

Jeremy Rothenberg, L.Ac.

862 Folsom Street San Francisco, CA 94107 | 415-449-0445 | jracupuncture@me.com | enlightenedbody.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Personal Information

Date of First Appointment	First Name		Last Name			Middle Initial
Date of Birth	Age	Gender	Height	Weight		
Street Address			City	State	Zip Code	
Phone (day): Home Work Mobile <i>Circle One</i>			Phone (eve): Home Work Mobile <i>Circle One</i>			
Email Address			Referred by?			
Emergency Contact (Name & Number)			Partner Contact (if not same as emergency contact)			

Primary Physician (full name if possible):	Telephone:
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Insurance Company:	Insured's Name (if not you):
Insured ID Number :	Policy Group or FECA Number:
Employment Status: Full-time Part-time Self-employed Retired Unemployed Student	
Employer:	Job Title:

Note on Insurance:

We will gladly check your insurance benefits for you if you do not know whether your plan covers acupuncture. We will work directly with your provider for reimbursement.

If you would like to make insurance claims yourself, we will offer you a super bill with the diagnostic codes your insurance company looks for to provide reimbursement.

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Medications

Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams.

NOTE: If need more space, use back of page.

Prescriptions				
Prescription Name	Purpose	Start Date	Current Dosage	Frequency

Supplements				
Supplement Name	Purpose	Start Date	Curent Dosage	Frequency

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Personal & Family Medical History

- Use a "C" for current problems
- Use a "P" for past problems
- Leave blank if not applicable.
- Please list age of relatives or age when they passed on.

	You	Mother	Father	Sister(s)	Brother(s)	Children
Current Age:						
AIDS / HIV						
Alcohol Problem						
Allergies						
Anxiety						
Anorexia / Bulimia						
Arthritis						
Asthma						
Back Pain						
Bursitis						
Cancer						
Depression						
Diabetes						
Heart Trouble						
Hepatitis						
High Blood Pressure						
Immune Disorder						
Kidney Disease						
Liver Disease						
Migraine						
Smoke Cigarettes						
Thyroid Disorder						
Weight Issue						
Other:						
Any known food or drug allergies?						

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UNDER-INSURED WAIVER

Please fill this form out if you do not have acupuncture benefits on your insurance plan.

I, _____, have expressed financial hardship due to lack of insurance and/or lack of funds to provider. Due to these circumstances I accept the payment plan below. The payment arrangements will be paid in full at time services are rendered. Delinquent payments may result in termination of this contract. If at any time my financial status or insurance status changes, I will notify provider immediately and resume the usual and customary rates as designated by my insurance company and/or private pay rates. Provider also holds the right to terminate this contract at any time, with prior notification, if breach of contract.

Payment Arrangement:

New Patient Fee: \$120

Return Visit: \$75

Frequent Visit: \$40

Cancellation Policy:

We kindly request 24 hours notice to cancel your appointment.

Cancellations within 24 hours will be charged 60% of the appointment fee.

Missed appointments will be charged the full appointment fee.

Print Name of Patient (Or Representative)

JEREMY ROTHENBERG, L.Ac.
Print Name of Practitioner

X _____

X _____

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INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Jeremy Rothenberg, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, nutritional and other forms of counseling.

I have been informed that acupuncture is a safe method of treatment, but that it occasionally will have side effects. These may include bruising, numbness or tingling near the needling sites that may last up to a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Highly unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable single-use needles, and maintains 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) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, 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 Jeremy Rothenberg, L.Ac., of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Jeremy Rothenberg, L.Ac., if I am or become pregnant.

I do not expect Jeremy Rothenberg, L.Ac., to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgment during the course of treatment which he thinks at the time, based upon facts then known, is in my best interests.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released 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.

Print Name of Patient (Or Representative)

JEREMY ROTHENBERG, L.Ac.
Print Name of Practitioner

X _____
Signature of Patient (Or Representative)

X _____
Jeremy Rothenberg, L.Ac.