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# JENNIFER ROOT, L.Ac.

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Licensed Acupuncturist & Traditional Chinese Medicine Practitioner

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## Patient Information

| First Name: | Middle Initial: | Last Name: | |
|---|---|---|---|
| Mailing Address: | City: | State: | Zip Code: |
| Home Phone: | Mobile Phone: | Business Phone: | |
| Email Address: | | Gender Identity / Pronoun Preferrence: | |

*Please indicate how you prefer to be contacted:*

☐ Home Phone ☐ Mobile Phone ☐ Business Phone ☐ Email

| Date of Birth (mm/dd/yyyy): | Current Age: | Height: | Weight: |
|---|---|---|---|

| Occupation: | Employer: |
|---|---|
| Relationship Status: | □ No Children<br>□ Children; Number & Age(s):_____ |

Emergency Contact: Phone Number: Relationship to You:

Referring and/or Primary Physician: Month / Year of Last Visit:

*How did you find us?*

□ Friend / Family / Colleague:_____ □ Online Search □ Social Media

□ Another Healthcare Provider:_____ □ Other:_____

*What is your experience with Chinese Medicie? (Check all that apply:)*

□ None □ Acupuncture □ Electro-acupuncture □ Cupping □ Guasha □ Tuina □ Qigong □ Herbal Medicine

## Terms of Admission

FINANCIAL POLICIES:

☐ ***Late Cancellations & Missed Appointments:*** I understand that if I provide less than 24 hours notice of an appointment cancellation, or fail to show for a scheduled appointment, I may be charged $40 for a missed appointment.

☐ ***Benefits Verification:*** I have been advised to verify my benefits directly with my insurer, and acknowledge that fees for treatment may not be covered by my insurance policy. I understand that Jennifer Root, L.Ac. is not an insurance company representative, and is not financially responsible for benefits verification, and does not guarantee insurer payment of billed charges.

☐ ***Financial Responsibility:*** I understand that all services rendered are charged to me, and I am personally financially responsible for all charges, regardless of insurance coverage or rejection of insurance claims. I assign any and all insurance benefits to Jennifer Root, L.Ac. If my insurer sends payments to me, I agree to send or bring those payments directly to this office upon receipt.

***By signing below, I acknowledge the following:***

☐ I certify that I understand the above, and that the information provided by me is true and correct.

☐ I have received a Notice of Privacy Practices regarding my health information.

☐ I authorize the release of any information necessary to coordinate medical care and to secure payment for services rendered.

Signature:_____ Date: _____