Aquino Acupuncture
& HOLISTIC HEALTH

PATIENT INFORMATION

Patient Name:			Date:
Birthdate:	Age:	Height:	Weight:
Home Address:			
City:		State:	Zip:
Preferred Phone:		E-mail:	
How did you hear about this office?		Occupation:	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnership			
Emergency Contact:		Phone:	
Primary Care Physician:		Phone:	
Date of your last physical exam:			
When did you last have lab (blood) work done?			
Were there any significant findings:			
Do you have medical insurance with acupuncture benefits ☐ Yes ☐ No ☐ Unsure If Yes, please provide our office with the name of participant, insurance card, and identification.			
Have you received acupuncture therapy before? ☐ Yes ☐ No If yes, when?_____			
If yes, Whom?			
For what condition?			

Patient Name:	Date:

OFFICE POLICY STATEMENT:

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Welcome to our office. Please take a moment to go over the following office policies.

Patients are responsible for all fees at the time services are rendered. We accept cash, check, Visa, Mastercard and American Express. There will be a service charge for returned checks. Any past due balances are subject to a late fee.

We are out of network providers, however, if you have an insurance policy that has acupuncture benefits, we will bill your insurance for treatment received at our office. You are responsible for payment of your estimated share at the time of your visit, including any co-payment, co-insurance or deductible. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit payment to Catherine Aquino, L.Ac. in the same amount as your reimbursement.

We must emphasize that as medical providers, our relationship is with you, and not your insurance company. As a courtesy, our office staff will call your insurance company to estimate your insurance benefits and coverage to the best of our ability. This is not a guarantee of coverage, and as the patient, you are ultimately responsible for knowing and understanding your insurance coverage and for the charges incurred at our office. We cannot guarantee coverage or payment by your insurance company, even when they quote benefits, there can be undisclosed terms or limitations resulting in less or in some cases no insurance payment. We recommend that you also contact your insurance company to verify coverage on your policy.

Appointments must be cancelled or changed within 24 hours of your appointment time. On less than 24-hour notice, you will be subject to a late cancellation fee equal to the full cost of the visit. For patients who are late 20 minutes or greater you may incur a late cancellation and be asked to reschedule your appointment. For patients who are up to 20 minutes late you may have a shortened session.

I, the undersigned, understand that if I am being seen for treatment/services not covered by my insurance carrier, I am responsible for the entire bill when services are rendered.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

By signing below, I hereby acknowledge that I have read and agree to the policies and terms stated above.

Client/Patient/Guardian (Print Name): _____

_____ Date _____

Client/Patient/Guardian Signature