Jean Donati Acupuncture, LLC
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410-984-3700

New Patient Information

Name _____ Today's Date _____

Street Address _____ Unit _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____

Gender _____ Height _____ Weight _____

Occupation _____ Employer _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** ____/____/____