S·A·A
Seattle Acupuncture Associates

seattleacupunctureassociates.com
509 Olive Way, Suite 618
Seattle, WA 98101
206.622.0246

PATIENT REGISTRATION

Print Form

First Name | Middle | Last

Address | City | State | Zip Code

Home Phone | Cellular Phone | Business Phone

Birthdate | Age | Gender | Social Security Number

Employer | Email Address

Name Of Emergency Contact | Phone Number | Relationship to you

Appointment Date | Primary Reason for Today's Visit?

Which Acupuncturist Do You Have An Appointment With? | Which Clinic?

Name of Primary Care Physician | Physician's Phone | Referring Provider

Primary Insurance Company | Insured's Name | Insured's Date of Birth

Member Number | Group Number | Insurance Phone Number

Insurance Company Address | Is This An Auto Accident Claim? | Is The Claim Open?

Claim Number | Adjuster's Name | Phone Number | Date Of The Accident

For Office Use Only: DX CODE:

PLEASE MAKE SURE THAT ALL INFORMATION
IS FILLED OUT COMPLETELY AND ACCURATELY.

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PATIENT HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX.

YES	NO	
☐	☐	Have you ever had acupuncture before?
☐	☐	Do you wear contact lenses?
☐	☐	Are you pregnant? If yes, what stage?
☐	☐	Are you attempting to get pregnant?
☐	☐	Do you participate in any sports? Please list.
☐	☐	Do you take any medication? Please list.
☐	☐	Have you suffered an acute injury lately? Please describe.
☐	☐	Have you ever had surgery? If yes, what kind and when?
☐	☐	Please list any other medical conditions that your practitioner should be aware of?
☐	☐	May we contact your health care provider regarding your records?

S*A*A TREATMENT AGREEMENT :

It has been made clear to me that acupuncture is not a substitute for medical examination or diagnosis and that it is recommended I see a physician for any ailment I might have. I have stated all my known medical conditions and take it upon myself to keep my practitioner updated on my physical health.

I, the undersigned, agree to be treated with acupuncture and related techniques. I understand that there is no implied nor stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Signature _____ Date _____

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CLINIC POLICIES

PLEASE READ THE FOLLOWING POLICIES CAREFULLY

Cancellation Policy

We are committed to serving our patients. To ensure appointment times, for New Patients we require a 48 hour advance notice to change or cancel your appointment time. For Established Patients, we require a 24 hour advance notice to cancel. This enables us to schedule other patients waiting on our cancellation list.

Failure to properly notify our office will result in a $45 late cancellation fee or a $90.00 no show fee. A charge will not be assessed if we can fill your appointment time. We understand that extenuating circumstances do exist. Please discuss your circumstances with the front desk.

Should you no show twice for a scheduled appointment you will be placed on a same day only scheduling request.

Financial Agreement

Co-payments are due at the time of service. If you do not have insurance, payment in full is due at the time of service. A $35.00 fee will be assessed (per RCW 62A.3-515&520) on checks returned NSF. Balances exceeding 90 days past due, will be referred to our collections department. For individuals requiring special financial arrangements, a 1% charge per month (per RCW 19.52) will accrue. Arrangements must be made in advance with the Seattle business office at 206-622-0246.

Patients with Insurance:

Our office does not guarantee that your insurance company will pay. Some insurance companies do not cover for acupuncture. It must be understood that the contract for services is between you and your insurance company. If your claim is denied for any reason, you are responsible for the full amount of the bill. Our office will not enter into a dispute with your insurance company over an unpaid claim.

I have read and understand the above policies.

Signature _____ Date _____