



NANIE CARRILLO
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Patient Information Initial Visit

(Please Print and complete in full)

Name _____ Today's date _____

Address _____

City _____ ZIP _____ Phone _____

Email _____ Birthday _____ Age _____

Referred to our clinic by _____

Emergency Contact _____ Relation _____

Emergency Contact Telephone Numbers _____

Would you like to receive our newsletter via email ? Y N

Employment

Full Time _____ Part Time _____ Retired _____ Unemployed _____ Student _____

Occupation _____ Employer _____

Primary Health Care Source

Physician's Name: _____ Telephone #: _____

Date of last visit: _____ Purpose of visit _____

Purpose for today's Visit _____

Have you ever had an acupuncture treatment? When and for what reason? _____

Financial Information and Agreement

The best care can only be provided on the basis of mutual understanding. I, therefore, encourage you to discuss any financial questions that you have at this time.

Cash, checks and credit cards are accepted for payment. Rates are as follows:

Initial visit is \$125.00, follow-up visits are \$85.00, second and third visits in the same calendar week are \$75.00. Initial visit must be paid in full at time of service.

Please initial:

_____ \$30.00 will be charged for a returned check.

_____ Missed appointments and late cancellations with less than 24 hour notice will be billed at \$70.00.

_____ Unless a specific payment plan is agreed upon and put into writing, I reserve the right to charge interest on unpaid bills. After 3 months of unpaid bills 5% compounded interest will accrue on any owed balance.

_____ I prefer to pay my balance in full at time of service

_____ I prefer to make other payment arrangements prior to services being rendered.

I, (please print) _____ understand that I am financially responsible for all chores incurred and I understand and agree with this policy.

Signature _____ Date _____

Parent or Guardian, Signature _____ Date _____