

Sarah Taylor, L.Ac., MTCM  
509 Olive Way Suite 1258  
Seattle, WA 98101  
Phone: 206-257-9343

## PATIENT CONFIDENTIAL INFORMATION

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

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:  
(parent/guardian signature if patient is minor)

Date: