Acupuncture Center Of Bradenton
Initial Intake Form

General Information

Name_____Birthdate____/____/_____Age_____Gender_____

Address_____City_____State_____Zip_____

Phone numbers (please mark * next to best number):

Home_____Cell_____Work_____

E-mail address_____

If you would like our office to accept insurance payment for Acupuncture Services, verification of insurance coverage (on our website) must be completed 2 days prior to visit.

Please visit: AcupunctureCuresPain.com (Insurance Verification)

Employer _____Health Insurance Co._____

How did you hear about us? _____If via person, name:_____

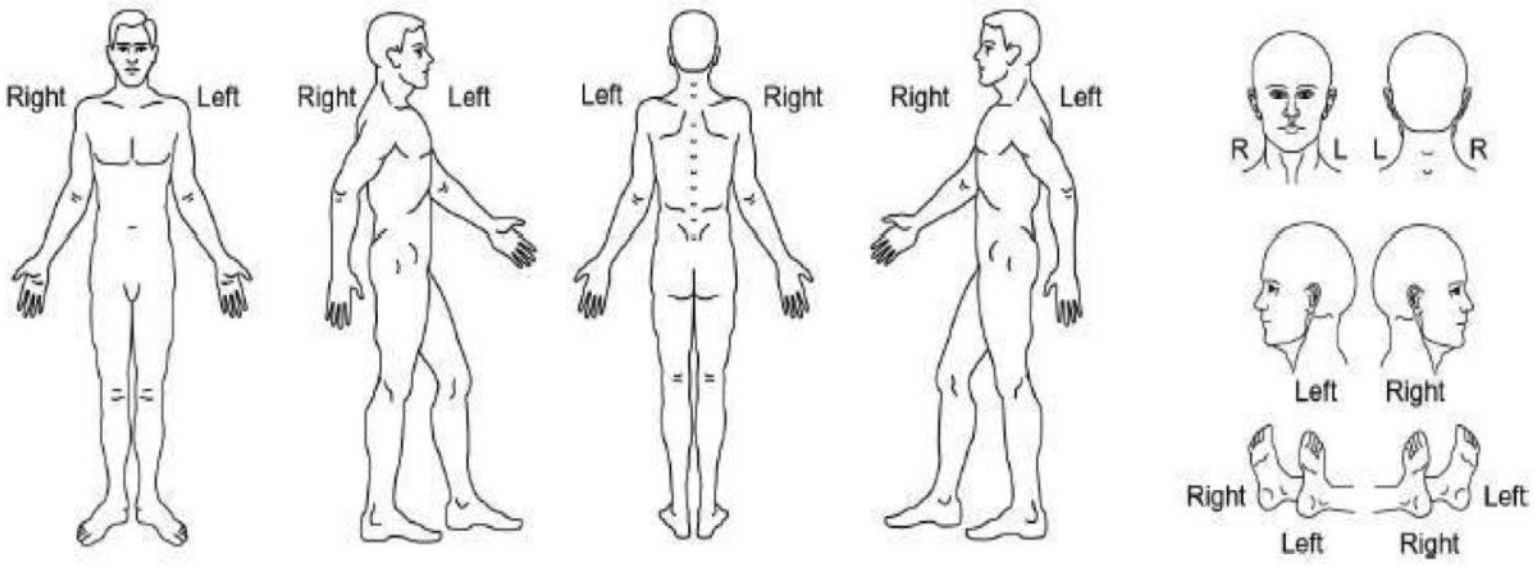
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Acupuncture Center Of Bradenton. I authorize the Dr. Greenberg to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of acupuncture care, regardless of insurance coverage. I also understand that there is no guarantee of treatment results and I give permission to be administered acupuncture and adjunctive treatment.

The patient understands and agrees to allow Acupuncture Center Of Bradenton to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature: _____ Date: _____

PLEASE COMPLETE ON BACK SIDE