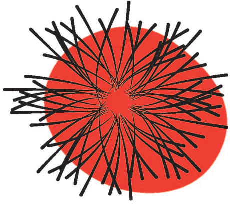

Sanzen Acupuncture

12750 SW 2nd Street, Suite 102, Beaverton, OR 97005
phone: 503-277-1430
www.sanzenacupuncture.com

First Name: ____________________ Last Name: ______________________________ Date: ______________

Age: ________ Date of Birth: ______/______/______ Gender: M ☐ F ☐ Marital Status: _______________

E-Mail Address:____________________________________ Preferred Contact: Email ______ Text _______

Living With: Spouse: ☐ Partner: ☐ Parents: ☐ Children: ☐ Friends: ☐ Alone: ☐

Street Address: ____

City: ____ State: _____________ Zip Code: ______________

Employer: _____________________________ Occupation: ____

Home Phone: ______________________Work Phone: ____________________ Cell Phone: _________________

Emergency Contact: ____________________________ Phone: _______________ Relationship:______________

HEALTH HISTORY INFORMATION

Major Complaints: List them in the order importance:

1) ____

2) ____

3) ____

Are you presently taking any medication-prescription or over-the-counter? Yes ☐ No ☐

If yes, what drug:____

Are you taking any supplements? (Vitamins, Herbal, Minerals, etc.)?___________________________________

Allergies (drugs, chemicals, foods):

Have you ever had any operations/surgeries? Yes ☐ No ☐

If yes, what and when: ____

Hospital Stay/Visit: ___________________________________Last Physical Exam:________________________

Are you Pregnant? Yes No N/A

How did you hear about us? Doctor referral ☐ Groupon ☐ Walk-in ☐ Internet ☐ Other ____________

____ ________________________________

Signature of Patient or Guardian of Patient Date

INFORMED CONSENT

I voluntarily consent to be treated by the Sanzen Acupuncture. The Clinic offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

The treatments consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and meridians
2. Use of electrical, mechanical, or devises to stimulate acupuncture points and meridians
3. Indirect Moxibustion
4. Acupressure
5. Cupping
6. TuiNa
7. Infra-red Heat Lamp
8. Traditional Chinese Herbal Supplements
9. Dietary advice based on traditional Chinese medical theory

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following:

1. Some pain following treatment in the insertion area
2. Minor bruising
3. Infection
4. Needle sickness
5. Patients with severe bleeding disorders or pace makers should inform the practitioner prior to any treatment.

<u>If you are pregnant or have a history of seizures, you should also inform the practitioner.</u>

I understand that there is neither an implied nor stated guarantee of success of effectiveness of a specific treatment of series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I hereby authorize the Sanzen Acupuncture to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim. With notification, I also authorize the Sanzen Acupuncture to obtain my medical records from other physicians or medical centers.

Payment in full is expected at the time of each appointment. The clinic will help you in preparing the necessary papers for your insurance. I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates after 3 missed appointments when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

Thank you for you cooperation and consideration.

Signature____Date___________

Patient's Representative or Parent____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Sanzen Acupuncture
12750 SW 2nd Street, Ste 102, Beaverton, OR 97005 503-277-1430
sanzenacupuncture.com

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- 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 Manager 503-277-1430.

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.

Your signature below is acknowledgment that you have reviewed these privacy practices. Please inform our office staff if you would like a copy.

____ ____________________
Patient or legally authorized individual signature | Date

____ ____________________
Printed name | Relationship: Parent, legal guardian, representative.