Patient information
Holistic Medicine and Acupuncture,LLC
9 Professional Circle, suite 212, Colts Neck, NJ 07722. (732) 780-1155

Today's Date_____

PERSONAL INFORMATION
Name _____S.S #_____Date of Birth_____
Age_____ Gender_____ Marital Status_____ Occupation_____
Phone # (W)_____(H)_____(Cell)_____
Email Address_____
Mailing Address_____
_____
Name and cell number of the emergency contact person_____

PARENTS' INFORMATION IF PATIENT IS A MINOR
Father's name_____cell #_____Occupation_____
Mother's name_____cell #_____Occupation_____

How did you hear about us? _____
Primary physician's name, phone #, and address_____
_____
Health condition you are consulting for:_____
_____
Have you had acupuncture treatment before?
If yes, where and when _____
Are you seeking other health care professional's help for your current condition? Y__N__
If yes, please list their names, specialties, phone #s, and addresses_____
_____
PAST MEDICAL HISTORY_____
_____
FAMILY HEALTH HISTORY_____

Are you taking any medications?_____
Are you allergic to any medication?_____
Are you taking any supplements or herbs?_____

I have read and agreed to the HIPAA form, . By signing this form, I am consenting to Holistic Medicine and Acupuncture to use and disclosure of my Protected Health Information to carry out Treatment, Payment and Healthcare Operations

_____-
Patient's or parents' signature if patient is a minor

Consent form for Holistic Medical treatments and (or) acupuncture

I came to Dr. Huang for holistic care of my medical conditions. Holistic treatments may include but not limited to nutritional consultation, lifestyle changes, exercise, nutritional supplements, herbs, bioidentical hormones and acupuncture. In the rare instance, patient may experience certain side effects or untoward reaction including but not limited to those related to allergic reaction, intolerance or incompatibility with medications. I will inform Dr. Huang all the medications I am taking.

If I choose to receive acupuncture, I was informed that acupuncture is an art of healing involving the stimulation of specific points on the body to heal diseases or relieve pain. The stimulation may be produced by needles, heat, pressure and electric currents etc. In the rare instances, patient may experience certain side effects or untoward reaction including but not limited to those related to infection, fainting, bleeding, lung or other organ puncture. Small number of patients may experience short period of drowsiness, and I was instructed not to drive if was effected. Contraindications for acupuncture include history of bleeding disorder or current anticoagulation therapy, implanted pacemaker, damaged heart valve, prosthetic valve or pregnancy. I will inform Dr. Huang if any of these conditions exist.

I understand Dr. Huang is a pediatrician, a physician acupuncturist, a holistic medicine and anti-aging physician. She is not here to replace my own physicians to provide my regular health care, diagnose or treat my other medical conditions. I came to her after my own physician had made the diagnosis of the specific problem and had ruled out the need of other medical intervention before the holistic treatments. I will continue seeing my own physicians for health monitor and treatments. No guarantee of results has been made.

I understand it requires a series of treatments to significantly change my condition. Dr. Huang informs me that she does not take any insurance and does not provide emergency care, hospital service, 24 hours or vacation coverage. I will consult my own physicians for these services. I will make my follow up appointment way ahead of time so I won't run out of my prescription medications or supplements when Dr. Huang is away from her office. I also understand that the supplements are not returnable.

Privacy Practice Acknowledgement

I hereby acknowledge that I was provided a Notice of Privacy Practices and was given the opportunity or review it. By signing this form, I am consenting to Holistic Medicine and Acupuncture to use and disclosure of my Protected Health Information to carry out Treatment, Payment and Healthcare Operations.

Patient Name: _____

Signature: _____ Date: _____