

Mimi Tagher, LAc, LMT 7413 US 42 Suite 3 Florence, Ky 41042

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Social Security: \_\_\_\_\_

How did you hear about me: \_\_\_\_\_

Friend/Family (who): \_\_\_\_\_ Healthcare Provider: \_\_\_\_\_

Internet: \_\_\_\_\_ Yellow Pages: \_\_\_\_\_ Other \_\_\_\_\_

I understand that TCM may affect people on all levels: physical, emotional, mental, and spiritual, because it works within the entire body to restore balance. I understand that the duration of treatment varies person to person, depending on the specific illness and body constitution. I understand that treatment may include the use of acupuncture needles, cupping, mineral heat lamps, herbal formulas (raw and pill form), acupuncture, psychological advice, Chinese massage (Tui Na), electrical stimulation, and diet and nutritional counseling. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. If I have heart problems, have an infectious disease, am taking herbs or any drugs, am pregnant or suspect that I am pregnant, I agree that I will inform the practitioner before beginning the treatment. I understand that slight bruising from cupping or needles is a normal side effect, and that the herbal treatment must be administered as prescribed by the practitioner. I state that I have completed the patient information form completely and accurately, and understand and accept the risks involved in the treatment.

I hereby authorize Mimi Tagher to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by this practice. I direct my insurance carrier and/or its intermediaries to issue payment directly to Mimi Tagher. I am aware of the financial policy of Mimi Tagher and I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I have been advised that all attorney collection fees are my responsibility. A copy of this is as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_