ACUPUNCTURE OF
SAN FRANCISCO & MARIN

CONTACT INFORMATION				
Last Name: First:			Relationship Status:	
Date of Birth:	Contact Email:			
Mailing address:			Mobile Phone Number ( )	Home/Office Phone Number ( )
City:	State:	Zip:		
Occupation:	Weekly Hours:		Job Satisfaction Level:	

How did you hear about Acupuncture of SF & Marin? ______________________________	Other friends/family members seen here: ______________________________

HEALTH CONCERN(S)	
Reason for your appointment: 1.______________________________ 2.______________________________ 3.______________________________	Additional Comments:
Experience with Acupuncture? ❑ Yes ❑ No Acupuncturist's Name: Results:	Are there other health care providers you want me to collaborate with? ❑ Yes. ❑ No Name: ______________________________ Practitioner Type: ______________________________ Contact Info:______________________________

INSURANCE INFORMATION

Insurance Plan Provider:	Your Member/Subscriber ID:	Primary Insured's Name:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _______________________________	Social Security Number:	Primary Insured's Date of Birth:

IN CASE OF EMERGENCY

Contact Name:	Relationship to patient:	Mobile Phone: ( )	Home/Work Phone: ( )

CANCELLATION POLICY CONSENT

Acupuncture of San Francisco and Marin **requires 24 hours for appointment cancellations and rescheduling**. We respectfully request 48 hour notice when possible. Cancellations that take place within the last 24 hours prior to a scheduled visit will be responsible for a missed appointment fee. The first missed visit charge is $75 dollars. Every subsequent visit will be at the fully scheduled rate. No shows for appointments will be at the full visit rate beginning at the first visit. For patients who have insurance, missed visits and late cancellations are not covered by insurance. As such, you will be billed at the prompt pay rates accordingly. Your signature below shows consent and agreement to our practice cancellation policy.

____ ______________________

Patient/Guardian Signature **Date**

FINANCIAL RESPONSIBILITY

For Insurance Patients: ❑

I authorize my insurance benefits be paid directly to the physician. I also authorize the medical office of Jeffrey Szilagyi L.Ac. and/or insurance company to release any information required to process my claims. I understand and agree that if claims are denied by my insurance I am financially responsible for services rendered.

For Prompt Pay Patients: ❑

I understand that I am financially responsible for services rendered at the time of service.

____ ______________________

Patient/Guardian signature **Date**