

Manhattan Community Acupuncture
Jeanette Kim-Lau, L.Ac.
168 West 86th Street, Suite 1BW
New York, NY 10024
212-405-6126

Patient Name _____

Address _____

Tel Number (Cell): _____

Tel Number (Work): _____

Tel Number (Home): _____

Email: _____ Please provide your most frequently checked
Email address. We use Email to contact you for important notices. We do not spam or sell your Email
address!

Birth Date: _____ Age: _____

Height: _____ Weight: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number: _____

Referred by: _____

Have you ever seen an acupuncturist before? _____

Medications _____

Pregnant (if applicable) _____

For what reason are you seeking acupuncture and/or herbs?	
How and when did this condition develop?	
What other treatments have you tried for this condition?	

List all surgeries/procedures you have had with the approximate dates

List all other CURRENT health conditions you have together with any medications, herbs, or supplements you are now taking and how long you have been taking them

Condition	Western Medication/how long	Other remedies/how long
1.		
2.		
3.		
4.		

CANCELLATION POLICY

I understand Meridian Community Acupuncture holds my appointment for me, even when others request time. Consequently, I realize there is a *24-hour cancellation policy*. I acknowledge it is my responsibility to notify Meridian Community Acupuncture of my inability to keep any appointment time being held for me. If for any reason I am unable to call in this information on the prior business day (Monday through Saturday) I understand I will be charged a \$45 fee (\$55 for new patients). The cancellation fee is subject to change.

Thank you for your courtesy in upholding these policies with us.

Print Name _____

Signature _____

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Your practitioner, a Licensed Acupuncturist, is committed to your health and well-being. While Oriental medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education law, it is requested that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____ (patient) HAS BEEN ADVISED BY _____ (Licensed Acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

Patient Signature

Date

Licensed Acupuncturist Signature

Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine provided by the Licensed Acupuncturist named below. I have discussed the nature and purpose of my treatment with the Licensed Acupuncturist named below.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation and Tui Na (Chinese massage)

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is also another possible risk, although sterile, disposable needles are used in a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be in appropriate during pregnancy. Some side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the Licensed Acupuncturist or any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Licensed Acupuncturist who is caring for me if I am or become pregnant.

I do not expect the Licensed Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Licensed Acupuncturist to exercise judgment during the course of treatment which the Licensed Acupuncturist thinks at the time, based upon the facts known to them, is in my best interests.

I understand that portions of my records may be used for teaching or research purposes, however, my name and identifying information will not be disclosed. Otherwise, all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

To be completed by the Licensed Acupuncturist providing information and obtaining consent.

Date Consent Completed

Print Name of Patient

Print Name of Licensed Acupuncturist

Signature of Patient or Representative

Signature of Licensed Acupuncturist

Print Name of Patient Representative

