Mission Community Acupuncture

Patient Information

Name_____ Date_____

Address_____

City_____ Zip_____

Email_____

circle preferred phone Home phone_____

Cell phone_____ workphone_____

Date of Birth_____Occupation_____

Place of Birth_____

Status ( ) single ( ) married ( ) Partnered ( ) other_____

Emergency name & phone_____

Relationship to you_____

Physician's name & phone_____

Chief complaint_____

_____

Other problems you'd like to work on_____

How did you hear about this office?_____

Fees are due at the time of treatment.
→Please give 24 hours notice in advance of a change or cancellation of appointment or You will be charged in Full

*Initial here*_____

NOTICE OF PRIVACY PRACTICES--- ACKNOWLEDGEMENT

_____

We keep a record of the health care services that we provide for you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office of Mission Community Acupuncture.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. Please ask if you would like to review it or take home a copy.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE DATE

_____ _____

PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT RELATIONSHIP (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE)

(NOTATION, IF ANY, BY STAFF)

This form will be retained in your medical record.