REED ACUPUNCTURE &
EASTERN MEDICINE, LLC
403 W. State St., Suite 104, Aberdeen, WA 98520
360-589-7148 • www.reed-acupuncture.com

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so in writing. Write above each line.

Name M.I. Last Name Mr. ☐ Ms. ☐

Address City State Zip

Home Phone Cell Work E-mail address

Social Security Number, last four Date of Birth

Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Name of Spouse_____

Employer Occupation

Emergency Contact Telephone Relationship

Who do we thank for a referral? _____

24-HOUR CANCELLATION POLICY

Reed Acupuncture & Eastern Medicine, LLC (Reed AEM) takes pride in the quality of care it offers its patients. In order to do this we have a strict cancellation policy. Ms. Reed requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, a $45.00 fee will be billed to you.

I, _____ authorize Reed AOM to bill me for cancellation fees, insurance co-payments and related charges at my address on file.

Patient Name (print) Patient Signature Date

INSUFFICIENT FUNDS

I _____ understand that all payments are due at time of service. Reed AEM accepts cash or checks, and Visa, MasterCard or Discover. Additional fees, which typically are not covered by my insurance plan(s) will be charged for services such as copying of medical records, and completion of disability forms. A fee of $45.00 will be charged for checks returned for insufficient funds.

Patient Name (print) Patient Signature Date