PATIENT REGISTRATION FORM

(Please complete and sign before your appointment)

patient name: _____
first middle last

address: _____
street city state zip

home phone: _____ age: _____ birth date: _____ sex: m f

other phone: _____ referred by: _____

SSN number: _____ employer: _____
(required for work comp) (required for work comp)

e-mail: _____ emergency contact: _____
(for appointment notification) name and phone number

billing information – ___ PPO insurance ___ work comp ___ Kaiser/Prospect ___ cash/check/cc

* Please present your insurance card or authorization letter for photocopying

What is your co-pay (if applicable)? _____

If my acupuncture benefits are not yet verified, I agree to one of the following:

_____ Pay my charges in full at time of service until verification is confirmed. My account will be credited upon verification.

_____ Place my credit card information on file, which will be charged for any outstanding portion of my balance.

Credit card: visa, m/c Name as it appears on card: _____

Credit card number: _____ exp date: _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

Date: _____ patient's (or guardian) signature: _____

Patient Information Acknowledgement Form

(permission to share health information with your doctor or insurance carrier)

I have read and fully understand Uchida Acupuncture's PATIENT INFORMATION ACKNOWLEDGEMENT FORM. I understand that Uchida Acupuncture may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Uchida Acupuncture will consider requests for restrictions on a case- by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes noted in Uchida Acupuncture's PATIENT INFORMATION ACKNOWLEDGEMENT FORM. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____

IMPORTANT, PLEASE READ: The following page is an ARBITRATION AGREEMENT that our malpractice insurance carrier requires each patient we treat to read and sign. Signing this agreement means that if there is a medical dispute, we agree to settle the matter through a neutral arbitrator (often a retired judge) rather than a suit in court. Binding arbitration means that you can still present your case, obtain a speedier resolution and lower legal costs. If you still have questions, please ask us for more information. Thank you.