North Shore Oriental Health Care Center

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TODAY'S DATE: _____

PATIENT REGISTRATION INFORMATION

NAME:_____ DOB: _____/_____/_____ ☐ M ☐ F
First Name Middle Initial Last Name

ADDRESS: _____ APT: _____

CITY:_____ STATE: _____ ZIP: _____

MOBILE PHONE: _____ EMAIL ADDRESS: _____

EMPLOYER:_____OCCUPATION:_____

EMPLOYER ADDRESS: _____ WORK PHONE: _____

Who should we thank for referring you? _____

EMERGENCY CONTACT: _____ PHONE:_____

PRIMARY INSURANCE:

Person Responsible for Account: _____
First Name Middle Initial Last Name

Relationship to Patient: _____ DOB: _____ SSN: _____

Address: _____ Home Phone: _____

City:_____ State: _____ ZIP: _____

Responsible Party Employed By: _____ Occupation: _____

Employer Address: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group#: _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Person Responsible for Account: _____
First Name Middle Initial Last Name

Relationship to Patient: _____ DOB: _____ SSN: _____

Address: _____ Home Phone: _____

City:_____ State: _____ ZIP: _____

Responsible Party Employed By: _____ Occupation: _____

Employer Address: _____Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group#: _____

ASSIGNMENT AND RELEASE (INSURANCE INFORMATION):

I hereby authorize payment directly to Dr. Jiaji Sun all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance, for all services rendered on behalf of my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

NORTH SHORE ORIENTAL HEALTH CENTER (PATIENT CONSENT):

Consent for procedures of the treatment by herbal products & acupuncture

1. I hereby authorize Dr. Jiaji Sun or associates or assistances of his choice at North Shore Oriental Health Center to perform upon me the treatment of Acupuncture of suggest taking herbal products (food supplements) which have not been evaluated by the F.D.A.
2. My doctor Jiaji Sun has fully explained to me the nature and purposes of procedure and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomfort and risks that may arise, as well as possible alternative methods of treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.
4. I confirm that I have read and fully understand the above.
5. We, the undersigned, do affirm that Mr./Ms./Mrs. _____ has been advised by Dr. Jia Ji Sun, to consult a physician regarding conditions for which such patient seeks Acupuncture treatment.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working, or associated with or service as back up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I realize acupuncture may be considered as an investigative procedure in the United States. There are some risks to treatment including but not limited to some bruising of the skin and or slight bleeding. The risk of infection is small when all needles are sterile. Needles are considered sterile while n they are either disposable or are autoclaved according to applicable state legal requirement.

I have had an opportunity to discuss with the acupuncturist named above with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts there known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by singing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and/or any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: _____
(Or Patient representative; indicate relationship if signing for patient)

Office Signature: _____ Date: _____