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name First Middle [Mr.] [Miss] Marital Status (Check One) [Mrs.] [Ms.] Single/ Mar/ Div/ Sep/ Wid

Is this your legal name? If not, what is your legal name? (Former Name) Birth Date Age Sex [Yes] [No] / / [M] [F]

Mailing Address Home Phone No. () City State Zip Cellular Phone No. ()

Occupation Employer Employer Phone No. ()

Referred by (Please check one box) [Dr.] [Le Tip] [Web]

[Family] [Friend] [Close to Home/Work] [Yellow Pages] [Other]

E-mail Address: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address) Relationship to Patient Home Phone No. Work Phone No. () ()

The above information is true to the best of my knowledge. I understand that payment is due at the time of service and that I am financially responsible for any amount not covered by my insurance. I also authorize Melinda Choy, L.Ac. or my insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date

OFFICE POLICY

- A. All fees for medical services are due at the time of each treatment. If you have insurance that covers acupuncture, we will be happy to submit the bill on your behalf. You are required to pay any copayment, deductible, and non-covered charges at time of service.
- B. If you need to cancel an appointment, please give us a minimum of 24 hours notice.
- C. Herbal patent medicines are recommended for you and you only. Do not give herbal formulas to anyone else.

Initials _____

FOR YOUR INFORMATION

- 1. Sometimes after receiving an acupuncture treatment you may feel a little bit light-headed. If that is the case please sit down for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed.
- 2. Occasionally you may get a small hematoma (a small dime sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern- it will go away in a few days. Gentle pressure applied to the site will stop any bleeding that is occurring under the skin.
- 3. We use only sterile disposable needles that are used once on each patient.

Initials _____

INFORMED CONSENT

My signature authorizes Melinda Choy, L.Ac. to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Board. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement during the course of the procedure which the acupuncturist feels at the time, based on the facts known, is in my best interests. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I authorize the release of any medical or other information necessary for insurance claim processing.

Signature _____

Date _____

Witness _____

Date _____