Phoenix Rising Acupuncture
2 Pomperaug Office Park Suite 101 Southbury, CT 06488

CONFIDENTIAL INFORMATION

Name: ___________________________
Age: ______ Date of Birth: _______ Marital Status: S M D W P
Address: ____
City: ____________________ State: _________ ZIP: ___________________
Telephone: (Home) _____________ (Work)______________(Cell)________________
Please circle which number you would like us to use: Home Work Cell
E-mail: ____
May we use your email address to send communications regarding Phoenix Rising Acupuncture, LLC? Y/N
Occupation: ______________________ Employer: __________________________
How did you hear about Phoenix Rising Acupuncture? ___________________________

_________CONSENT TO TREATMENT

I request care for my medical condition and do hereby voluntarily consent to the rendering of care and management of my medical condition using Acupuncture and related treatments (Electro-acupuncture, cupping, moxibustion, infra red heat lamp, ion pumping cords, Gua Sha, Tui Na, Qi Gong) that the Licensed Acupuncturist considers to be necessary or advisable. The side effects from an acupuncture treatment are usually minimal and include feeling lightheaded or relaxed. Some forms of treatment may cause bruising which will diminish within 3-7 days and not need medical attention. The Acupuncturist is aware of these side effects and takes measures to prevent them.

_________PAYMENT WHEN SERVICES ARE RENDERED

I understand that payment is required for services on the day an acupuncture service is rendered. I also understand that Phoenix Rising Acupuncture LLC is not accepting insurance coverage for services, therefore I will be paying on the day of service using either cash, check, money order, or credit card. In the event that a check is returned to Phoenix Rising Acupuncture LLC, there will be a service charge of $35 for which I am responsible.

_________CANCELLED/MISSED/APPOINTMENT TARDINESS

I understand that I need to give **at least 15 hours notice** when I have to cancel a previously scheduled appointment. If I do not give at least 15 hours notice of cancelling my appointment, I may be charged the full price of that appointment. I will also be charged the full price for any missed appointments, although emergencies that cannot be avoided do happen and in that case the Acupuncturist will make the charging decision. If I arrive late for a scheduled appointment, the amount of time which was missed by being late will not be refunded nor will the scheduled appointment time be extended if that impedes on another client's appointment.
Credit Card Information: MC/ VISA (circle one)

Number: _____________________________________ Exp: ________
NOTE: Your credit card information will be kept in a secure/locked location. It will **only** be used for missed or cancelled appointments. See paragraph above for explanation.

_________HIPAA PRIVACY

Federal privacy guidelines have been established to safeguard you health information. HIPAA explains how, when and why we may use and share your protected health information (such as other medical professionals, insurance, etc.). Sign below if you understand your rights. If the Acupuncturist is required to disclose your health information to state or federal agencies, you will be notified. A formal copy of our privacy statement is available to you upon request.

By signing this form, I agree to all terms and policies written above.

Signature: ______________________________ **Date:** ____________________