Acupuncture Herbal House, LLC
124 Country Club Drive
Titusville, FL 32780
Phone: 321-360-6080
Fax: 321-383-0872
E-mail: contact@acuherbhouse.com
Web: www.acuherbhouse.com

Please fill in the following information as completely as possible. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Date_____

Name _____ **Home Phone (____)**_____
Last First Middle
Address_____ **Business Phone: (____)**_____
Number, Street
_____ **Zip Code:**_____
City State
E-mail address_____ **Cell Phone (_____)**_____

Occupation_____**Social Security#**_____

Birthday_____**Sex: M , F Height**_____ **Weight**_____**Age**____**MaritalStatus** _____ **Children**_____

Place of Employment _____

Work Phone _____**Best # To Reach You**_____

In Case of Emergency Contact_____
Name Phone# Relationship
How did you learn about our office?_____

1. Have you ever had Hepatitis? Yes No If yes, When_____
2. Do you have AIDS or HIV infection? Yes No How long? _____
3. Have you ever had any surgery? Yes No Please list type and year below_____
_____
4. Have you ever had heart problems or symptoms? Yes No Please explain:_____
_____
5. Are you taking any medications or pain pills at this time? Yes No List below: _____
_____
6. Are you taking any nutritional supplements at this time? Yes No List below: (vitamins, minerals, etc)_____
_____
7. Have you had Acupuncture before? Yes No For what problem:_____
Previous doctor /acupuncturist's name:_____
8. Do you have any problems with needles , dizziness, nausea, or fainting ? Yes No
9 .Reason for your visit:
_____
_____

We accept the following forms of payment.。 Please circle the method of payment you plan to use today.

VISA MASTER CARD AMERICAN EXPRESS DISCOVER CASH CHECK

Financial Policy / Cancellation Policy: Payment is due at the time of Service

ACUPUNCTURE HERBAL HOUSE, LLC

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

• Protected health information may be disclosed or used for treatment, payment or health care operations

• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

• The Practice reserves the right to change the Notice of Privacy Policies

• The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease

• The Practice may condition treatment upon the execution of this Consent.

_____

This Consent was signed by:_____

Printed Name - Patient or Representative

_____

Signature

Relationship to Patient (if other than patient):_____

Date:___ /___ /___

Witness:_____

Printed Name - Practice representative

Date:___ /___ /___

ACUPUNCTURE HERBAL HOUSE, LLC

TREATMENT CONSENT FORM

I, _____, hereby consent to be treated with acupuncture and herbal medicines by Chris Lim, AP or whomever he designates in his absence.

I understand that acupuncture is performed by the insertion of fine needles into specific points on the body with the intent of improving body functions and/or relieving pain. I understand that only pre-sterilized, disposable needles will be used. I further understand that the needles may cause some temporary localized pain, bruising, or light headaches. "Moxibustion" a.k.a. heat therapy may also be used and natural herbal medicines may be prescribed.

I am in full compliance with the fact that in the event I decide to seek treatment from a health practitioner outside this clinic and patient records need to be transferred, all herbal prescriptions/acupuncture points on the records are copyrighted, the exclusive property of **THIS** clinic and may not be used without express written permission from **THIS** clinic. Any request of patient records by me or any other health practitioner I decide to transfer to for purposes of using copyrighted herbal/acupuncture prescriptions of **THIS** clinic without permission is strictly prohibited.

I accept the fact that there is no guarantee concerning the outcome of my acupuncture or herbal treatments and I understand that I may stop treatment at any time. I also accept that there are **NO REFUNDS** on any services, including herbal medicines.

Payment must be made in full at the time of treatment.

_____ _____

Signature of Patient or Guardian Date

The employees of Acupuncture Herbal House, LLC endeavor to maintain your confidentiality to the best of their ability. If you have any questions or concerns regarding the privacy of your records, please contact the office manager.