



R. Antonio Whiteley, L.Ac.
6200 Wilshire Blvd. Suite 805
Los Angeles, CA 90048

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Email: _____

Social Security Number (insurance patients only): _____

Emergency Contact: _____

Whom may we thank for referring you to this office? _____

Have you ever received acupuncture before? _____

If yes, when? _____ For what condition? _____

Reason for today's visit: _____

How long have you experienced this condition? _____

Your condition is alleviated by: _____

Your condition is aggravated by: _____

Other therapies you have tried for this condition: _____

Please check any condition you currently have or have had in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug problem | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Staphylococcus |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |

Surgeries, Hospitalizations, Major Accidents: _____

Please list any current medications: _____

Do you have any drug allergies? _____

Any general allergies? _____

Please list current vitamins, herbs, and other supplements: _____

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Although Chinese Medicine has a great deal to offer as a health care system, it should not be construed as being a cure for all disease or malady. Therefore

We the undersigned, do affirm that _____(patient) has been advised by **R. Antonio Whiteley, L.Ac.** to consult a physician regarding the condition(s) for which such patient seeks acupuncture treatment.

Patient Signature

Date

Licensed Acupuncturist

Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatment and other procedures associated with the practice of Traditional Chinese Medicine provided by **R. Antonio Whiteley, L.Ac.** I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation and massage.

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 and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable 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.

I will notify **R. Antonio Whiteley, L.Ac.** if I am or become pregnant

I do not expect **R. Antonio Whiteley, L.Ac.** to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on him to exercise judgment during the course of treatment which he thinks at the time is best, based upon the facts known to him, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports. Otherwise all my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment. I 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 for any further conditions for which I seek treatment.

To be completed by patient (or patient's Representative if patient is a minor or is Physically or legally incapacitated)

To be completed by the licensed acupuncturist providing information and obtaining consent

Print Name of Patient

Signature of Licensed Acupuncturist

Signature of Patient or Representative



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Payment and Cancellation Policy

Payments for acupuncture treatments can be made by cash, check, credit or debit cards. Make checks payable to **R. Antonio Whiteley**. Full payment is due at the time services are rendered.

If your insurance covers acupuncture treatment, we will be happy to bill your insurance on your behalf. If for any reason your insurance company does not pay for services rendered, you will be responsible for payment.

If you must cancel your appointment, please call within 24 hours of your scheduled appointment. You will be charged for same day cancellations. If Antonio has to cancel your appointment for any reason, he will call you 24 hours before your appointment. If he cannot reach you or leave a message with a family member or your voice mail, your rescheduled appointment will be of no charge.

If you miss an appointment, you will be charged for it. Payment is expected either at the next appointment or by mail. If for some reason Antonio misses your appointment, your rescheduled appointment will be of no charge.

I, _____, certify that I have read and understand
(Print Name) the statements above and agree to abide by them.

Patient Signature

Date