

**WASHINGTON STATE ACUPUNCTURE & CHINESE MEDICINE CENTER**  
663 S King St, Seattle WA 98104 Tel (206) 292-9646 Fax (206) 292-9650

**Patient Information Form (please print legibly)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Other names/Maiden Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Parent's Name (minors only): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Contact's Phone #: \_\_\_\_\_  
Emergency Contact is my: (specify relationship) \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

**Acknowledgement of Receipt**

Dr. Raymond Chan and Dr. Salina Chan are required to provide you with a copy of the Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact us at (206) 292-9646.

**I hereby acknowledge that I have received a copy of Dr. Raymond Chan and Dr. Salina Chan's Notice of Privacy Practices.**

**X** \_\_\_\_\_ Date \_\_\_\_\_  
Patient's Signature

**X** \_\_\_\_\_ Date \_\_\_\_\_  
Guardian/Representative's Signature

\_\_\_\_\_  
Relationship to Patient/Representative Authority

**OFFICE USE ONLY**

**Unable to Obtain Acknowledgement**

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: \_\_\_\_\_.

- Patient refused to sign acknowledgement.
- Patient is physically unable to sign acknowledgement.
- Other: \_\_\_\_\_