



J. Douglas Weinstein, M.Ac., L.Ac.

www.LiveWellMedicine.com

jdouglasweinstein@yahoo.com

Hershey, Pennsylvania Office

1106 Cocoa Ave.
Hershey, PA 17033
717-520-1212

Columbia, Maryland Office

7750 Montpelier Road
Laurel, MD 20723
410-794-6186

Dear New Patient,

I want to thank-you for choosing me for your acupuncture needs. I send this letter to serve as both a welcome to you and to help orient you as to what we need in order to best serve you at your first appointment.

Enclosed you will find a patient information form and a cancellation agreement form. Please read these thoroughly, fill in the blanks and bring them with you to your first appointment. On the day of your appointment please refrain from eating anything that will change the color of your tongue (i.e. cherries, hard candy, coffee, grape juice, etc.) several hours before your appointment. Also arrive having had enough in your stomach so that you are not too hungry or too full.

Feel free to call if you need directions to my office, and please arrive on time.
I look forward to meeting you and working with you.

Sincerely,

J. Douglas Weinstein, M.Ac.

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New Patient Information

Welcome to my Acupuncture Practice, Live Well Medicine. Please take a few minutes to read through the following topics that will help to prepare you for your first visit. Also, make sure you print and fill out the appropriate medical forms and bring them with you to the visit. If you have any questions or concerns, we can discuss them at the beginning of your first appointment or you can call the office.

Appointments

If possible, please take the time to schedule your appointments in advance. This will ensure that you receive and retain the time slot that is best for your schedule. If you need to make changes to an already scheduled appointment, please do so as soon as possible. Remember, it is your responsibility to cancel any unwanted appointments. If you are unsure of your appointment, please call the office.

Cancellation Policy

We require **at least 24** hours notice to cancel an appointment. If you have missed or rescheduled an appointment with less than 24 hours notice, you will be responsible for the entire office visit fee. Our cancellation policy is waived for emergencies and acts of nature. We run a very tight schedule, so if you find that you are running late, please give the office a call to avoid making an unnecessary trip. We will, however, do our best accommodate your circumstances.

Payment and Insurance

We accept cash, personal checks, Visa and MasterCard. We ask that you pay at the time of your visit. We will bill your insurance company if you are an insurance client, with acupuncture benefits (Maryland). Our office will check your insurance benefits or you. In Pennsylvania, while acupuncture is generally not covered by insurance, we are always willing to check your benefits before your visit to see if your policy is an exception.

Needles

This office uses sterile, disposable needles.

The Day Of Your Visit

Please make sure you do not eat or drink anything that will stain your tongue for at least an hour before arrival, as we need to examine your tongue. You will be most comfortable if you wear loose, clothing, as acupuncture involves palpation and treatment of various parts of the body. Draping will be provided to ensure modesty. Please refrain from wearing excessive jewelry, as some metals may interfere with the efficacy of the therapy. Also, please refrain from wearing perfume, strongly scented oils and/or lotions on the day of your visit.

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Cancellation Policy Agreement

Dear New Patient,

As you know, cancellations of appointments must take place at least 24 hours prior to the appointment to avoid billing. Because I always have a waiting list, and time slots are very tightly scheduled, a missed appointment is both a loss to me and another person that I might have treated in that time slot. My answering machine takes messages for changes and cancellations, so except for cases of extreme emergencies, you will be billed for the session that you missed.

Please sign and date the form below, to indicate your understanding of this agreement.

Thank you in advance for your consideration.

Douglas

Patient's Name

Patient's Signature

Date Signed

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Informed Consent For Acupuncture And Chinese Medicine Treatment And Care

I hereby request and consent to the performance of acupuncture treatments and other Chinese Medicine procedures, including various modes of physiotherapy, on me by J. Douglas Weinstein, M.Ac., who is a licensed acupuncturist.

I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, Tui-Na (Chinese massage), gua-sha, and nutritional counseling.

I understand that herbs and nutritional supplements are traditionally considered an important and safe part of the practice of Chinese Medicine. I understand that J. Douglas Weinstein, M.Ac., may recommend that I take a Chinese herbal formula(s) and/or nutritional supplements. I will immediately inform J. Douglas Weinstein, M.Ac., if I experience any adverse reaction to the herbs and/or nutritional supplements.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content of the consent, and by signing below I agree to receive the above-named treatments and procedures from J. Douglas Weinstein, M.Ac. I also understand there is always a possibility of an unexpected complication, and I understand that no guarantee can be made concerning the results of the treatments on me by J. Douglas Weinstein, M.Ac. I intend this informed consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from J. Douglas Weinstein, M.Ac.

I understand that it may be necessary for J. Douglas Weinstein, M.Ac. to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives J. Douglas Weinstein, M.Ac. permission to release any medical records for the reasons set forth in this paragraph.

Patient's Name

Patient's Signature

Date Signed