Physician Evaluation Form

(Pursuant to the requirements of 22 TAG §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) ______________________________ am notifying the Licensed Acupuncturist providing treatment of the following:

__ Yes __ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

__ Yes __ No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

__ Chronic pain __ Smoking
addiction __ Weight loss __
Alcoholism Substance abuse

Patient Signature Required____ Date__________

We are not responsible for untrue statements made by patients

I hereby agree to irrevocably release and waive any and all claims and/or liabilities against Spa Reveil, its officers, owner and staff.

HIPPA Acknowledgement and Appointment Reminder Form

I acknowledge that I have been provided access to the "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with whoever answers the phone. Individual practitioners may also use information striped of any personal identifiers for research and educational purposes. By signing this form I am giving my practiontioner and/or staff authorization to contact me with these reminders and to utilize my information for research and educational purposes.

________________________	________________________
Patient Name (print)	Date
________________________	________________________
Patient Signature	Privacy Representative/Date

Authorization for Release of Health Information (Optional)

I, ________________________________, hereby authorize my practitioner and/or staff the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

________________________ ________________________

________________________ ________________________

________________________ ________________________

Patient's Signature Date