

**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: \$285. Return office call fee: \$190/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: \_\_\_\_\_

Wendy Mintiero, Licensed Acupuncturist & Craniosacral Therapist

## 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.

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Signature of client or guardian

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Date