Turtle Pond Acupuncture Clinic

1426 Fillmore Street, Suite 202
San Francisco, CA 94115
www.turtlepondacupuncture.com

Phone: (650) 242-5737
Fax: (415) 752-6088
Email: Turtlepondacupuncture@hotmail

Patient Information Form

Please print clearly

Name: _____Age: _____

Date of Birth: _____ Gender: Male / Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home-_____ Cell-_____

Email Address: _____

Occupation: _____

Referred by: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Preference of Language:_____

Medical Insurance Carrier: _____

Policy Number/ID: _____

Group Number: _____

Weight: _____ Height:_____ Temp:_____

Blood Pressure:_____/_____ HR:_____

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CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, massage, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that It may have some side effects including bruising and/or numbness or tingling near the needling sites that may last a few days.

There have been rare instances reported in which a patient fainted, developed a scar or infections, experienced a spontaneous abortion, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). The herbs and nutritional supplements that have been recommended are considered safe in the practice of Chinese medicine. Some herbs may have undesirable effects in larger doses than we recommend. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea or rashes. I will notify my acupuncturist if I am pregnant since some herbs can be harmful.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend 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.

Patient Signature: _____ Date: _____

Acupuncturist Signature: _____ Date: _____

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Medical History

MAJOR COMPLAINT/HEALTH PROBLEM YOU WOULD LIKE US TO TREAT:

_____

_____

_____

HOW DID THIS CONDITION DEVELOP?

_____

_____

_____

HOW LONG HAS THIS CONDITION PERSISTED?

_____

_____

_____

IS THERE ANYTHING THAT MAKES IT BETTER OR WORSE?

_____

_____

_____

IF YOU HAVE PAIN—IS IT SHARP OR SHOOTING, PINS AND NEEDLES, OR DULL? CHRONIC OR ACUTE?

_____

_____

_____

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ANY SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.):

_____

_____

_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

_____

_____

_____

LIST ANY OTHER MEDICAL HISTORIES YOU WOULD LIKE TO ADDRESS:

_____

_____

_____

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

_____

_____

_____

LIST ANY MEDICATIONS/HERBS/DRUGS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

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Financial Policy

I understand that health insurance policies are an arrangement between an insurance carrier and myself. I assume full responsibility for verification of benefits including which services are covered under my policy, the portion of fees covered, and an annual maximum of coverage. Furthermore, I understand that Turtle Pond Acupuncture will prepare any necessary reports and claim forms as a courtesy to assist me in collecting reimbursement from my insurance company and that I will collect the amount covered directly from my insurance company. Any amount paid to the provider will be reimbursed to the patient by check upon receipt. Turtle Pond Acupuncture does not bill secondary insurance companies or third party carriers. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment in full at the time of service.

Your appointment time is reserved specifically for you. Therefore, Turtle Pond Acupuncture requests at least 24 hours notice for any cancellation or rescheduling of appointment times. Repeat missed appointments or short notice cancellations may result in a missed appointment fee of $45.00. Exceptions to this policy include cancellations due to illness, family or personal emergency, and last-minute changes in the scheduling of procedures with your medical doctor. Please notify Turtle Pond Acupuncture as soon as possible if you are unable to keep your appointment for any of these reasons. Payment is due at the time of treatment.

Turtle Pond Acupuncture Fee Schedule:

Initial Visit with treatment- $140.00*
Return Acupuncture treatment- $95.00-$135.00*
Prepay package (10 treatments +1 free) - $950.00*
Herb and supplement prices are variable according to medication prescribed and amount of medication prescribed
*Additional charges may apply for additional treatment modalities based on medical necessity and the complexity of the condition(s) to be treated.

Please sign and date below stating that you have received and understand the above policies

Name: _____ Date: _____

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