**Sarah Taylor L.Ac.**
**1904 3rd Ave Ste 735 Seattle, WA 98101**
**Tel: 206-257-9343**

# PATIENT CONFIDENTIAL INFORMATION

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **Mailing Address:** | | **Social Security #:**<br><br>**Sex:** | |
| **Home Phone: ( )** | | **Business Phone: ( )** | |
| **Fax: ( )** | | **Email:** | |
| **Age:** | **Date of Birth:** | **Partner Status:** | |
| **Occupation:** | | **Driver's License #:** | |
| **Employer:** | | **Phone: ( )** | |
| **Emergency Contact:**<br><br>**Relationship:** | | **Phone: ( )** | |
| **Have you previously been treated with Chinese medicine?**<br>**If so, for what complaint?** | | | |
| **Health Care Practitioners/Doctors you see on a regular basis:**<br>**If so, for what complaint?** | | | |
| **Personal Physician's name:**<br><br>**Date of last physical:** | | **Phone: ( )** | |
| **For Minors: List both parents' or guardians' names and address (if different from above).** | | | |
| **Referred by:** | | | |

## OFFICE POLICY

**All fees for medical services and herbal supplements are due at the time of visit. If you need to cancel an appointment, please give me a minimum of 48 hours notice. I will be happy to reschedule your appointment. You will be expected to pay for your appointment in the event that the appointment is cancelled less than 24 hours in advance.**

**Initials:_____**

**I understand that I am ultimately responsible to pay for all services rendered to me. I agree to the above terms and cancellation policy.**

**I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other health care operations.**

**I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**I have received Sarah Taylor's notice of Privacy Policies.**

| | |
|---|---|
| **Signature:**<br>**(parent/guardian signature if patient is minor)** | **Date:** |