6319 N. Fresno St., #102
Fresno, CA 93710
Tel: 559-573-2022 / Fax: 559-439-2720

Healing Hand
ACUPUNCTURE & HERBS CLINIC

300 E. Mineral King Ave., # 202
Visalia, CA 93291
Tel: 559-375-5518 / Fax: 559-439-2720

PATIENT REGISTRATION

WELCOME

The doctor and staff of Healing Hand Acupuncture Clinic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to Acupuncture care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PATIENT INFORMATION

Name: _____ □ Married □ Single □ Divorced □ Other

Street: _____ Telephone (Home): _____

City: _____ Telephone (Cell): _____

Email: _____ Telephone (Work): _____

Social Security #: _____ Occupation: _____

Date of Birth: _____ Age: _____

Primary Care Physician Name: _____

Contact in Case of Emergency, Name: _____

Telephone #: _____

This visit is the result of an: □ Auto Accident □ Work Injury □ Other: _____

Assignment

I hereby authorize direct payment of acupuncture benefits to the Healing Hand Acupuncture Clinic for services rendered by the doctors of the clinic in person or under the doctor's supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Agreement

I hereby agree that I willingly accept acupuncture cares which are rendered by the staff of Healing Hand Acupuncture Clinic and I understand the treatments, which is for improving my medical condition for optimal results.

Patient's Name: _____ Date: _____

Patient's/ Guardian's Signature: _____

Personal Injury Questionnaire

Name : _____ □ Driver : R. M. L

Height: _____ □ Front : R. M. L

Weight: _____ □ Back Passenger: R. M. L

Age: _____ □ Pedestrian

Male □ Female □ □ Slip & Fall

□ Other: _____

1. Date of Accident: _____

2. What direction were you headed? North □ South □ East □ West □

On: _____ City: _____

3. What Direction was other vehicle headed? North □ South □ East □ West □

On: _____ City: _____

4. Were you struck from Behind □ Front □ Left □ Right □

5. Were you knocked unconscious? Yes □ No □ If yes, how long?: _____

6. Was police notified?

7. Injuries at the time of accident? _____

8. When did the pain begin? (Immediately after accident / Hour after accident / Days after accident)

9. Seatbelt? Yes □ No □ Child restraint? Yes □ No □

10. In your words, please describe the accident: _____

_____

11. Did you receive emergency treatment? Yes □ No □

If yes, name of hospital: _____How long was your stay in the hospital? _____

X-Rays: Yes □ No □ What area was X-rayed: _____

12. Have you seen other doctors for this condition? Yes □ No □

If yes, name of hospital: _____How long was your stay in the hospital? _____

X-Rays: Yes □ No □ What area was X-rayed: _____

13. Are you taking any medication now? _____

14. Complaints at this time:_____

_____

15. Do you notice any activity restrictions as a result of this injury?

Yes □ No □ If yes, please describe in detail: _____

16. Did you have any physical complaints before the accident?

Yes □ No □ If yes, please describe in detail: _____

17. Have you ever been involved in an accident before? Yes □ No □

If yes, auto accident date: _____ Treated with whom: _____

Area injured: _____ Any residuals: _____

Any Disability: _____ Case: Open/Closed: _____

18. Have you ever been involved in work injuries before? Yes □ No □

If yes, work injury date: _____ Treated with whom: _____

Area injured: _____ Any residuals: _____

Any Disability: _____ Case: Open/Closed: _____

19. Other

Other/Date: _____ Area injured: _____

Fractured? Date: _____ Area: _____ Residuals: _____

Surgeries? Date: _____ Area: _____ Residuals: _____

Surgery as a result of accident? _____

Any residuals: _____

Is patient disabled? _____ From: _____ To: _____

Pregnant? _____ How many months? _____ L.M.P: _____ Last day worked? _____

20. Attorney information

Name: _____ Phone: _____

Health insurance: _____ Name: _____

Auto insurance: _____ Name: _____

Policy number: _____ Med pay: _____

21. Special Notes

_____

_____

_____

_____

_____

Are you taking any medicine for?			
Blood pressure	Yes □	No □	
Heart disease	Yes □	No □	
Birth Control	Yes □	No □	
Diabetes	Yes □	No □	
Others			

Patient‘s Signature: _____ Date: _____

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To: Attorney _____

_____

_____

RE: Patient medical record and Doctor's lien

Patient's Name: _____

DOA: _____

I do hereby authorize the above doctor or clinic to furnish you, my attorney, with a full report of his/her case history, examination, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney and/or any subsequent attorney, to pay directly to the doctor such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any bills that are due to his/her office and to withhold such sums from any settlement, claim, judgment, or verdict as may be necessary to adequately protect said doctor/clinic, and I hereby give a line and assignment in my case to the doctor/clinic against any and all proceeds of any settlement, claim, judgment, or verdict which may be paid to you, my attorney, or myself and for the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I made directly and full responsible to the doctor/clinic for all medical bills submitted by him/her for services rendered me and that this agreement may be solely for the doctor's clinic additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover.

I agree that this is enforceable against any and/or all subsequent attorney representing me in regard to the accident and/or incident. I further agree that if I change my residence or my attorney, I will notify the doctor within thirty (30) days of such change including attorney's name, address, and telephone number. If I do not notify the doctor within the time prescribed, then all money will be due and payable immediately. The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney' fee and costs incurred in that action or proceeding or in efforts to negotiate the matter.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record for the above patient hereby agree to observe all the terms of this lien and agrees to withhold such sums from any settlement, claim, judgment, or verdict as may be necessary to adequately product the doctor. I agree that a finance charge at an interest rate of 2% per month will be imposed by doctor for every month that the above-named client's/patient's claim has been resolved the doctor remains unpaid. I agree that a rubber stamped signature or other facsimile of my signature on this document will be valid, and a copy of this document bearing such rubber stamped signature or facsimile signature may be used in the same manner as if I had manually affixed my signature hereto.

Dated: _____ Attorney's Signature: _____