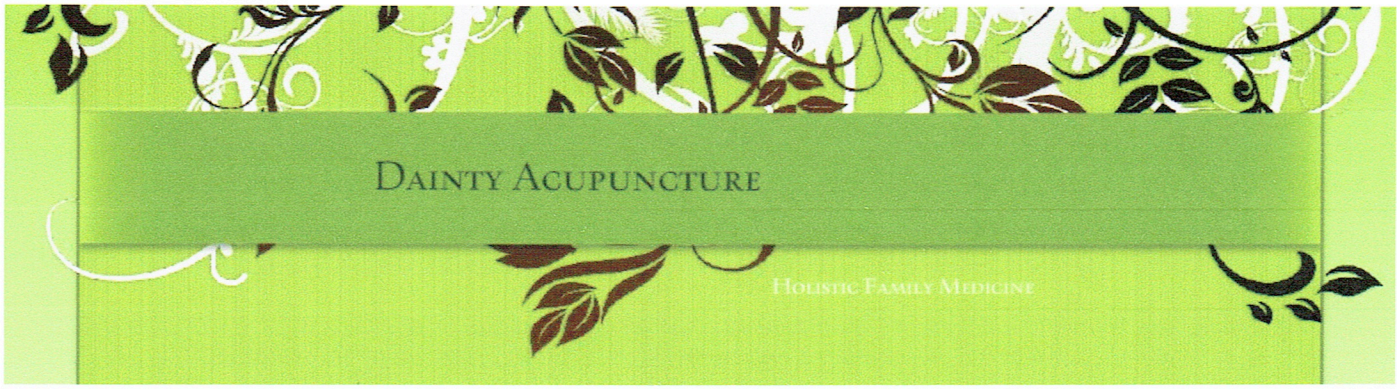


Patient Information

First Name_____ M.I._____ Last Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell _____ Work _____

Email_____ Age_____ DOB_____

Gender M F Occupation_____

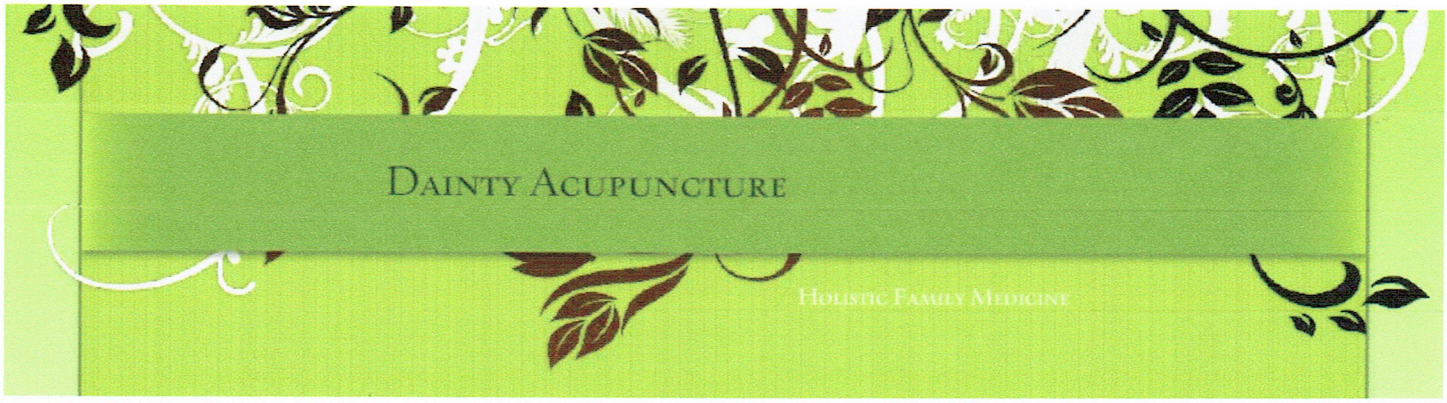
Married ☐ Single ☐ Domestic Partner ☐

Name of Spouse/Partner _____

Emergency Contact _____ Phone Number _____

Referred By _____

2990 S. Sepulveda Blvd., Suite #205 Los Angeles, CA. 90064 ∞ P 310.895.3891 ∞ F 310.496.2717 ∞ shelly@daintyacupuncture.com



Terms and Conditions of Service

Acupuncture Information and Guidelines

Acupuncture is designed to naturally balance, heal, and rejuvenate the body. In order to fully absorb and integrate the benefits of your treatment, avoid strenuous activity or stressful situations for the remainder of the day. Please drink plenty of water after your treatment. Please inform your practitioner of any sensitivities, injuries, or transmittable diseases to ensure your safety, and the safety of your practitioner.

Office Policies

Cancellations and rescheduling of appointments must be done at least 24 hours in advance. You will be charged the full price of your service for any cancellations made less than 24 hours before the scheduled appointment. A bill will be mailed to the address you provided to us. A $25.00 fee will be charged for any returned checks. Returned checks must be replaced by a secured form of payment (credit card or cash). Payment is due when services are rendered. By signing below, you authorize the release of any information necessary to your insurance company in order to process your claim. Should accounts be referred to an attorney or collection agency, attorney's fees and collection expenses incurred shall be payable in addition to the other previous amounts due.

Medical Records

Dainty Acupuncture will not release your records to anyone unless you have signed the "Release of Records" form, or we are instructed to do so by a subpoena or your insurance company. You give Dainty Acupuncture permission to obtain medical records from previous physicians or medical centers.

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

_____

Date

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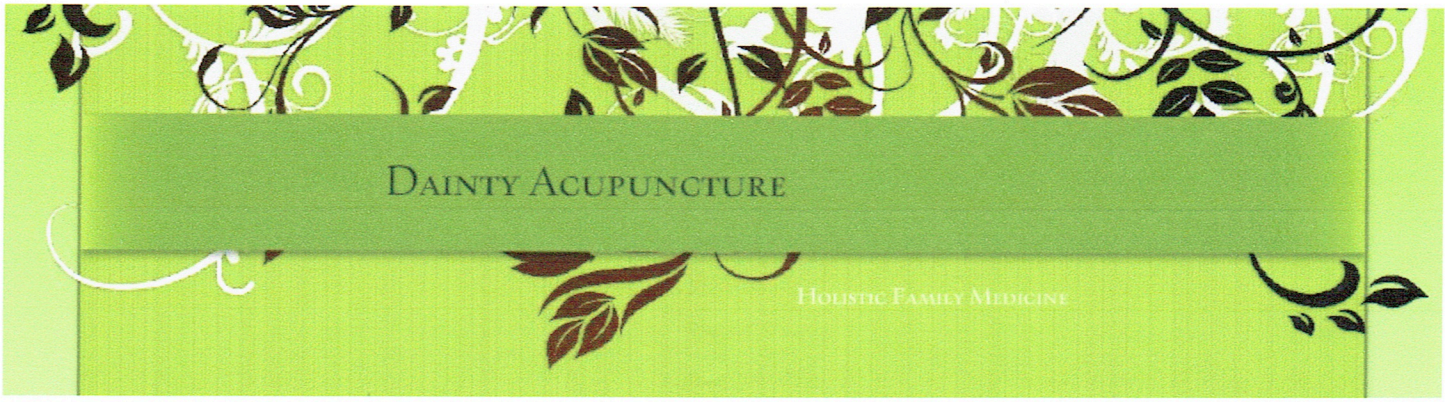

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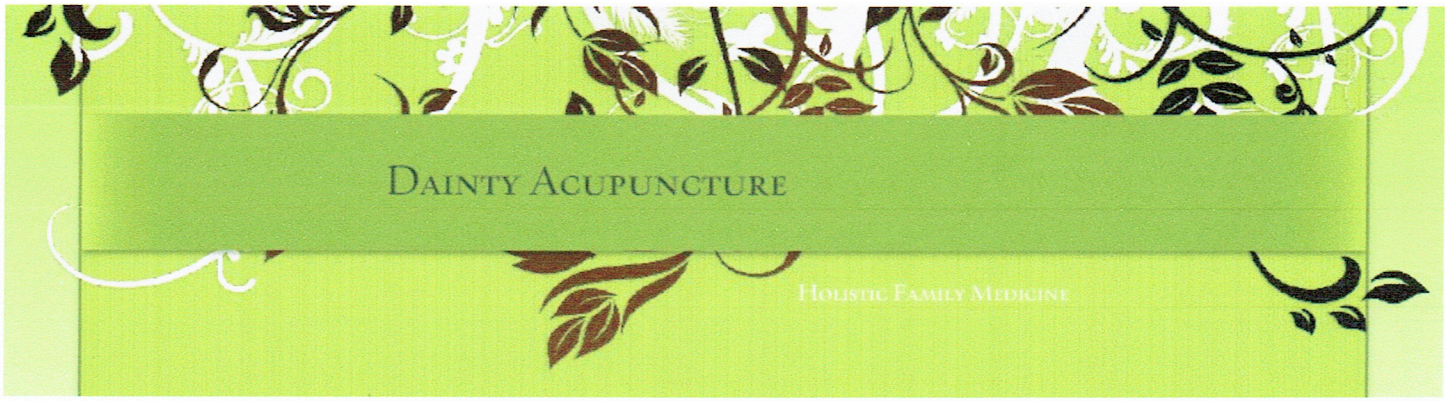

Permission to keep credit card on file

Name_____

C/C #_____

Expiration _____

V-code _____

Address_____

Zip code _____

By signing this form I agree that my credit card may be used to process payments for services rendered without signature, in my absence.

Patient Signiature **Date**

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