Acupuncture and Wellness of Charleston, LLC
Mailing address: 164 Market Street, #302, Charleston, SC 29401
Acupunctureandwellness@yahoo.com; 843-513-7477

Patient Information

Last Name: ______________________ First Name: ______________________ Middle Name: __________________

Address: ________________________________ City: __________________ State: ______ Zip Code: __________

SS#: ______________ Home Ph:(______)__________ Work Ph:(______)__________ Cell Ph:(______)__________

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): **❍ Home ❍ Work ❍ Cell**

Date of Birth: __________ Sex:______ Other names that records may be kept under: ______________________

Are you a student at another university or college? Y N What is your current status? FT PT Are you currently employed? Y N

Employer/School: ________________________________

Mother's Name (minors only): ______________________ Father's Name (minors only): ______________________

Emergency Contact: ______________________ Relationship to Emergency Contact: ______________________

Contact's Phone #1: (_______)______________ ❍ Home ❍ Work ❍ Cell Do you have special needs?: ❍ No ❍ Yes (see front desk)

How did you hear about us? ❍ Newspaper Ad ❍ News Story ❍ Mailer/Flyer ❍ Website ❍ Workshop/Event ❍ Medical Referral ❍ Friend/Family ❍ Yellow Pages ❍ T.V. Ad ❍ Insurance Co. ❍Other: ______________________

The following information is requested for our grant and federal reporting requirements and is optional

Marital Status *(circle one)*: Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership Other

Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other

Number of members in your household: ______ **Gross annual household income:** ______________ /year

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

Address: ______________________ City: ______________ State: _______ Zip: __________ Phone: (_______)__________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X ____ ______________________

Guarantor's Signature **Date**

Terms of Agreement

Financial Terms: I understand that payment is due at the time of each visit. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.
Privacy terms: Acupuncture and Wellness of Charleston, LLC is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact Catherine Jones, ND, MSA, LAc.

I hereby acknowledge that I have received a copy of Acupuncture and Wellness of Charleston, LLC's Notice of Privacy Practices.

X ____ ______________________

Patient's Signature Date

X ____ ______________________

Guardian/Representative's Signature Date

____

Relationship to Patient/Representative Authority

OFFICE USE ONLY

Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _________________.

❍ Patient refused to sign acknowledgement.

❍ Patient is physically unable to sign acknowledgement.

❍ Other: ____