



Helen Ye, MS, LAc
 1445 Fillmore Street
 San Francisco, CA 94115

Patient Information

Patient Name _____ Today's Date _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone () _____ Office () _____

Other Phone () _____ Email _____

Birth Date _____ Age _____ Gender _____ Soc. Sec. # _____

Single Married Divorced Widowed Domestic Partnership Other

Referred by _____

Emergency Contact _____ Relationship _____

Phone # (home)() _____ (office or cell)() _____

Physician's Name _____ Phone () _____

Physician's Address _____ Date of last visit _____

Employment Please check all that apply

full-time part-time self-employed student unemployed retired

Occupation _____ Number of hours worked/studied in past week _____

Employer's Name _____ Phone () _____

Employer's Address _____

Partner's Name _____

Partner Employer's Name _____ Phone () _____

Partner Employer's Address _____

Billing and Insurance

Account paid by self other: _____

Primary Insurance _____ Phone () _____

Primary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy # or ID # _____ Group # _____

Policy re: Insurance, Payments & Charges: Please check with your insurance company to ascertain whether acupuncture services are covered under your policy. For insurance purposes, a superbill will be provided for your files. Payment is expected at the time of service. Health care spending accounts cover acupuncture - you can submit a receipt and be reimbursed through your spending account. Missed appointment fees are not covered by insurance. Returned check fee is \$25 per check. Please provide 48 hours notice for cancellations; otherwise, a charge will incur.

I have read and understand the above policy. By signing below, I agree to abide by these policies.

 Patient Signature _____ Date _____

I do not wish to be on the email list to receive newsletters and announcements with health tips and information.