Kagawa Kampo Clinic
830 Stewart Dr #108, Sunnyvale, CA 94085
Phone: (408) 647-5439

Welcome to Kagawa Kampo Clinic. To help us provide you with the best possible care, please fill out this form as accurately as possible. All the information will be kept confidential.

Name: _____
First Middle Last

Address: _____
Street City State Zip code

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Birth Date: ___ ____ /_____ / _____ Age: _____ Place of Birth: _____
MM DD YY

Marital Status: □ Single □ Married □ Other Sex: □ F □ M

Occupation: _____

In case of emergency, contact: _____
Name Relationship Telephone

How did you hear about us? _____

Do you have Private Insurance? □ Yes □ No

Office Policy:

All fees for medical services are due at the time of visit unless arrangements have been made between Kagawa Kampo Clinic and your insurance company. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company/responsible party are not successful, I will remit the balance due in full upon notification. Please note that all published prices reflect a courtesy discount for cash patients.

Cancellation Policy:

If you need to cancel an appointment, please give us a minimum of 24 hours notice. We assess a cancellation fee for less than 24 hour notification.

- My signature authorizes the Kagawa Kampo Clinic to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese medicinal herbs within the scope of practice granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.
- I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels based upon the facts than known, is in my best interests.
- I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
- I authorize the release of any medical or other information necessary for insurance claim processing, and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.
- I have received the Kagawa Kampo Clinic Notice of Privacy Practices.

Signature: _____ Date: _____
(*Patient, Parent or Guardian*)