EPIC HEALTHCARE
PATIENT REGISTRATION FORM

NAME_____ DATE OF BIRTH _____

HOME ADDRESS _____

_____

(CITY) (STATE) (ZIP CODE)

PHONE _____

E-MAIL _____MAY WE SEND YOU E-MAIL?_____

EMERGENCY CONTACT _____

Relationship

ADDRESS_____

PHONE _____

NAME OF PRIMARY CARE PHYSICIAN? _____

PHONE _____

HOW DID YOU HEAR ABOUT US?_____

I, the undersigned, certify that I have insurance coverage and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

_____ _____

signature of patient date

KERRI WESTHAUSER, L.AC.

☐ 1330 New Hampshire Ave.
Washington, DC 20036

☐ 8218 Wisconsin Ave., Ste 318
Bethesda, MD 20814

☐ 803 W. Broad St., Ste 720
Falls Church, VA 22046

1-703-231-3930

CONSENT FORM

I do hereby consent to be treated with acupuncture. I understand that acupuncture is performed by the insertion of needles through the skin, with or without the use of electric stimulation, with or without the application of heat (moxibustion, TDP Lamp), and/or other techniques (i.e. cupping, manipulation, alpha stim) at acupuncture points.

I understand that certain side effects may result from treatment. These could include but are not limited to slight bleeding, bruising, or soreness at the insertion site. Fainting is rare but may occur when a patient is highly anxious, extremely fatigued, or hungry.

I understand that there is no guarantee concerning the effect of the treatment provided to me and that I am free to discontinue treatment at any time.

I understand that this form of treatment is not a substitute for western medical treatment and that if I am under a physician for care for a particular ailment or condition, I should continue my care until advised differently from my doctor.

I understand that payment is due at the time of services rendered.

I have carefully read and understand all the preceding and am fully aware of what I am signing.

signature of patient _____ date _____