PATIENT REGISTRATION (Please PRINT)

Name:_____
(First, Middle, Last)

SSN: _____

Address: _____

Apt. No.: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth:_____

BILLING & INSURANCE INFORMATION

Primary: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Relationship to Patient: _____

Patient's sex: [ ] M [ ] F

Email: _____

[ ] Single [ ] Married [ ] widowed [ ] Divorced [ ] Other

Email Address: _____

Employer: _____ Occupation: _____

Work Number: _____ Extension: _____

Emergency Contact: _____ Phone _____ Relationship: _____

Primary Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Secondary Insurance: _____ Policy Number: _____

Group No: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Relationship to Patient: _____

FAILURE TO CANCEL APPOINTMENT OR NO-SHOW WITHIN 24 HOURS WILL RESULT CHARGE OF $60.

INSURANCE AUTHORIZATION & ASSIGNMENT: I hereby authorize the acupuncturist, I-Hsin Tammy Chang, to furnish information to my insurance carriers (if any) concerning my illness and treatments, and I hereby assign to the acupuncturist all payments for medical services rendered to me. I certify that the information reported regarding my insurance coverage is correct. I permit the acupuncturist to use a copy of this authorization in place of the original.

Payment is due at the time of service. I understand I am responsible for any amount not covered by my insurances(s).

NON-PAYMENT: I understand that if my account is turned over to a collection attorney or agency; I will be responsible for any additional fees as allowed by law.

MEDICAL RECORDS RELEASE: I hereby authorize the acupuncturist to release my medical records to, and to discuss my care with my treating physicians and any other Health Care Providers, Hospitals and Clinics. I further authorize any and all of my treating physicians, health care providers, hospitals and clinics to release my medical records, including but not limited to the treatment or evaluation of alcohol or drug use, HIV/AIDS and or psychiatric conditions to the acupuncturist.

By signing this form, I also authorize the practitioner to communicate with me by emails.

SIGNATURE _____ DATE _____