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, Bing Su, Corey Ojima, Pei-Hwa Lin and Shaobai Peter Zhang 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, Bing Su, LEAMP, Corey Ojima, ND, LEAMP, Pei-Hwa Lin, LEAMP, MAcOM and Shaobai Peter Zhang, LMT's Notice of Privacy Practices.

X ______________________________ ______________

Patient's Signature Date

X ______________________________ ______________

Guardian/Representative's Signature Date

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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: ______________________________