**REED ACUPUNCTURE &**
**EASTERN MEDICINE, LLC**
403 W. State St., Suite 102, 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 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?** _____

**PRIMARY INSURANCE** Cash ☐ Group ☐ Work/Comp ☐ Auto ☐ Other ☐

Name of Insurance Co. ID#. Group#

Name of Primary Insured Date of Birth Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Secondary Insurance Name of Primary Insured Date of Birth

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understanding that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient) *at time of service*.

Patient Name (print) Patient Signature Date

**REED ACUPUNCTURE &**
**EASTERN MEDICINE, LLC**
403 W. State St., Suite 102, Aberdeen, WA 98520
360-589-7148 • www.reed-acupuncture.com

**24-HOUR CANCELLATION POLICY**

Reed Acupuncture & Eastern Medicine, LLC (Reed AOM) 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 $40.00 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 due to current federal and insurance regulations, *all* co-payments, co-insurance and deductibles are collected at time of service. Reed AOM 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 $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee will be charged on all past due accounts and co-pays not paid at time of visit.

Patient Name (print) Patient Signature Date

We encourage you to contact us promptly for assistance in the management of your account.
We are here to help you, and we will be happy to answer any questions you may
have regarding your treatment or insurance coverage.