# WASHINGTON STATE ACUPUNCTURE & CHINESE MEDICINE CENTER

**663 S. King St, Seattle WA 98104 Tel (206) 292-9646 Fax (206) 292-9650**

## Patient Information Form (*please print legibly*)

Last Name: ______________________ First Name: ______________________ MI: ______

Date of Birth: ______________________ Gender: __________ Marital Status: ______________________

Address: ____________________________________________

City: ______________________ State: __________ Zip: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Place of Birth: ______________________ Email Address: ______________________

Family Physician: ______________________ Physician Phone #: ______________________

Emergency Contact: ______________________ Contact's Phone #: ______________________

Emergency Contact is my: (Specify Relationship) ______________________

Occupation: ______________________ Referred by: ______________________

Insurance Company: ______________________ Subscriber ID #: ______________________

## Acknowledgement of Receipt

Raymond Chan, Sik Chi Stanley Chan and Bing Su are required to provide you with a copy of the Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact us at (206) 292-9646.

**I hereby acknowledge that I have received a copy of Raymond Chan, LEAMP, Sik Chi Stanley Chan, LEAMP LMP's, and Bing Su, LEAMP Notice of Privacy Practices.**

**X** ____________________________________ ______________

Patient's Signature Date

**X** ____________________________________ ______________

Guardian/Representative's Signature Date

____________________________________

Relationship to Patient/Representative Authority

**OFFICE USE ONLY**

### Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _________________.

- ❍ Patient refused to sign acknowledgement.
- ❍ Patient is physically unable to sign acknowledgement.
- ❍ Other: ____________________________________________