Healing Traditions LLC, Wendy Mintiero EAMP, LMT
4444 Woodland Park Ave N, Suite 211, Seattle, WA 98103 T:206-504-9547

CONFIDENTIAL CLIENT INFORMATION

Patient Name:________________________ Date:________________________

Address:________________________ Home/cell phone:________________________

City/State/Zip:________________________ Work phone:________________________

Email address:________________________ Date of Birth:________________________

Date of accident/injury/onset:________________ Referred by:________________________

REFERRING PHYSICIAN INFORMATION

Physician name/title:________________________ Phone:________________________

Address:________________________ Fax:________________________

City/State/Zip:____

MEDICAL INSURANCE INFORMATION

Name of Insured:________________________ Policy #:________________________

Date of birth of insured/policy holder:____________ Relationship to insured:________________

Insurance Plan:________________________ Group#:________________________

Ins. Billing Address:____

Phone:________________________ Copay amount:__________

PERSONAL INJURY INFORMATION (if applicable)

Name of insured party:________________________ Claim #:________________________

Insurance plan:________________________ Policy #:________________________

Billing Address:________________________ Phone:________________________

City/State/Zip:________________________ Claim Adjuster:________________________

Name of Attorney:________________________ Phone:________________________

Address:____

1 I am aware that sessions are scheduled for 60 to 90+ minutes, and that time is being held expressly for me. I agree to give my practitioner 24 hours notice if I have to cancel or reschedule an appointment BY PHONE.**If I cancel with less than 24 hours notice or miss an appointment with no call, a fee of $100 will be charged directly to me for that session**.

2 I agree to the release of any medical information my health insurance may need in order to process payment. I assign medical benefits to be paid to Wendy Mintiero/Healing Traditions

2 In the event that my insurance coverage expires or a claim is refused, I understand that I am personally responsible for all fees unless another arrangement has been made. First office call fee: $260. Return office call fee: $175/hr.

3 HIPAA: I give Wendy Mintiero permission to share records and pertinent health information with other qualified healthcare providers for the purpose of benefiting my plan of care.

Patient or guardian Signature:________________________________

Date:________________________________

CONSENT FORM FOR TCM and other Treatments

I, the undersigned, hereby authorize Wendy Mintiero EAMP, to perform the following specific procedures:

Acupuncture: the insertion of special sterilized needles through the skin into underlying tissues at specific points on the body.

Cupping: a technique to relieve symptoms in which cups made of glass are placed on the skin with a vacuum created by heat or other device.

GuaSha: rubbing on an area of the body with a blunt, round instrument.

Moxa: indirect or direct burning on an acupuncture point using stick, string, or ball moxa to relieve symptoms.

Herbs: patent herbal formulas in pill form, medicinal topical liniments or plasters, homeopathic internal remedies, flower essences.

Acutonics: use of sound tools--tuning forks, singing bowls, bells, didgeridoo--on or over acupuncture points and in the body's energy field.

Craniosacral therapy: use of light touch to palpate restrictions in the body's tissues and facilitate their release.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection or blistering at site of procedure; temporary discoloration of skin; nausea, loose bowel movements; abdominal cramping; aggravation of symptoms existing prior to the treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem, and strengthening the constitution.

With this knowledge, I voluntarily consent to the above procedures.
I hereby release Wendy Mintiero EAMP from any liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.
I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

____ __ _____________

Signature of client or guardian Date