Healing Roots Acupuncture
60 Austin Street, Suite 302, Newtonville, MA 02460
(617) 549-5648

Today's Date:

Patient Information

Please Print Clearly

Name: Gender: Birth Date:

Preferred Name: Place of Birth:

Mobile Tel:

Mailing Address City State Zip

Marital Status: Home Tel:

Occupation: Employer: Work Tel:

Work Address City State Zip

Email Address:

Relative or Friend to Contact in Case of Emergency:

Name Relationship Telephone

How did you hear about our office?

If the Patient is a minor, please complete the following information:
Responsible Party:

Name Relationship Telephone

Address

Primary Insurance / Assignment and Release

Payment is required at the time of service. We accept cash, checks, Visa, MasterCard and American Express. We will gladly provide you with a superbill to submit for insurance reimbursement. Please contact your insurance company for information about what services they will cover.

Insurance Company:

Insurance Type: (please circle) HMO PPO/POS Auto/Med-Pay Medicare HSA / FSA

☐ Yes, please provide me with a superbill for services

Appointment Punctuality & Cancellation Notice

The appointment time you requested is reserved especially for you and your provider. Out of mutual respect, we request that you be on time for you appointment. If you arrive late, we will do our best to accommodate you; however, you will still be responsible for the full fee even though your appointment time may have to be shortened or rescheduled. ***In addition, we ask at least 24 hours notice for any changes of your appointment.*** This allows us to schedule other patients and helps you avoid paying for unattended office visits.

We understand that situations occur where it is in the best interest of both the patient and provider to terminate the relationship. In these cases, we will do our best to refer the client to someone who may better meet their needs. However, we do maintain the option to deny services to anyone at any time. I have read, understand, and agree to the appointment punctuality and cancellation notice request.

Signature Date

Most of our referrals are through our patients. We appreciate your confidence in our clinic and we thank you for your support.