PATIENT REGISTRATION (Please PRINT)

Name:____________________ (First, Middle, Last)

SSN: ____________________

Address: ____________________

Apt. No.: ____________________

City, State, Zip: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Date of Birth:____________________

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

BILLING & INSURANCE INFORMATION

Primary: ____________________

Policy Number: ____________________

Group Number: ____________________

Subscriber's Name: ____________________

Subscriber's DOB: ____________________

Relationship to Patient: ____________________

Patient's sex: [ ] M [ ] F

Email: ____________________

Email Address: ____________________

Employer: ____________________ Occupation: ____________________

Work Number: ____________________ Extension: ____________________

Emergency Contact: ____________________ 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.

INSURACNE 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 render to myself. 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-PAYEMNT: 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 ____________________