Yin's Acupuncture & Herbs Clinic
5899 Preston Road, Building 8, Suite 801
Frisco, TX 75034
(972) 668-2626

Patient Registration

(Please Print)

Patient's last name:	**First:**	**Middle:**
(Please Select) Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Wid	**Birth Date:** **Age:** **Sex:** ☐ M ☐ F	
Street Address:	**City:**	**State:** **Zip Code:**
Home phone no.:	**Cell phone no.:**	**Email:**
Occupation:	**Employer:**	**Employer phone no.:**

Emergency Contact:	**Emergency Number**	
Reason for visit today:		
Is this an emergency? ☐ Yes ☐ No	**Injury/Illness Date:**	**Similar Symptoms before?** ☐ Yes ☐ No
Is your accident related to employment? ☐ Yes ☐ No	**Motor Vehicle accident?** ☐ Yes ☐ No	
Have you had acupuncture before? ☐ Yes ☐ No	**Have you used Chinese Herbal Medicine?** ☐ Yes ☐ No	
How long have you had this condition?	**Is it getting worse?**	
Does the condition bother your: (Please Select) ☐ Sleep ☐ Work ☐ Other? (what)		
What seems to be the initial cause:		
What seems to make the condition worse:		
Are you under the care of a physician now? ☐ Yes ☐ No **If yes, what for?**		

Who is your physician?	**Phone:**
How did you get our information?	
Patient Signature:	**Date:**

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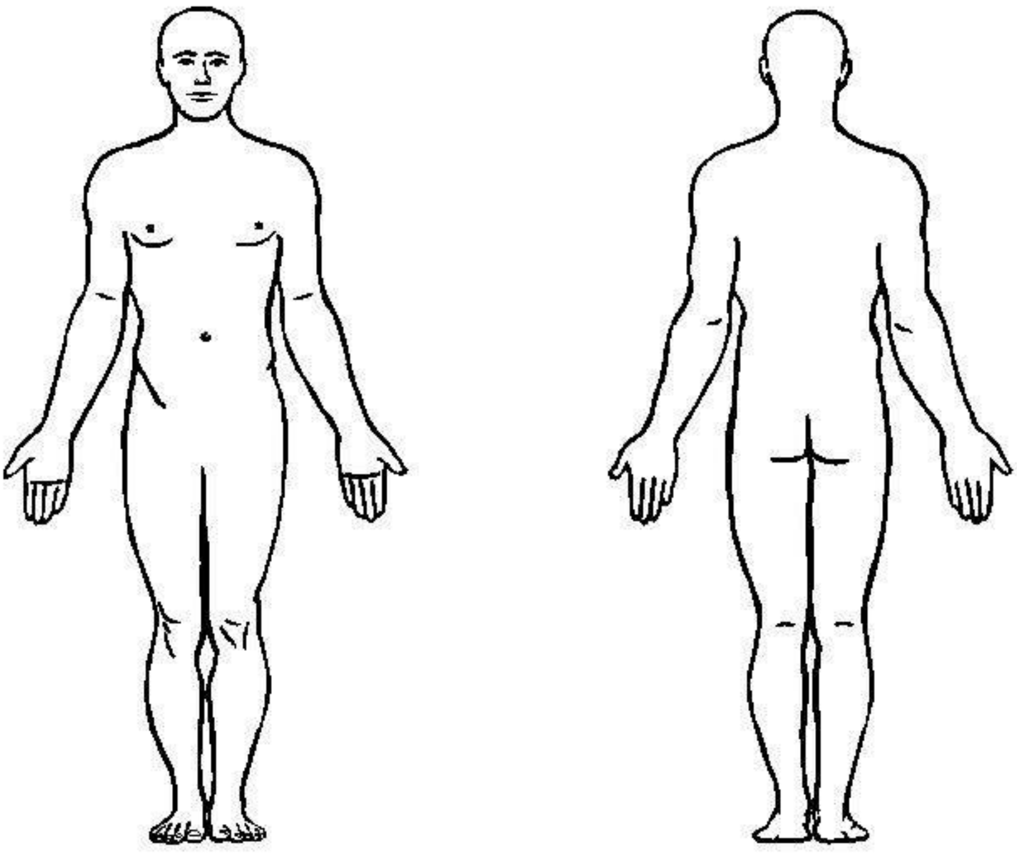
Patient Pain Drawing

Name (please print) ____ Date_________________

Mark the area on your body where you feel the sensations described below, using the appropriate symbol.

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY:	**A = ache**	**B = burning**	**N = numbness**
	P = pins and needles	**S = stabbing**	**O = Other**



0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

No pain Highest Pain

Please rate your current pain by Selecting the appropriate number above

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Due to difficulties with our schedule, we kindly ask our patients to give us a 24-hour cancellation notice to avoid a full appointment charge.

Thank you!

__________________________ _________________

Patient’s Signature Date

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NOTICE TO THE PATIENT

(Pursuant to the requirements of Section 183.7 of this title (relating to Denial of License Discipline of License) and Section 6.11, subsections (b) through (d), V.A.C.S., article 4495b, governing the practice of acupuncture.)

I, (patient's name) ______________________________, am notifying the Acupuncture & Herbs Clinic

☐ Yes ☐ No — I have been evaluated by a physician or dentist for the conditions being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician for the condition being treated by the acupuncturist.

☐ Yes ☐ No — I have received a referral from my chiropractor within the last 90 days for acupuncture.

After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature____ Date____________________

Optional Form to be completed by patient (Pursuant to the requirement of section 183.6(e) of this title and Texas code, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature________________________________ Date_________________________

Acupuncturist's signature__________________________ Date_________________________

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INFORMED CONSENT TO TREATMENT

I consent to acupuncture and other procedures associated with Traditional Chinese Medicine by the clinic doctor (Licensed Acupuncturist) named below. I have discussed the nature and purpose of my treatment with the doctor named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risk of acupuncture includes spontaneous miscarriage. Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of Moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the doctor of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the doctor who is caring for me if I am or become pregnant. I do not expect the doctor to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor thinks at the time, based upon the facts then known, and is in my best interests.

I understand the doctor may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and form any future condition(s) for which I seek treatment.

____________________________________	____________________________________
(Print Patient Name)	(Print Doctor Name)
____________________________________	____________________________________
(Signature of Patient)	(Signature of Doctor)
____________________________________	____________________________________
(Minor Patient Representative)	(Print Name of Translator/Witness)
____________________________________	____________________________________
(Date Consent Completed)	(Signature of Translator/Witness)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I. PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ________________________________ E-mail:______________________________

Date of Birth: ______________________________ SSN: ________________________________

II. TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this consent, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations for you.

Notice of Privacy Practice: A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of uses and disclosures we may make of your protected health information, and of important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Xie Yin, L.Ac.
Address: 5899 Preston Road, Building 8, Suite 801, Frisco, TX 75034
Telephone: (972) 668-2626

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent will NOT affect any actions we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating if you revoke this consent.

III. SIGNATURE

I, ______________________________________, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: ____ Date: _________________________________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____